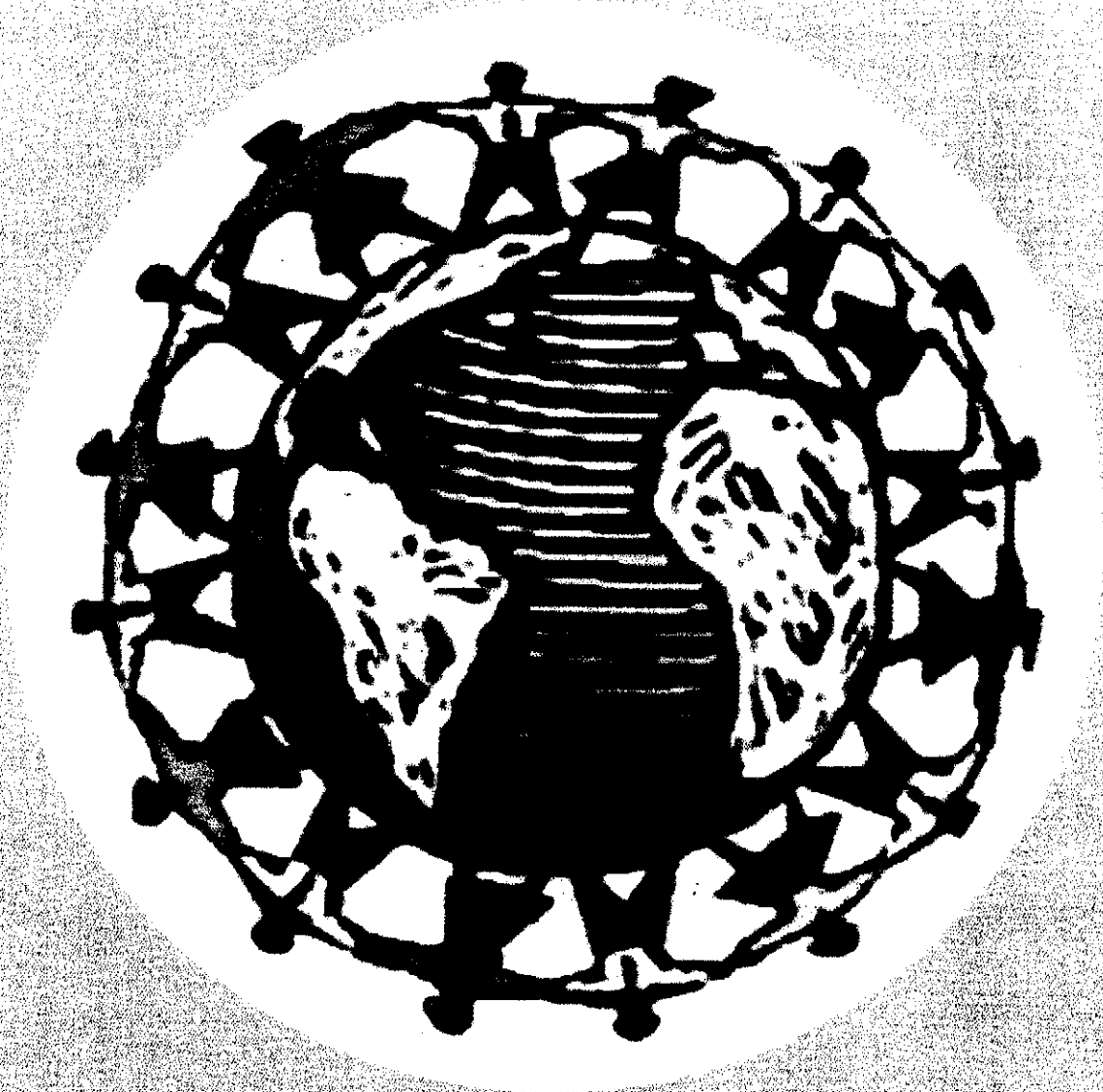


National Sexual Assault Policy



Department of Health

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FOREWORD

Acts of sexual assault have a devastating impact on both those who survive them, and on their caregivers. The relatively high incidence of sexual assault in South Africa at the present time puts significant pressure on the health care system as a whole. The Department of Health has committed itself to ensure that various measures, including intensive training, and the provision of sensitive and useful guidelines, are put in place to enable health professionals to deal humanely and effectively with the survivors of sexual assault. Clearly, this is a major public health challenge.

The first policy guidelines for survivors of sexual assault were compiled in 1998. In the six years that have passed since then, countless workshops and consultations have been held, first to implement the original guidelines and then to monitor their usefulness. We have learned a great deal in this process and have now incorporated what we have learned into this new set of policy guidelines. They will replace the 1998 version.

What makes these policy guidelines particularly valuable is that they incorporate a holistic approach towards the management of sexual assault together with an overall focus on the general improvement of women's health and quality of life. This is completely in keeping with the provisions of the *Convention on the Elimination of All Forms Discrimination Against Women (CEDAW)*, a universal charter that aims to improve the lives of woman everywhere, and that South Africa is a party to. These policy guidelines seek to translate the principles enshrined in CEDAW into action.

We cannot afford to allow a policy document such as this one, to gather dust in a drawer or on a shelf. It is imperative that all health professionals familiarise themselves with its contents and then put the precepts contained in it into practice. In doing so, we will not only be fulfilling our duty as health professionals, but we will, at the same time, be contributing to the holistic repair of the lives of those woman and children who have had the misfortune to suffer sexual assault. Truly, we owe it to each one of them to uphold their dignity and assist in their healing.



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Minister of Health

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Phoenix Assessment and Therapy Center	
South African Gender-based Violence and Health Initiative	
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1. Introduction

Health care for sexual assault patients has been a relatively neglected area of service provision. Substantial gaps in services have been described in many parts of the country (as outlined in section 3.5 below), with repeated reports that the process of health and justice seeking exposes patients to further trauma. These policy guidelines aim to redress past neglect of sexual assault care in the health sector by placing the patient's health needs centrally in service provision.

Sexual assault care in the health sector has to give precedence to the health needs of the patient. This includes immediate and long term psychological support, pregnancy prevention, STI prevention and treatment and HIV counselling and prevention. They also include access to proficient medico-legal examination to gather evidence for the prosecution of cases. The provision of comprehensive sexual assault care with the delivery of the service by trained staff is one of the guiding principles of the policy framework. Sexual assault care providers are therefore challenged to look beyond the medico-legal needs of patients to their mental and physical health needs.

