South African Medical Journal
First published January 1884
April 2013, Vol. 103, No. 4 SAMJ

Rape in South Africa – a call to action

The recent public outcry over the brutal rapes and murders in New Delhi, India, and in the Western Cape, South Africa (SA), has rudely awakened civil society from apathy to shock about what is regarded as a common violent act against women and children, but is often ignored. The United Nations High Commissioner for Human Rights, Dr Navanethem Pillay, herself a South African, has made an impassioned plea to all members of civil society, including key role-players such as members of the criminal justice and healthcare systems, to be vigilant and mindful of their key responsibilities in protecting women and children against such violence.

SA has one of the highest incidences of rape in the world. In 2009, 68 332 cases of rape were reported to the South African Police Services (SAPS). SAPS statistics suggest that someone is raped every 35 seconds,[1] but according to the National Institute for Crime Prevention and Rehabilitation (NICRO) only one in 20 rape cases is reported to the SAPS. Barriers to reporting the crime of sexual assault are a lack of faith in the criminal justice system and the medical services, and the secondary trauma sometimes suffered by survivors at the hands of the SAPS and health services.[2,3]

Rape is one of the most devastating of personal traumas. Victims' lives have been shattered and sometimes lost, as in the recent cases referred to above, and their psychological and physical privacy invaded. Survivors experience feelings of shock, disbelief, numbness, fear, anger, guilt, self-blame, sadness and sometimes elation, and behavioural changes such as withdrawal, sleep disturbances, hypervigilance, mood swings and poor concentration; lifestyle changes and avoidance are common. The emotional scars take months, and sometimes years, to heal.[2]

The majority of rapists are known to the victim; relatives of victims comprise 21% of sexual offenders.[3] Schoolteachers are the most common child rapists and are responsible for 33% of rapes of minors.[3] And, just when they most need support, many rape survivors feel alone and let down by loved ones, friends, and the institutions that ostensibly exist to protect them.[4]

My experience working in the four rape crisis centres (CCs) in the eThekwini Health District (at Addington, Prince Mshiyeni Mission and Mahatma Gandhi hospitals and the Pinetown District Surgeon's Office) has shown that despite systematic reforms in health policy, there has been no significant change in the quality of services offered to rape survivors. Over the period 2002 - 2010, there was a 43% increase in the numbers of rapes reported at these CCs.

Outside of these CCs, the other healthcare facilities in the Durban region do not provide a dedicated service to survivors of rape. This reality constitutes an immediate barrier to reporting rape, the survivor choosing not to do so for fear of being turned away from a healthcare institution not equipped to 'handle' rape survivors, or being referred to one of the CCs, necessitating transport in a police vehicle which, in turn, entails a considerable time delay or worse. A further barrier to receiving care is that medical staff operate under the misapprehension that all rape survivors must first lay a charge with the SAPS and thereafter be referred to the 'district surgeon'. The police, if the first point of contact is with the criminal justice system, are often uninformed and unsympathetic.[5] Despite recent efforts to improve the system, a woman complaining of rape may have no choice but to give a statement to an untrained and unsympathetic male officer, within the hearing of others waiting for attention.[5]

Even in facilities dedicated to the management of rape survivors, there are several problems. Reform efforts have not been consistently applied across all health districts, and there is a serious scarcity of human and financial resources and a lack of appropriate training and clinical competence in clinical forensic medicine, all compounded by staff apathy, resistance and non-adherence to protocols.

While it deserves to be stated that post-apartheid SA has made great strides in providing primary healthcare services, despite our legacy of apartheid with the distortions it created in healthcare funding and provisioning, the truth is that basic medico-legal services have lagged behind.

