

# Current approaches to the management of adult survivors of sexual offences

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The adequate management of survivors of sexual offences is vital to ensure that both the healthcare and medicolegal needs of survivors are met. This article provides step-wise guidelines on current approaches to the management of adult survivors of sexual offences, which include the collection of evidence, medical management and treatment.

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Recently, a number of sexual crimes committed in South Africa (SA) raised alarm both locally and internationally. The cases of Anene Booysen<sup>[1]</sup> and Sinxolo Mafevuka<sup>[2]</sup> come to mind, as well as newspaper headings such as ‘Rape victim turned away from hospital’. All of these contribute to the emotional discussions reverberating from these continued crimes, and emphasise the need for the proper management of survivors of sexual offences. Dedicated clinical forensic centres, such as Thuthuzela centres,<sup>[3]</sup> are available across SA; however, in many settings, there are no dedicated service centres, and survivors are seen in provincial day hospitals and emergency departments, among, and competing with, other patients waiting to receive medical care. Often, the attending clinician is an inexperienced junior doctor, who may not have received specific training in the management of survivors of sexual offences.

## Objective

This article aims to provide clear guidelines to the attending clinician when managing adult survivors of alleged sexual offences. These include the dual responsibility of attending to the healthcare and medicolegal needs of the survivor.<sup>[4]</sup>

## Definitions

It is helpful for the clinician to understand the legal definitions of sexual offences, as contained in the Criminal Law (Sexual Offences and Other Related Matters) Amendment Act No. 32 of 2007 (Table 1).<sup>[5]</sup>

However, it is imperative that the clinician should realise that rape is not a medical, but a legal definition and that the clinician can never testify or confirm whether ‘rape’ occurred or not. The clinician can collect evidence and give testimony on what was found during the physical examination, and merely present and explain the objective evidence to court.

It is vital to understand that in many instances no injuries are present, which does not exclude the possibility that forced penetration could have occurred. It is the role of the judge or magistrate to decide, after reviewing all available evidence and testimonies, whether a sexual crime was committed or not.

## Approaches to survivors of alleged sexual offences

Anyone who reports an alleged sexual offence should be attended to in a non-judgemental way, ensuring the best outcome of the medicolegal investigation, while preventing secondary trauma. Survivors should be advised how to preserve DNA evidence prior to examination, especially if they are transferred to be seen, or while awaiting examination (Table 2).

**Table 2. General comments for survivors with regard to DNA evidence collection**

- Advise the survivor not to wash/change clothing. In cases where the clothes and underwear were changed, these garments can be brought to the healthcare facility for possible collection if they have not been washed
- Survivors should be encouraged to hand over contaminated clothing, condoms, bedsheets, etc. from the crime scene to the investigating officers
- Avoid eating, smoking, drinking, chewing bubblegum and brushing teeth where oral penetration has taken place
- Avoid defecation, if possible
- Avoid wiping the vulva after urination in case there is an urge. The nursing staff should be reminded to tell the patient that toilet paper should not be used to wipe the vulva after the patient has given a urine sample for pregnancy testing

**Table 1. Legal definitions**

Genital organs	Includes the whole or part of the male and female genital organs, and includes surgically constructed or reconstructed genital organs
Sexual penetration	Any act which causes penetration to any extent whatsoever by: <ul style="list-style-type: none"><li>• The genital organs of one person into or beyond the genital organs, anus, or mouth of another person</li><li>• Any other part of the body of one person, or any object, including any part of the body of the animal, into or beyond the genital organs or anus of another person</li><li>• The genital organs of an animal, into or beyond the mouth of another person</li></ul>
Rape	Any person (A) who unlawfully and intentionally commits an act of sexual penetration with a complainant (B), without the consent of B, is guilty of the offence of rape

### Different scenarios

A survivor may present to a healthcare facility under various circumstances, and management should be guided by the presenting history and wishes of the survivor.