The level of rape reported in community-based surveys is very substantially higher than that reported to the police. This points to major barriers to reporting rape to the police. Such barriers include fear of further trauma, especially lack of confidentiality, stigmatisation and not being believed, fear of retaliation by the perpetrator, and a perception that such reporting would be unlikely to result in punishment of the perpetrator. Research on the magnitude of the problem of sexual assault, recognition of these barriers to reporting cases and the need to increase the likelihood of punishment of sexual assault perpetrators (as outlined in section 3.4 below) have informed the development of this policy.

Contemporary international agreements and a range of national legislation and policies uphold gender equality, people-centred development and health and human rights. The National Sexual Assault policy guidelines were developed in the context of the human and health rights rationales, and are consistent with the political and health service reforms which are now being implemented in the country.

2. Background

2.1 Sexual offences legislation

Sexual crimes in South Africa at present are prosecuted under both common law and statutory law. The common law of South Africa is based on Roman-Dutch principles, which have been modified to a considerable extent by English law, by legislation, and by certain influences from Europe. Sexual crimes prosecuted under common law include rape, sodomy, bestiality, incest, public indecency and indecent assault, while sexual intercourse with minors is prosecuted in terms of the Sexual Offences Act (23 of 1957, as amended). [This will change with the enactment of the Sexual Offences Amendment Act]

Rape as it is currently defined, consists of intentional, unlawful sexual intercourse with a female without her consent. Rape is recognised in marriage in the Family Violence Act of 1993. South African legal practice presumes that a girl or boy under the age of twelve years is incapable of consenting to sexual intercourse. Obviously whether this is the case can be debated but the rule is justified on grounds of public policy. Therefore sexual intercourse with a girl under 12 years is always rape and is prosecuted as such under common law. Sexual intercourse with a girl under the age of 16 years, with her consent, is illegal in terms of the Sexual Offences Act (see below), and without her consent is common law rape.

It is widely recognised that the Sexual Offences Act, Act 23 of 1957, needs substantial revision and the South Africa Law Commission after extensive consultation presented a new Draft Bill to the Minister of Justice in December 2002. This revision recognises people's rights to diversity in sexual preferences but serves to protect people from coerced sexual acts. It is hoped that new sexual offences legislation will be tabled before the end of 2003. The revision of the law will reflect substantially different moral values and judgements from that which have underpinned previous laws. The new developments in legislation are attempting to redefine sexual assault and this informs the definitions used in this document.

2.2 Sexual Assault

The term sexual assault is used in this policy 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, 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. Women and men of all ages may experience rape; it may involve penetration or attempts at penetration of a range of body orifices by a range of body parts or other objects.

2.3 Medico-legal evidence

Whilst the law on sexual assault provides an essential part of the context for understanding sexual assault health care provision, it is important that health workers do not see the legal framework as impinging on their primary professional responsibilities, which are to their patient. Unless the patient decides to report the incident to the police the health worker's role will be confined to that of meeting health needs and providing information. It is not the responsibility of the health worker to determine 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 respect patients' decisions regarding involvement of the police in the case. In the case of children and the elderly, reporting sexual assault to the police is not optional but required by law, in terms of the Child Care Act (74 of 1983) and the Aged Persons Amendment Act (100 of 1998).

None the less, if legal cases are to be pursued medico-legal evidence seems to be critical. South African Police Services and the criminal justice system recognise the importance of medico-legal evidence. A new sexual assault evidence collection kit (SAECK) has been introduced to improve the collection of evidence and all evidence undergoes DNA analysis. South African courts rely very heavily on medico-legal evidence in many cases in supporting the patient's account including the assertion that coercion was used, helping to place the accused at the scene of the assault. The description of the extent of the harm suffered by the patient may influence the sentence. Medico-legal evidence is not strictly necessary in order to achieve a conviction in a sexual assault case but in practice cases rarely go to court without it.

2.4 Standards and Norms for Primary Health Care

In 2000, the National Department of Health brought out a document entitled "The Primary Health Care Package for South Africa -- a set of norms and standards". One of the sections highlights PHC responsibilities with regard to domestic violence and sexual assault. The document recognises the need for inter-departmental and inter-sectoral collaboration in delivering services. The responsibilities outlined in that document include that:

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

- The victim is given brief information about the legal process and the right to lay a charge.
- If the victim now indicates a desire to lay charges the police are called to the clinic.

The document emphasises that all patients should be referred to the next level of care when their needs fall beyond the scope of competence of clinic staff. The document also states that referral is necessary to a trained and accredited health provider. Given the current situation with few providers trained to conduct examinations after sexual assault and domestic violence in most provinces (Webster, 2002), the implementation of the standards and norms at PHC is not feasible. This document seeks to set in place principles and practice that can be implemented by provinces for the delivery of sexual assault services.

The guidelines, outlined in this sexual assault policy document, recognise the need to have trained health providers providing the care for and conducting examinations of patients after sexual assault. It seeks to take account of recent evidence and development in delivering effective and holistic health care after sexual assault. This document would update and replace some of the provisions made in the Standards and Norms Guidelines for Primary Health Care.

3. Current status of sexual assault

3.1 Magnitude of the problem of sexual assault

In the year 2000, 52,550 cases of rape and attempted rape of women were reported to the South Africa police, 21,438 of which were of minors under the age of 18 years and of these 7898 were under the age of 12 years (mostly between 7 and 11 years). Prevalence rates of reported rape varies between provinces. In addition 2,934 cases of indecent assault of men were reported, 1,627 of which were of minors. The highest risk group for sexual assault are teenagers and young women (CIAC 2002).

The rate of rape reported to the police in 1996 was 240 cases per 100 000 women. Research suggests that this represents the tip of the iceberg of sexual assault in the country. A representative community-based survey found that in the 17-48 age group there are 2 070 such incidents per 100 000 women per year (Jewkes & Abrahams 2002). Sexual assault among men has not been the subject of much research and may be equally or more under-reported. It is particularly a problem in prisons.