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007[6] (the Act) has direct relevance for health practitioners. The Act deals extensively with the commercial sexual exploitation of children, changes the legal definition of rape and sexual assault, sets down what services ought to be available for survivors of sexual assault, and deals with compulsory testing of alleged perpetrators of rape. Under the Act, the term 'sexual assault' is used to encompass a range of acts involving unlawful sexual penetration or attempts at 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 a person, into the anus, mouth or genital organs of another person. Hence, women and men of all ages may experience sexual assault that may involve penetration or attempts at penetration of a range of body orifices by a range of body parts or other objects.[6]

Sexual assault policies in SA have undergone radical change. The National Sexual Assault Policy 2005 (National Policy)[7] and Management Guidelines for Sexual Assault Care[8] identify strategies to achieve provision of healthcare immediately after sexual assault, collection of evidence using the sexual assault evidence collection kit and documentation of evidence in the prescribed J88 form, post-exposure prophylaxis, and ongoing psychological counselling and care. The National Policy also provides guidelines for healthcare professionals and the provision of an adequate 24-hour service[7] for the clinical management of sexual assault. The HIV & AIDS and STI National Strategic Plan 2007 - 2011[9] (objective 2,9) further buttresses the provisions under the National Policy.

Rape is a violent crime and must be regarded as a medical emergency; survivors are often physically assaulted, with resultant head injuries, fractures, drug intoxication, penetrating organ injuries, etc. Doctors at primary healthcare level are reluctant to engage in medico-legal work owing to lack of expertise and training and the time constraints imposed by an already high workload.[4] Yet medical personnel have a statutory duty to provide emergency care to rape survivors, as required by the Constitution[10] and the National Health Act[11] and an ethical duty of care stipulated by the HPCSA.[12]

CCs should be established as a priority at *all* district hospitals to serve as the first port of call for survivors of sexual assault. Such facilities must be purpose-designed to cater for the victims of sexual abuse, including child sex abuse,[7-9] and ensure privacy and

confidentiality. They must operate on a 24-hour basis as one-stop multidisciplinary services to offer the victim(s) medical care by competent, trained and empathic medical and nursing staff, an SAPS desk for reporting the assault, and wash facilities. Psychological and social support should be available, at least on a referral basis.

An effective medico-legal system is needed if SA is to fulfil its responsibilities to protect the human rights of its women and children under international law.[13] Prevention of sexual violence requires responses that extend well beyond, but clearly encompass, the health sector. Health professionals have a crucial role to play in ensuring that health services meet the needs of the survivor.

K Naidoo
Department of Family Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban
naidook@ukzn.ac.za

1. South African Police Services. The crime situation in South Africa 2009-2010. http://www.saps.gov.za/statistics/reports/crimestats/2010/totals.pdf (accessed 17 December 2010).
2. Robertson M. An overview of rape in South Africa. Centre for the Study of Violence and Reconciliation. http://www.csvr.org.za/articles/artrapem.htm (accessed 9 September 2011).
3. Jewkes R, Levin J, Mbananga N, Bradshaw D. Rape of girls in South Africa. Lancet 2002;359(9303):319-230. [http://dx.doi.org/10.1016/S0277-9536(01)00242-8]
4. Suffla S, Seedat M, Nascimento A. Evaluation of medico-legal services in Gauteng: Implications for the development of best practices in the after-care of rape survivors. Johannesburg: UNISA Institute for Social and Health Sciences and Centre for Peace Action and MRC-Unisa Crime, Violence and Injury Lead Programme, 2001.
5. Human Rights Watch. South Africa: Violence against women and the medico-legal system (HRW report A904). 1997. http://www.hrw.org/news/1997/08/07/south-africa-medico-legal-system-fails-women-victims-violence (accessed 29 October 2012).
6. Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007.
7. National Sexual Assault Policy of 2005. http://www.tlac.org.za/content/view200/81 (accessed 9 September 2011).
8. National Department of Health. The primary health care package for South Africa – a set of norms and standards. Victims of sexual abuse, domestic violence and gender violence. http://www.doh.gov.za/docs/policy/norms/part1y.html (accessed 9 September 2011).
9. HIV & AIDS and STI National Strategic Plan 2007 - 2011. http://www/info.gov.za/otherdocs/2007/aidsplan2007/index.html (accessed 17 December 2010).
10. Constitution of the Republic of South Africa Act 108 of 1996.
11. National Health Act 61 of 2003.
12. Health Professions Council of South Africa. Health Professions Act: Ethical Rules of Conduct. www.info.gov.za/gazette/regulation/2008/30952_390.pdf (accessed 17 December 2010).
13. Convention on the Elimination of All Forms of Discrimination against Women. 1981. http://www.un.org/womenwatch/daw/cedaw/ (accessed 17 December 2010).

S Afr Med J 2013;103(4):210-211. DOI:10.7196/SAMJ.6802