In most cases, a survivor will report to a police station first, in which case a detective from the Family Violence, Child Protection and Sexual Offences (FCS) unit of the SA Police Service (SAPS) should be contacted. The detective should assist the survivor to open a case and arrange examination and evidence collection, if applicable, at the relevant healthcare facility. The examination and evidence collection are time sensitive, with a general cut-off of 120 hours since the time of the alleged incident for the evidence collection, and 72 hours for the provision of post-exposure prophylaxis against HIV.

### General comments

A mentally competent adult survivor has a choice to lay a charge with the police or not. If the survivor wishes to lay a charge, but reports to a healthcare facility first, the attending clinician should contact SAPS/FCS to request an officer to attend to the survivor at the healthcare facility. This avoids sending the survivor back to the police station first to report the incident.

The Independent Police Investigative Directorate (IPID) should be contacted should the alleged perpetrator be a police official.

The SAPS/IPID official has to supply the relevant medicolegal documentation (SAP 308 form, Affidavit 212 form), the J88 form, and sealed, unopened sexual assault evidence collection kit(s) (SAECK(s)).

### Survivor presents with severe injuries

If a survivor is admitted with severe injuries or is in a serious medical condition, the following guidelines apply:

- Forensic examination and evidence collection should be done only after stabilisation of the patient's condition.
- If a survivor has to be referred to the next level of care, ensure that the necessary information (such as forensic evidence that has not been collected yet) is communicated to the next facility and advise that, where possible, the survivor must not be bathed/washed prior to evidence collection.
- Collect any removed clothes/items from the scene that may be with the survivor, and hand these over to the investigating officer, or keep these in a safe and locked cupboard until collected by the investigating officer.

### Survivor presents ≤120 hours after the alleged incident and wishes to lay a charge with the police

Give the case priority as an emergency, and attend to the survivor as soon as reasonably possible. Provide the survivor with the necessary privacy. The clinician is responsible for the following:

**Step 1.** Arrange containment counselling if available. Prepare the patient and obtain informed consent to proceed with the examination and evidence collection (SAP 308 form and consent form inside the evidence collection kit to be signed by the complainant/guardian, investigating officer and clinician).

**Step 2.** Take a detailed history, following the information requested on the J88 form, and add clinical notes in the hospital folder.

**Step 3.** Conduct a medical examination and collect evidence (guided by the details of the sexual offence) in the presence of a chaperone, who is preferably of the same sex as the survivor (more details on evidence collection are given below). If available and applicable, arrange or perform photographic recording of injuries.

**Step 4.** Carefully document findings in an objective and understandable manner on the J88 form, and sign and complete the Affidavit 212 form. Take care to describe the injuries, using accurate wound terminology.

**Step 5.** Perform medical tests (see Medical management below).

**Step 6.** Provide medical treatment (see Medical management below).

**Step 7.** Arrange follow-up visits at the appropriate healthcare facility, as indicated, at 1 week, 6 weeks and 3 months.

**Step 8.** Offer the survivor a comfort pack (if available) and bath/shower if facilities are available.

**Step 9.** Hand over the completed medicolegal documentation (original) to the investigating officer and keep copies in the survivor's file, in a secure location as per local facility arrangement.

### Survivor presents >120 hours after the alleged incident and wishes to lay a charge with the police

The same steps are to be followed as above, except:

- There should be no collection of evidence (except in the case of termination of pregnancy after alleged rape, where the products of conception should be retained for DNA analysis, using the appropriate Tissue Collection Kit to be provided by the FCS unit).
- HIV prophylaxis is prescribed up to 72 hours after the alleged incident.
- Emergency contraception should be provided, if indicated, up to 120 hours after the alleged incident.

### Survivor does not wish to lay a charge with the police, but requests medical advice and treatment

A survivor does not forfeit her/his right to medical advice and treatment when no case is opened with the police.<sup>[6]</sup> Explain to the survivor that it may be of value to proceed with evidence collection if within the 120-hour period after the alleged incident in case s/he changes her/his mind about laying a charge. Obtain informed consent and proceed with the procedure in the same order as before, according to the time passed since the alleged incident. If the survivor consents, evidence may be collected (SAECK obtained from the FCS unit) and kept at the healthcare facility in a locked cupboard for 30 days in case the survivor changes her/his mind. Document your findings carefully in the survivor's clinical notes.