3.2 Health consequences

Sexual assault can profoundly affect the physical, emotional, mental and social well being of women, men and children. Whilst genital and other bodily injuries often result from the force used in the rape, many patients 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, 37% of rape survivors had evidence of non-genital injury and 38% had evidence of genital injury (Martin 1999). These findings are similar to those from the United States and Canada. Similarly whilst many patients demonstrate very visible signs of distress after sexual assault, some

respond to the trauma with extreme composure or numbness. This should not be interpreted as a sign of lack of impact. It is very important that lack of injuries and lack of overt distress are not interpreted as indications that a sexual assault complaint is unfounded or impact was insignificant.

Irrespective of signs immediately after sexual assault, patients are at risk of a range of medium and long-term health problems. These include pregnancy, sexually transmitted diseases including HIV, urinary tract infections, pregnancy-related problems and mental health problems including depression, post-traumatic stress disorder, sleep difficulties and (attempts at) suicide (WHO forthcoming). Women who have experienced sexual assault have been shown to experience problems related to the assault for many years afterwards, including post-traumatic stress, depression, substance abuse, chronic pelvic pain, and they are at greater risk for a repeated sexual assault than other women. Adult survivors of child sexual abuse have been shown to be at greater long-term risk of substance abuse, mental health problems and unsafe sexual practices than the general population (WHO forthcoming). Victims of sexual violence are also at risk of stigmatisation in their communities. Research on the health impact of men is not available, however rape of boys has been shown to result in very similar mental health consequences as that of women (WHO forthcoming).

Mental health problems, primarily post-traumatic stress disorder, depression and substance abuse are common after rape and have profound social consequences. They may result in dropping out of school or other education, loss of function at work, difficulties in sexual expression and diminish the range of activities which the person feels comfortable doing. The family and raped person's partner often do not cope very well and family units may break down in the aftermath of sexual assault. These issues highlight the need for careful attention to the mental health of patients who have been sexually assaulted and for health workers to have specialised training in their management.

3.3 Causes of sexual violence

Understanding causes of rape is important for prevention. There are many factors increasing the risk of a man becoming sexually violent. Some of these factors are related to the attitudes, beliefs and behaviours of the individuals involved, while others are deeply rooted in the social environment. The different factors have an additive effect, in that the more factors are present the greater the likelihood of sexual violence. Some factors may be more important at different ages than others. These factors both influence the likelihood of rape, but also the social and institutional reaction to it, which in turn may influence its likelihood (WHO 2002).

3.3.1 Factors increasing men's risk of committing rape

- social norms of male superiority and male sexual entitlement
- high levels of all forms of violence in society
- weak sanctions against men who are sexually violent
- social expectations that women are responsible for behaving modestly and controlling their sexuality
- men using alcohol or drugs

- men holding attitudes and beliefs supportive of sexual violence, including coercive sexual fantasies and blaming women for arousing them
- a pattern of behavior that is impulsive, antisocial, and hostile toward women
- associating with sexually aggressive peers including in gangs
- having been sexually abused as a child
- growing up in a family environment characterized by physical violence, little emotional support, and few economic resources
- poverty – linked to perceptions of inadequacy as a man
- weak societal laws and policies related to gender equality and sexual violence

3.3.2 Factors increasing women's vulnerability

Certain groups of women are more vulnerable to sexual assault than others and one aspect of preventive strategies should involve efforts to reduce this vulnerability. Again the more factors a woman has the greater the vulnerability. Risk of male rape is not known beyond generally high risk in prison populations.

- being young
- using alcohol or drugs
- having mental health problems, particularly post-traumatic stress disorder
- being in an intimate relationship, especially one characterized by physical and emotional violence
- where sexual violence is perpetrated by an intimate partner; being more educated and economically empowered increases vulnerability
- poverty, particularly influencing lack of access to private vehicles for transport, less secure housing, the need to collect water and firewood, and vulnerability to risk taking when employment seeking
- shift work
- having more sexual partners
- involvement in sex work
- having previously been raped or sexually abused and not having an opportunity to deal with the vulnerability factors underlying that assault

3.4 Factors influencing reporting cases

Whilst the overwhelming majority of rapes reported by women to the police are perpetrated by strangers or men known by sight, research indicates that women are much more likely to be sexually coerced by an intimate partner than by a stranger (Dunkle 2002). The majority of women experiencing sexual coercion do not currently come forward to health services or the police.

Barriers to reporting cases include not being believed. This is a very important source of further trauma for sexual assault survivors. Others are difficulties with physical access, fear of the examination, fear of being blamed, fear of retaliation by the perpetrator, and fear of the legal processes, including experiencing rudeness and poor treatment. Many women and men are concerned that if they seek care after sexual assault their reputations will be ruined because health workers and facilities do not respect confidentiality.

Many women do not go to the police because they anticipate that ultimately their action will not result in their perpetrator being punished. At present this is the most likely outcome of sexual assault complaints. Police data indicates that in 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 (CIAC 2001).

3.5 Sexual assault services

Until recently, District Surgeons who were employed by the State for this task undertook sexual assault medical examinations. They were usually general practitioners, a few of whom had attended a short course in forensic examination. Some District Surgeons were highly motivated and took a special interest in sexual assault cases, however there were many complaints that they were hurried, disinterested in sexual assault patients, judgmental and insensitive (Human Rights Watch 1997). Patients were usually given very little information about the medical examination, particularly about procedures and how they relate the court process, about pregnancy, HIV/AIDS and the reasons for medication given (Stanton et al., 1997; Francis, 2000). The examination was often cursory and documentation of evidence was poor. Many District Surgeons did not like to attend court because delays in procedures resulted in their being taken away from other work for substantial periods of time. In a given area there were few District Surgeons, which often contributed to women having to wait many hours before being examined.

In response to the problems with the District Surgeon system, it was phased out in most provinces over the period from 1996 to the present time. Sexual assault medical services are currently provided by all doctors in the public health system and can be provided by any private practitioner. The system was revised without taking account of the necessity for formal training or evidence of competence. The overwhelming majority of doctors who currently provide sexual assault care have had no specific training, the quality of examinations and documentation of evidence is still poor, quality of testimony and interpretation of their findings is weak and many of the doctors see few cases each year, which gives little opportunity to become experienced in this area of work. Service delivery is further complicated by the rapid turnover of doctors in the public sector and emigration. Rape patients still often have to wait a long time before getting care, their health needs beyond the medico-legal examination are not well met and the quality of the facilities in which the examination takes place is often poor (Webster et al 2002, Suffla et al 2001, Human Rights Watch 1997). These problems with the current service represent an injustice to the patient. In Northern Cape nurses were trained to do sexual assault examinations in a pilot project, however, deployment of these trained nurses has not been optimal. Other provinces have started training nurses to do sexual assault examinations however, it is still too early to assess whether this cadre of nurse will be appropriately deployed.

One Stop Centre: This is a model of service delivery initiated by the Department of Justice and is often referred to as the Thutuzela model. There are five centres of this nature across the country. These centres were primarily set up to facilitate the legal process and increase convictions of perpetrators of rape. It is an inter-sectoral model that has a coordinator and victim empowerment officer employed by the

Department of Justice located in a designated centre usually within an existing hospital. The health facility usually makes one health care provider available to the service and others are called in as needed. The coordinator usually establishes a relationship with local South African Police Service investigating officers who then respond to the needs of patients and staff at the centre.

4. International and national context

4.1 International agreements and charters

A series of global government conferences, organised by the United Nations in the 1990s, produced an agenda for action for socially equitable, sustainable development for the 21st century. These conferences – including the Convention on the Elimination of all forms of discrimination against Women, CEDAW (1993), the World Conference on Human Rights (Vienna, 1993), the International Conference on population and development, ICPD (Cairo, 1994), and the Fourth World Conference on Women (Beijing 1995) – culminated in a progressive, ambitious agenda for social equality, justice, development and peace.

In September 1998 SADC heads of state or government signed an addendum to the 1997 Declaration on Gender and Development on The Prevention and Eradication of Violence Against Women and Children. The addendum calls for laws such as sexual offences and domestic violence legislation making various forms of violence against women clearly defined crimes, and taking appropriate measures to impose penalties, punishment and other enforcement mechanisms for the prevention and eradication of violence against women and children. They call for the review and reform the criminal laws and procedures applicable to cases of sexual offences, to eliminate gender bias and ensure justice and fairness to both the victim and accused. In addition to the legislative components, the SADC declaration states that health services (as well as police and prosecutorial services) need to be accessible, effective and responsive, they also call for the establishment of specialised units to redress cases of violence against women and children.

4.2 Constitution, national legislation and policies

National commitment to upholding human and sexual rights and access to health care after sexual assault is seen in the Constitution and relevant legislation and policies.

- The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996): enshrines the right of bodily integrity and the right of access to health care:
 - Everyone is equal before the law and has the right to equal protection and benefit of the law. The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. No person may unfairly discriminate directly or indirectly against anyone.’ (*Equality*)

- Everyone has the right to freedom and security of the person, which includes the right to be free from all forms of violence from either private or public sources'
- Everyone has the right to bodily and psychological integrity, which includes the right: to security in and control over the body; and not to be subject to medical and scientific experiences without their informed consent.' (*Freedom and security of the person*)
- Everyone has the right to human dignity and the right to have their dignity respected and protected' (*Human dignity*)
- Everyone has the right to have access to health care services, including reproductive health care; ... no one may be refused emergency medical treatment' (*Health care, food, water and social security*)
- Every child has the right to be protected from maltreatment, neglect, abuse or degradation. The child's best interests are paramount in every matter concerning the child' (*Children*)
- The Child Care Act 1983 (Act No. 74 of 1983) states that:
Minors of 14 years and older may consent to their own medical examination and treatment without the assistance of parents/guardians

In practical terms this means that children of age 14 years and older may approach a health facility after sexual assault and may receive full care including emergency contraception, STI treatment and HIV testing and the facility may not inform the child's parents/guardians of the visit. Girls of 14 years and older may be prescribed any form of medical contraceptive without the assistance or knowledge of their parents/guardians. Children under 14 years of age need the consent of their parents/guardians before being examined or supplied with any medication. Where a child is involved the best interests of the child are paramount in all matters concerning that child.

- The Aged Persons Amendment Act (100 of 1998) provides for the notification of abuse or suspected abuse (including sexual abuse) of an aged person by anyone who examines, attends or deals with an aged person.
- The Prevention of Family Violence Act (133 of 1993) reformed the law in respect of violence between spouses and partners in a "common law" marriage. Prior to the passing of this Act, although persons who committed these acts were criminally liable for their actions, offenders were seldom charged, mainly because family members were reluctant to testify against them. Furthermore, procedures for obtaining court interdicts against offenders were cumbersome and expensive. The Prevention of Family Violence Act, 1993 provides for a simpler, cheaper and more effective procedure. In terms of South African common law it was not possible for a husband to be convicted of the rape of his wife prior to this Act being passed. The Act recognises rape in marriage and provides for conviction for transgression of the Act.

- The Domestic Violence Act, 1998 (Act No 116 of 1998): aims to afford victims of domestic violence the maximum protection from domestic abuse that the law can provide; and to introduce measures which seek to ensure that the relevant organs of the State give full effect to the provisions of the Act, and thereby to convey that the State is committed to the elimination of domestic violence. Under the law, abusers may be arrested without a warrant and dangerous weapons seized. An abuser may be convicted of marital rape even if the parties are married according to civil, religious or customary law.
- The Health Sector Strategic Framework 1999-2004, National Department of Health: contains the following health priorities within its ten point plan to strengthen implementation of efficient, effective and high-quality health services: improving quality of care (through, for instance, the launching of the Patients' Rights Charter); and decreasing morbidity and mortality rates through strategic interventions that relate directly to sexual health such as decreasing the incidence of HIV/AIDS, reducing teenage pregnancy, improving women's health and tackling violence against women and children.
- The Patients' Rights Charter, National Department of Health: directly upholds and promotes the right of access to health care. Other rights of particular relevance to sexual assault services that are contained in the Charter are: confidentiality and privacy of information concerning patients' health and treatment; choice of health services (such as a particular provider or facility) in line with normal ethical standards and prescribed service delivery guidelines; treatment by a named health care provider; and informed consent and decision-making on matters regarding their health problem, proposed treatment and costs involved.
- The Batho Pele ('People First'), 1999, National Department of Public Service and Administration: is the White Paper on transforming public service delivery. The main thrust of the document is the establishment of a culture in which all State employees put the public and customer first and are accountable for the service they give. The framework consists of the following seven principles of public service delivery: consultation; service standards; courtesy; information; openness/transparency; responsiveness; and value for money.
- The Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996): 'promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her beliefs'. A pregnancy may be terminated on the request of the woman during the first 12 weeks of gestation and from the 13th week up to and including the 20th week of the gestational period in a variety of circumstances, including if the pregnancy resulted from rape or incest. Health workers are obliged under the Act to advise women on their right to a Termination of Pregnancy.
- The National Contraception Policy Guidelines, National Department of Health 2002: this seeks to promote sexual and reproductive rights and choices, particularly around the prevention of unwanted pregnancy. The policy seeks to provide high quality contraceptive services within the framework on

comprehensive sexual and reproductive health care, including the prevention and management of STIs/HIV.