### Evidence collection

Evidence collection is to be guided by the history and details of the alleged sexual offence. SAECKs are provided by the investigating officer. Never accept SAECKs if the seals are broken or any evidence of tampering is evident, and maintain the chain of evidence.

Previously, a single box that contained all the various steps/packages for forensic evidence collection was provided. This has been changed to separate evidence collection kits, which are to be used according to the type of assault.<sup>[7]</sup>

Consider the detailed history of the sexual assault and request the necessary and appropriate kits before starting with your examination of the survivor and evidence collection (Table 3).

### Medical management

The medical management, similar to the evidence collection, is guided by the presenting history and the time elapsed since the alleged incident.

### Investigations

The following investigations should be performed:

- pre- and post-HIV-test counselling and a rapid HIV test
- baseline rapid plasma reagin (RPR) test (for syphilis)
- urine pregnancy test
- further testing for sexually transmitted infections (STIs), if indicated
- screening for hepatitis B if the immunisation status of the individual is unknown.

**Table 3. Evidence collection\***<sup>[7]</sup>

In most cases, samples are only collected from the genital area of the survivor	Collect when indicated by the type of rape/sexual assault	Collect reference specimens for DNA analysis and to compare hair samples	Collect, if present
Swabs are usually collected from the external genitalia (vulva/scrotum); vagina/penile shaft and glans; or peri-anal area (D1 or D7)	Anorectal (D1) Oral (D2) Any area with body fluids (D2)	Blood (D2) Pulled pubic hair (D3) Pulled head hair (D3) Buccal sample (DB)	Underwear, clothing (D1, D5) Fingernail debris (D2) Sanitary pad/tampon (D1) Loose pubic hair (D3) Loose head hair (D3) Debris (D2) Condoms Wipes/towels if used after the incident

D1 = adult SAECK; D7 = use this kit if the survivor is <12 years of age.  
\*Numbers and letters in brackets refer to the relevant evidence collection kits.

**Table 4. Prophylaxis and medication**<sup>[8]</sup>

Prophylaxis	Medication
STI prophylaxis (provide within 72 hours after the alleged incident if there is a history or signs of penetration)	Ceftriaxone 250 mg intramuscularly as a single dose, metronidazole 2 g orally as a single dose, and azithromycin 1 g orally as a single dose
Antiretroviral prophylaxis (provide within 72 hours after the alleged incident)	Rapid HIV test non-reactive Tenofovir 300 mg + emtricitabine 200 mg: 1 tablet once a day for 28 days OR Zidovudine 300 mg + lamivudine 150 mg: 1 tablet 12-hourly for 28 days AND Add a protease inhibitor in all cases Lopinavir/ritonavir 200/50 mg: 2 tablets 12-hourly for 28 days OR Atazanavir/ritonavir 300/100 mg daily Note: Give the first dose of antiretroviral medication as soon as possible General comments Tenofovir is contraindicated in renal disease or with concomitant use of nephrotoxic medicines, e.g. aminoglycosides (check baseline creatinine clearance first if this is to be prescribed) Where tenofovir is contraindicated, switch to the second choice If zidovudine is not tolerated, consult or refer to a specialist HIV clinic for further management Lopinavir/ritonavir often causes diarrhoea. If lopinavir/ritonavir is not tolerated, switch to atazanavir/ritonavir If the perpetrator is known to be HIV-positive, consult an HIV specialist for advice on post-exposure prophylaxis, or phone the HIV hotline for advice: 0800 212 506 HIV test reactive (confirmed) Refer for counselling and HIV care and management at the closest appropriate healthcare facility
Emergency contraception (provide as soon as possible and not >120 hours after the alleged incident)	Emergency contraceptive pills <sup>[9]</sup> First choice: Escapelle (levonorgestrel 1.5 mg) 1 tablet orally as a single dose, or, if not available, Ovral (ethinyl oestradiol and norgestrel) 2 tablets stat and 2 tablets 12 hours later, or Norlevo (levonorgestrel) 2 tablets stat Add an anti-emetic and repeat dose if vomiting occurs within 2 hours after ingestion of medication For women already using enzyme-inducing drugs, including antiretrovirals; or within 30 days of discontinuing them, the dose should be increased by 50%, e.g. Escapelle 2 tablets stat or Norlevo 3 tablets stat or Ovral 3 tablets stat and 3 tablets 12 hours later Copper-bearing intrauterine contraceptive device Alternative option to emergency contraceptive pills
Other	Anti-emetic medication Metoclopramide 10 mg orally, 8-hourly; take 30 minutes before a meal Simple analgesics If necessary and no contraindications exist (paracetamol 500 mg orally, or ibuprofen 200 mg orally with or after a meal)