- The Youth and Adolescent Policy Guidelines, 2001, Department of Health: states that the elimination of domestic and sexual violence is a priority. Intervention strategies outlined in the policy guidelines emphasise the need for improved access to health services for young people.
- The Transformation of the Health System White Paper, 1997, National Department of Health: the section on health promotion and communication identifies violence as a 'priority problem'. The section on mental health gives the National Department of Health responsibility for 'developing and promoting specific programmes addressing... child abuse, women abuse and the management of victims of violence, in collaboration with other sectors' and community level responsibility for 'development of special programmes addressing aspects of violence within communities, with an emphasis on children and women'. Its objectives include to 'improve counselling services for, and management of victims of attempted suicide, violence and rape'.
- The White Paper on Social Welfare, 1997, National Department of Welfare: this notes strategies for dealing with violence against women including raising national consciousness that abuse of women is unacceptable; provision of a range of support services for women who have been raped and sexual abused including support for immediate and long term trauma and through legal proceedings; and education on women's rights.
- The Population Policy, 1998: towards achieving the goal of human development, the strategies of the policy include:

'promoting the responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the high-risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS, through the provision of life skills, sexuality and gender-sensitivity education, user friendly health services and opportunities for engaging in social and community life.'

5. Framework

5.1 Vision

Our vision is a high quality, coordinated, and holistic sexual assault service, which meets the health needs of the rape survivor, the needs of the criminal justice system for well-presented medico-legal evidence and the needs of the community in contributing to community protection and justice.

5.2 Mission

Our mission is to create an effective, enabling framework to guide the process of developing, implementing and monitoring clinical guidelines, training programmes,

procedures, practices, laws and policies, which serve to deliver an effective service for women, men and children who have been sexually assaulted.

5.3 Goals

The goal of this policy is:

- To improve health care after sexual assault for women, children and men in South Africa.

5.4 Objectives

- To establish an institutional framework within the Department of Health to guide the collaboration and cooperation between different Directorates.
- To establish designated, specialised, accessible, 24 hour health care service for the holistic management of patients to improve health status after sexual assault
- To operate as part of an intersectoral service, establishing and maintaining links with the community and key stakeholders at all levels of government and service provision e.g. Department of Safety and Security, South African Police Services (SAPS), Department of Justice or Department of Social Development and social worker
- To provide training structures, guidelines and standards
- To utilise monitoring and evaluation as a tool to ensure quality of sexual assault services

5.5 Assumptions

The ability of the Department of Health to deliver on these policy guidelines will depend on the support of staff at all levels of the department. A series of assumptions were made in developing the guidelines, including:

- All management levels across all tiers of government in the relevant directorates including Maternal Child Women's Health, AIDS, Mental Health and Gender will support the sexual assault policy and clinical guidelines.
- Directorates and institutions across all tiers of government will budget for and receive the necessary funds for the implementation of the policy.
- Health personnel will participate in training that is outlined through this policy.
- Trained Health Service providers will have access to, and apply, clinical guidelines for the delivery of sexual assault services.
- Patients with special needs will be considered in accessing sexual assault services.
- Communities will support health services.

5.6 Institutional responsibilities

Objective 1: To establish an institutional framework within the Department of Health to guide the collaboration and cooperation between different Directorates.

The Maternal Child Women's Health and Nutrition Cluster is responsible for the overall driving, coordination and management of the implementation of sexual assault services in the National Department of Health. A number of other clusters

and directorates have a role to play in the implementation of this policy. These roles are outlined in the **Table 1** below.

Table 1: Allocation of functions within the National Department of Health

National Department of Health	
Role of Human Resources Cluster	<p>Work studies to identify workload, staff needs including psycho-social support needs</p> <p>To liaise with academic institutions to change the curriculum for undergraduates/staff in basic training and post-basic/post-grad courses in collaboration with the provinces</p> <p>To coordinate and provide training on sexual assault examination,</p> <p>To liaise with the Professional Councils regarding specialised training</p> <p>To ensure the employment assistance program meets the needs of staff experiencing stress from providing sexual assault services</p>
Role of Maternal, Child & Women's Health and Nutrition Cluster	<p>To facilitate and coordinate the implementation of policy and staff development</p> <p>Provide clinical guidelines for the holistic care of sexual assault survivors, including needs of special groups such as children and the elderly</p> <p>Monitor implementation at provincial level and establish indicators for monitoring and evaluation</p> <p>To provide input into training and curriculum development</p> <p>To liaise with laboratory services</p> <p>To work with quality assurance to ensure standards are met and maintained</p>
Role of Gender Focal Point Directorate	- to provide the overall gender framework in which this sexual assault policy is located
Role of HIV/AIDS Cluster	<p>- To assist with the implementation of policy, guidelines and protocols on post-exposure prophylaxis and STI treatment</p> <p>To ensure that sexual violence is addressed in lifeskills programmes</p> <p>To assist the MCHW Directorate to update protocols when indicated</p>
Role of Mental Health Directorate	- To assist in training
Role of Health Promotion	- To raise awareness of sexual violence laws, services, risks and rights
Health Research and Epidemiology Unit	<p>- To commission relevant research that would inform the delivery of sexual assault services</p> <p>- Contribute to the evaluation of the implementation of the sexual assault policy and service delivery including client satisfaction</p>
Hospital Services	- Providing an overall health facility plan
Quality Assurance	- Ensure that quality of services is met and maintained
Communication	- responsible for developing a communication strategy including liaison with the media
Pharmaceutical	- To ensure the availability of drugs on the EDL for the management after sexual assault
Chronic diseases, disabilities and geriatrics directorate	- To ensure that the special needs of older people and disabled people are met

National, provincial and local Departments of Health

Each cluster or directorate of the National Department of Health will work with and support its counterpart at provincial and/or local level to implement these policy guidelines. The need for a new position at provincial level, a Clinical Forensic Medical Officer, has been identified by the National Clinical Forensic Medicine Committee. This position is critical to the implementation of this policy, with its substantial service management, training and supervisory responsibilities.

5.7 Services

Objective 2: To establish designated, specialised, accessible, 24 hour health care services for the holistic management of patients to improve health status after sexual assault

Guiding principles

1. This service seeks to integrate the disparate clinical and forensic service provision for patients who have been sexually assaulted
2. Care for sexual assault patients should be provided in a holistic, survivor-centered framework.
3. No patient should be turned away if they have not reported assault to police or choose not to report sexual assault
4. Non-judgemental provision of services. The allegation is always assumed to be true and the patient is made to feel confident that they are believed, not blamed and treated correctly and with dignity.
5. All patients should be thoroughly informed about medical and legal procedures, services available and legal rights
6. Patient should be encouraged to make their own informed decision regarding reporting the case to the police and that this decision should be respected
7. If the patient decides not to report sexual assault to the police at that time, the examination should be completed, documented and evidence preserved if the patients agrees and consents.
8. Services should be provided at no cost
9. Services for sexual assault patients should be seen as a specialist service and not part of the core package of Primary Health Care.
10. Services should be provided by specialists – both Doctors and Nurses who have completed the required training.

Strategies:

1. Provision of health care after sexual assault:

Patients should be seen promptly when they present at the facility and they should be examined not more than two hours afterwards.
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2. Sexual Assault examination kits should be available at facilities that provide sexual assault services

Having sexual assault examination kits available at the facility would facilitate the patient making their own informed decision regarding reporting the case to

the police. The examination could be completed, documented and evidence preserved even if the patient decides not to report sexual assault to the police at that time. Preservation of evidence is addressed below. Logistics to be agreed upon between SAPS and health services.

3. Providing proper treatment of injuries

Where there are serious injuries, the management of these should take precedence over all other aspects of treatment, however it is important that other health care needs are also met. If the patient is in need of referral to another centre for management of injuries this referral should be organised as it would with any other similarly injured patient. The referring clinician should also consider the need to manage risk of unwanted pregnancy and STIs and document injuries.

4. Ensuring safety and avoiding re-victimisation

When care seeking after the sexual assault, a patient is at risk of further assault from the perpetrator or a person acting on his behalf. Staff need to be aware of these risks and to involve security where appropriate. For this reason, as well as the need to prevent contamination of evidence, it is very important that the perpetrator and victim do not come in contact with each other again. One safety precaution is to ensure that the patient does not have to wait in a public area at any stage whilst she is in the health facility.

5. Preventing unwanted pregnancy

Appropriate emergency contraception should be made available to all women who present after sexual assault as required. Clinical management guidelines will provide guidance on the provision of emergency contraception.

6. Providing post-exposure prophylaxis for HIV

The principles regarding the provision of post-exposure prophylaxis to prevent the transmission are as follows:

- All sexual assault cases should be considered to be high risk.
- The time lapse between exposure and presentation at the health facility should be determined. It is recommended that ARV be administered within 72 hours of exposure.
- HIV testing and counselling should be offered to all patients presenting after sexual assault. It is recommended that giving the patient the results of the HIV test should be delayed where possible and a 3-day starter pack will be given to all patients.
- When patients return after three days an HIV test will be offered to those who did not agree to be tested before. Patients who were tested will receive their results and have post-test counselling.

7. Preventing and treating sexually transmitted infections

Syndromic management of STIs is recommended even though patients may not be symptomatic. (as per standardised guidelines)

8. Preventing and treating psychological distress

Providing a safe and private place in which to examine the patient is an essential first step in preventing psychological distress. Health care workers should respond

in a non-judgemental way. While comforting the patient, there should be clear acknowledgement of the patient's trauma. A skilled examination with due attention to detail will increase the patient's confidence in the system.

9. Providing access to psychological/psychiatric care.

The sexual assault provider should recognise that the patient has experienced a trauma and counsel them appropriately. After the examination they should make appropriate referrals for further counselling with an appropriate health care provider.

10. Medical certificates for sick leave

In making decisions about sick leave the sexual assault care provider needs to consider the psychological impact as well as the physical injuries.

11. On discharging the patient ensure that proper follow-up arrangements are in place

12. Ensuring the integrity of the evidence chain

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 practitioner, 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. The sexual assault kit should be carefully sealed with the seals provided so that the reference number on the seals matches that of the kit. 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 or refrigerator, by a specific person-in-charge and this should be clearly documented in the patient's notes or protocol form.

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. All keys should be carried by named responsible people at all times to prevent any possibility of unauthorised access to the evidence and a register maintained.

13. Clinical management guidelines for health care professionals

Clinical management guidelines for sexual assault patients should be produced in accessible poster format and displayed in each casualty department. They should include the contact details of accredited sexual assault examiners.

14. Provision of information to the patient

Patient information is an important part of sexual assault care. Information may be provided through one to one exchange with a health worker or through the dissemination of appropriate IEC materials. Reading material in an appropriate

language for a sexual assault patient to take home is important 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 care provider. The content of information to patients should include:

- a. What is involved in the examination and the process surrounding it
- b. Health risk after rape and the need for testing and treatment
- c. HIV risks
- d. On treatment regimens and their side effects
- e. Psychological impact and coping strategies
- f. Further support after rape either in the community or through a telephone help-line

Information is needed by the general public on how to access health care services after sexual assault and what to do (and not do). Appropriate ways of reaching the public in general and the local community around a facility should be used, including community radio and work with schools.

15. Documentation of evidence:

a. To provide appropriate and complete documentation of injuries
Documentation of evidence is a very important part of adequate medical care and the medico-legal examination. Sexual assault examiners need to be trained to document completely and precisely history, physical and genital injuries, other forms of evidence and medical treatment. Full details of the case need to be retained in the case notes for further medical management of the patient.

b. Collect forensic evidence in an appropriate and complete manner
Sexual assault care practitioners need to be able to perform correct and complete collection of forensic evidence and use of the evidence kit.