### Treatment

Treat all acute injuries evident on presentation, and provide antitetanus toxoid 0.5 mL intramuscularly if: (i) open wounds are present; (ii) the last vaccination was >10 years ago; or (iii) the vaccination status is unknown. Treat any other physical injuries as appropriate, or refer for further treatment if indicated. Treat established complications, such as infections or pregnancy, as applicable.

### Prophylaxis and medication

Information on prophylaxis and medication is given in Table 4.

### Follow-up visits

Document whether the survivor experiences any post-traumatic stress syndrome symptoms at each visit, and give advice regarding medication and blood results. Ensure that arrangements for counselling are in place. A repeat examination is only required if there was significant injury, and documentation regarding healing is required. Follow up blood results on hepatitis B serology (if this was indicated) and manage accordingly. Repeat the HIV and RPR tests at 6 weeks and 3 months. Enquire about menstruation and a repeat pregnancy test, if indicated, at 6 weeks and 3 months. Treat STIs if indicated. If the survivor became pregnant as a result of rape, and wishes to terminate the pregnancy, she should be referred to an

appropriate facility for a safe termination of pregnancy as soon as possible.

### Conclusion

As the prevalence of rape and sexual assault in SA is vast, clinicians can expect to be faced with providing relevant care for survivors of alleged sexual offences in an array of clinical settings. Meticulous and appropriate management of these survivors is paramount to assist their healing and the best possible judicial outcomes.

1. Eyewitness News. 2013. <http://ewn.co.za/2013/10/31/The-Anene-Booyesen-Stor> (accessed 12 April 2016).
2. News24. 2016. <http://www.news24.com/SouthAfrica/News/family-of-murdered-teen-sinoxolo-angry-with-cops-20160.11> (accessed 12 April 2016).
3. The National Prosecuting Authority of South Africa. 2016. <https://www.npa.gov.za/node/4> (accessed 10 April 2016).
4. Jina R, Jewkes R, Munjanja SP, et al. Report of the FIGO Working Group on Sexual Violence/HIV: Guidelines for the management of female survivors of sexual assault. *Int J Gynaecol Obstet* 2010;109(2):85-92. DOI:10.1016/j.ijgo.2010.02.001
5. South Africa. Criminal Law (Sexual Offences and Other Related Matters) Amendment Act No. 32 of 2007. <http://www.justice.gov.za/legislation/acts/2007-032.pdf> (accessed 8 April 2016).
6. South Africa. National Health Act of 2003. Regulations: Rendering of clinical forensic services. Government Gazette No. 33655, 2010. (Published under Government Notice R929.) [http://www.gov.za/sites/www.gov.za/files/33655\\_929.pdf](http://www.gov.za/sites/www.gov.za/files/33655_929.pdf) (accessed 22 April 2016).
7. Manta Forensic. 2016. Collection kits. [http://www.mantakits.co.za/?page\\_id=3753](http://www.mantakits.co.za/?page_id=3753) (accessed 11 April 2016).
8. National Department of Health. Standard Treatment Guidelines and Essential Medicines List for South Africa – Primary Health Care Level. 5th ed. Pretoria: NDoH, 2014.
9. Western Cape Government. Circular H33/2016. Provincial Contraceptive Guidelines. Cape Town, DoH, 2016.