16. Reporting of forensic evidence

The J88 form and clinical notes (case record) should be completed accurately and with attention to detail. Accurate reporting will ensure physical and genital injuries, and other forms of evidence are competently interpreted and this in turn will aid in professional presentation of evidence in court. The J88 form should be carbonised or copied so that a record can be kept in the patient's file along with any records of treatment and laboratory results.

17. Giving evidence in court

Sexual assault care practitioners need to be able to confidently and correctly present their evidence in court and interpret the findings within the parameters of their expertise. Their court performance should be monitored.

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. It is essential that the health care provider prepare their testimony by reviewing all records and notes that they may have made regarding their examination of the rape survivor and the relevant scientific literature. Ideally they should consult with the state prosecutor beforehand. This will enable

them to explain the findings and significance to the prosecutor and help them interpret the evidence.

18. Accreditation of Providers of the service

Provincial Departments of Health should accredit providers of sexual assault care. Accreditation criteria need to be formally established and the Forensic Medical Officer in each Province should undertake the process of accreditation and monitoring performance. Accreditation criteria should include completion of an approved training course, continued in-service training, annual workload and satisfactory performance as demonstrated through monitoring and supervision. For example, specialist provider must examine a minimum of 50 cases per year to ensure that competence is maintained.

19. Provisions of support services for health providers to prevent vicarious trauma

All sexual assault care practitioners are vulnerable to vicarious trauma. Prevention of this can be assisted by keeping the practitioner's workload within established parameters, for example a maximum of 150 cases per year. Paid working time should be available for debriefing. Ensuring that debriefing is available will be the responsibility of the Clinical Forensic Medical Officer.

20. Services have to be supervised, monitored and evaluated on a regular basis.

The Clinical Forensic Medical Officer of each province has responsibility for supervising and monitoring the service. Supervision should ensure that patient's rights and provider's needs are both met. Supervision should include giving on-going support with on-site training to sexual assault care practitioners to enable them to continually improve the quality of the service. It should be supportive and frequent, but adequate response to supervision will be linked to accreditation.

21. Provision of adequate facilities

- Services must have adequate facilities

Facilities should be adequate to protect the privacy and provide security to the patient. The basic minimum should be a room with walls and a door for examinations.

- Service must be available 24 hours per day

All services should be available 24 hours and a sexual assault care practitioner should be available at all times, including at night

- Minimum standards in terms of equipment must be met for a facility to provide a service.

All facilities be properly equipped according to national norms and standards (see Annex A). Equipment should be functioning and adequate and sustained supplies of medications and testing kits should be available at all times.

- Services can be provided at any level of facility as long as the guiding principles and minimum standards are met.

5.8 Inter-sectoral collaboration

Objective 3: To operate as part of an inter-sectoral service, establishing and maintaining links with the community and key stakeholders at all levels of government and service provision e.g. Department of Safety and Security, South African Police Services (SAPS), Department of Justice, Department of Social Development, social workers and NGOs.

Guiding Principles

- Should occur at all levels of the service (from primary service level through to national government)
- Services should be responsive to patient needs
- Services should be responsive to other sectors such as police justice and social development

Strategies:

1. Community-based users accountability group at service level

Each health facility should convene a sexual assault service users accountability group which would include previous patients and representatives from local NGOs or community-based organisations working with rape survivors. The role of the group is to facilitate dialogue between the service and service users, to ensure the service is responsive to the needs to the users and to provide further information and psychological support to sexual assault patients.

2. Feedback mechanism between sectors

All services should establish feedback mechanisms which enable problems and issues to be discussed between the police and criminal justice system, health sector and social workers.

3. Monitoring should be inter-sectoral

Monitoring should include consultation with service users, police and criminal justice system and social work about issues related to the service, the establishment of structures for inter-sectoral dialogue and service responsiveness to problems raised on an on-going basis. Clinical audits should be conducted.

4. At National and Provincial levels there needs to be communication between existing and new committees

Inter-sectoral committees should be established at Provincial levels and at National level to monitor sexual assault services, review evidence of effectiveness and facilitate communication at a policy level. The Clinical Forensic Medical Officer will provide reports to this committee. Collaboration needs to happen between different government sectors as well as between government and independent bodies and civil society. The different sectors involved are presented in **Table 2**.

Table2: Inter-sectoral collaboration between government departments and civil society

Parliament	Government	Independent bodies	Civil society
Portfolio committees of Health, Status of Women, Justice and Constitutional Development, Safety and Security, Social Development and Correctional Services	National and provincial departments of health ↕ Local government authorities ↕ Department of Safety and Security ↕ Department of Justice and constitutional development ↕ Department of Education ↕ Department of Social Development ↕ Department of correctional services ↕ Office on the Status of Women	Human Rights Commission ← South African Law Commission ↔ Commission for Gender Equality	Non-governmental organisations ↔ Academic Institutions Private Sector Research Institutions Medical Aid Schemes
↕ Women's caucus			

5.9 Training

Objective 4: To facilitate and fund a standards generating body (SGB) for training of sexual assault health care practitioners

Guiding principles

1. Sexual assault examination training should eventually form part of a clinical forensic training curriculum
2. No health care practitioner should conduct sexual assault examinations without appropriate and recognised training
3. Training must be undertaken by an accredited training facility or programme prior to practising
4. Training should be ongoing

Strategies

1. NDOH must establish a Standards Generating Body (SGB) to set standards for curriculum and training of sexual assault care practitioners
2. SGB functions would include:
 - a. Setting the standards
 - b. Guidelines for the core curriculum (including clinical components)
 - c. Provide training manuals and quality assurance
3. Each province must provide resources for training and identify and select suitable candidates to be trained. Ideally candidates should be in positions where they are likely to encounter sexual assault survivors;
4. There must be a clinical component to training.
5. Providers should be selected for training according criteria set by the Provincial Task Team.
6. After training providers should be supervised and supported to ensure that they can provide the services for which they have been trained.
7. Training received should be taken into consideration during senior management decision-making regarding staff placements and transfers.

5.10 Monitoring and Evaluation

Objective 5: To utilise monitoring and evaluation as a tool to ensure quality of sexual assault services

Guiding Principles

1. Monitoring should be systematic and structured
2. Monitoring and evaluation should use process and impact indicators
3. Monitoring tools must be developed which will be used in standardised manner in each province

Strategies:

1. The Clinical Forensic Medical Officer in each Province will be responsible for monitoring and evaluation
2. Key national, provincial and local indicators should be identified and appropriate data collected through the most suitable method.

The process indicators will assess the implementation of the policy at all levels of government and at health facilities. The long-term indicators will assess the impact on the health system, health service providers and sexual assault survivors.

3. A health information system will be established or improved to gather data

4. Each facility providing services must keep statistics.

There should be efficient mechanisms such as standardized data collection forms to collate and analyse data at facility, provincial and national levels to enable responsive programming. Mechanisms should include feedback of results to facility level and support for providers to interpret data they collected. Guideline for data collection must be standardized to make data comparable between provinces.

5. Monitoring should include the establishment of systems of clinical audit
The Clinical Forensic Medical Officer will have responsibility for establishing regular and on-going peer review of medical management, medico-legal services and performance in court. The Clinical Forensic Medical Officers in the nine provinces must be audited and have peer review.
6. Auditing tools and Standards of Operating Procedure must be developed for sexual assault health care providers in order to ensure standardised and reproducible audits of sexual assault care providers.
7. Operational research should be conducted using measurable indicators of achievement for various aspects of service delivery and their relationship to medical outcomes and outcomes of sexual assault cases in the criminal justice system.
8. Specific information should be collected on patients who receive anti-retroviral therapy in accordance with the HIV/AIDS Cluster Draft Protocol. This should include: Consent for ARV therapy, use of ARV medications including dosage and duration, adherence to therapy, tolerability of therapy, toxicity to therapy (if any), number of survivors accepting HIV testing, number HIV positive and negative at the initial visit, number of survivors who return for the one-week, 6-week and 3-month visit, the number who stop taking medication due to side-effects or other reasons, severity of side-effects should be evaluated and sero-conversion in survivors using and not using AZT should be documented and data kept in a central registry.

6. GLOSSARY

6.1 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 wilful 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.

6.2 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)

6.3 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. Women and men of all ages may experience sexual assault; it may involve penetration or attempts at penetration of a range of body orifices by a range of body parts or other objects.

6.4 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

6.5 Clinical Examination – examination for the purpose of diagnosis and care of the patient

IEC – Information Education and Communication material provided to patients at the facility. It should contain information about legal rights. Should also provide information on medication and side effects and referral information for support and counselling.

Sexual Assault Care – health care that addresses all the rape survivor's health needs and does not focus on the examination for the collection of evidence only. i.e. Holistic care.

6.6 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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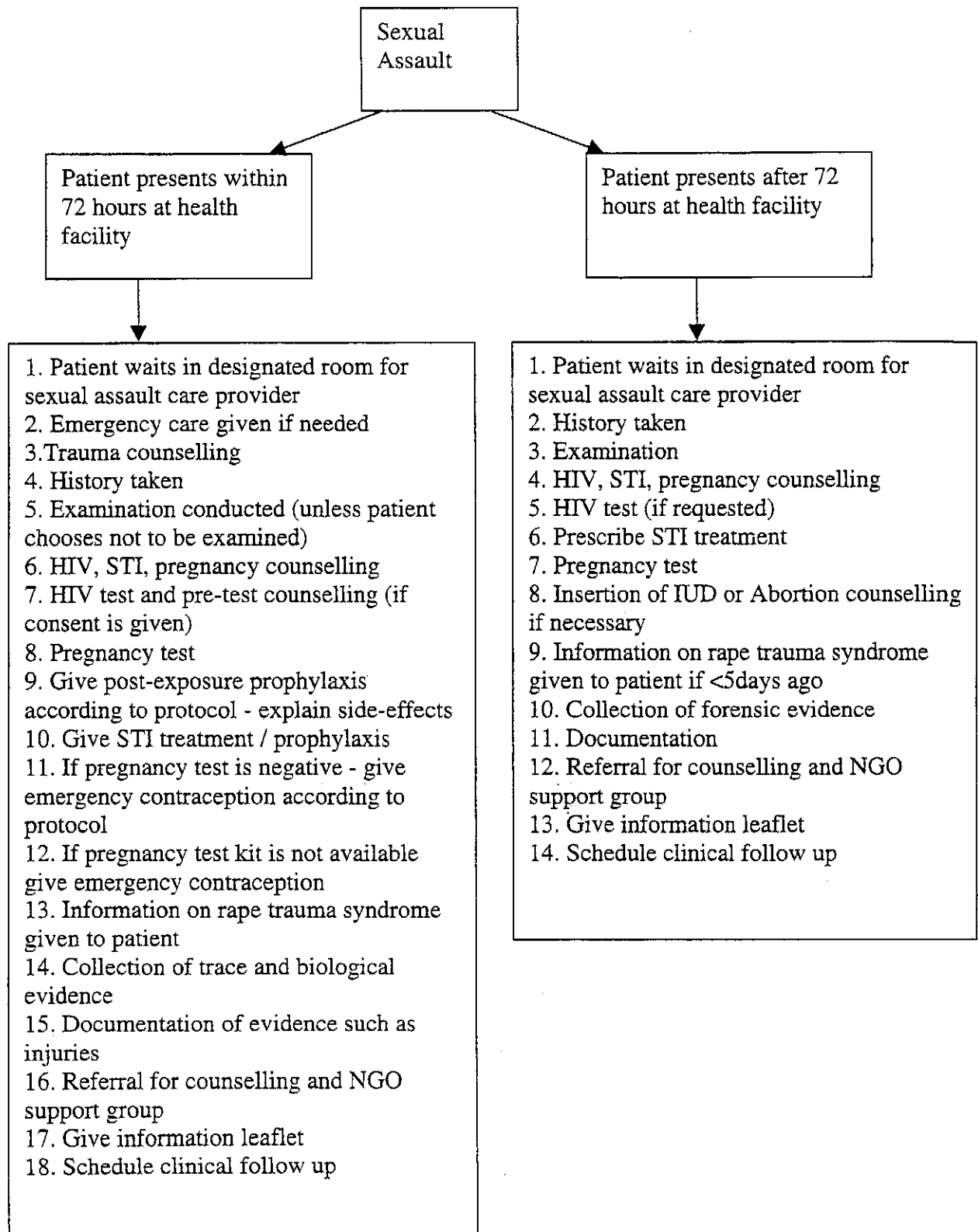
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Appendix A

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



Appendix B

Flow diagram showing the relationship between health services and SAPS

