The management of sexual assault victims at Odi District Hospital in the North-West Province: How can the quality of hospital care be improved?

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Abstract

Background: This six-month study at Odi Hospital in the district of Mabopane in the North-West Province was undertaken to gain insight into the way in which alleged sexual assault victims experienced the treatment they received from doctors, nurses and others and how the quality of the care they received can be improved.

Methods: Design: A descriptive cross-sectional survey was conducted using a questionnaire as well as interviews and focus group discussions.

Setting: Odi District Hospital in the North-West Province, South Africa.

Subjects: The subjects of the study were the patients who presented at Odi Hospital for alleged sexual assault between 1 March and 31 August 2001. A nurse or medical doctor completed a questionnaire for each patient. In addition, individual and focus group interviews were conducted with 20 rape victims, three rape crisis counsellors, nursing staff and doctors working in the casualty department.

Results: A total of 213 patients presenting at Odi Hospital during the research period formed the sample group of this study. This group consisted of one male (a four-year-old child) and 212 female patients. The majority were black (211) as only two were coloured people. The ages of the victims ranged from two to 70 years. The highest percentage of victims was in the age group 16 to 20 years (25.4%), followed by the age group 11 to 15 years (16.4%) and 21 to 25 years (14.1%). A total of 68.2% of the assailants were known to their victims. The assailants' estimated age ranged from 15 to 50 years, and in almost 80% of the cases they operated on their own. Most rapes took place in the victims' homes (36.2%) and visible lesions were found only in 32.4% of cases.

The following themes were identified and reported on: In terms of the "quality of service" offered by rape crisis counsellors, rape victims were "satisfied" with the service offered by rape crisis counsellors on the day of the assault and afterwards. The "waiting time" at the police station and at the hospital was apparently "too long". All parties involved agreed that the "waiting area" was not appropriate and that rape victims should be "separated" from other patients. As for the "consulting room", except for the younger group of victims, all other parties agreed that it "wasn't suitable" for the interview and examination of rape victims. There were mixed feelings about the attitude of nurses and doctors attending to rape victims. Some patients said that they were treated "nicely by both doctors and nurses". Others said they had the impression that "doctors and nurses did not believe they were really raped". Nurses and doctors complained about the "impatience of police officers and rape crisis counsellors".

Conclusion: The quality of care of sexual assault victims presenting at Odi Hospital can be improved. The waiting time of sexual assaulted victims is too long and attempts should be made to provide dedicated rooms and staff to assist in the care of sexual assault victims. Further, attention needs to be focused on ongoing educational activities as part of a holistic approach to management. Such education may assist in informing potential victims of the general modus operandi of perpetrators and encouraging victims of sexual assault to come forward without fear of victimisation.

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Introduction

Sexual assault is common and many thousands of women fall prey to this form of assault in South Africa annually.[1] On an international scale, it is estimated that 13% of women and 3% of men worldwide report sexual assault in their lifetime.[2]

Sexual assault is any form of nonconsenting sexual activity, which encompasses all unwanted sexual acts ranging from fondling to penetration. Sexual assault is a crime even if the victim knew the attacker, did not fight back, had intercourse with the attacker before the assault, or was intoxicated, drugged or unconscious. Sexual assault occurs in all age, racial and socio-economic groups.[3]

Many women never fully recover from this life-threatening trauma[4] that can have a substantial impact on the physical, psychological and social health of the victim. In addition, recovery of sexual assault victims post assault is complex and influenced by many intervening conditions.[1]

According to the Rape Crisis statistics of 1998, South Africa has the highest per capita rate of reported rape in the world (116 for every 100 000 of the population). Rape is both a very underreported and sometimes an inappropriately reported crime.[5] The survivor of sexual assault may choose not to report to avoid revictimisation through the course of medical treatment, involvement with the police and the criminal justice system. She fears she will not be believed, or she does not conceptualise her unwanted sexual encounter as sexual assault.[6]

In South Africa, rape protocols mostly consist of obtaining the history of the sexual assault. During the physical examination special attention is given to genitalia, anus, mouth, neck, breasts, inner thighs, buttocks and shoulder blades to assess the patient for physical injuries and to collect evidence for forensic evaluation and possible legal proceedings. A rape kit helps guide the clinician through the collection of forensic evidence and aids in the preservation of evidence.

The laboratory examination of assault victims includes a ß-HCG for all women of child-bearing age, VDRL or RPR at the initial visit and again three months later, based on local epidemiology, hepatitis serology *(hepatitis B) and serology for HIV (after pretest counselling).

Basic core services that need to be provided include screening, treatment and prevention of sexually transmitted infections, care of physical injuries, emotional support, emergency contraception[7,8,] hepatitis B vaccination and the anticipation of psychosocial consequences.[9] In South Africa, the completion of the J88 police assault form accompanied by the SAP 308 police consent form is essential.

All rape management protocols insist on the interview and examination being done in a quiet and secluded private room of a hospital, with a female nurse or rape crisis counsellor attending. All staff members are urged to be extremely gentle and caring to avoid 'secondary rape' or 'secondary victimisation'. However, in everyday practice in a busy emergency room, hospital staff simply want to process patients as quickly as possible, and management standards of sexual assault victims often do not reach the required standard referred to in guidelines.[10] Rape victims therefore receive, at best, bare minimum services[11] and very often the psychological support much needed by the victims is neglected.

Male rape is underreported as men who have been raped often do not seek medical attention.[12] It is well documented that women who have experienced sexual assault evidence a wide range of psychological sequelae, such as fear, anxiety, panic, depression, sexual dysfunction, post-traumatic stress disorder (PTSD), problems in social adjustment as well as secondary depression and substance abuse. PTSD appears to be the most frequent outcome of rape. The physical symptoms most frequently reported are not injuries sustained from the trauma but somatic and psycho-physiological reactions to severe stress.[13]

Emergency departments are often inadequately prepared to deal with sexual assault victims and to provide ongoing relevant training to members of staff.[14] Rape victims often perceive service standards to be inadequate and the standard of care to be lower for rape victims than for other patients receiving care in the same emergency department.[15] There remains a need to provide patients with more comprehensive care. For this to be achieved, emergency care departments need to be adequately equipped structurally and in terms of process.[14] Medical staff should increase their knowledge and skills in sexual assault care16 to provide first-response medical care and crisis intervention to sexual assault victims presenting at emergency departments.[17]

The importance of the role played by the medical doctor in the management of sexual assault therefore cannot be underestimated. The compassion and caring attitude of the physician can assist the individual to become a survivor of rape and not remain a victim.[18]

Methods

This study is a descriptive cross-sectional survey. The setting was Odi District Hospital in the North-West Province. The aim of this study was to describe the management and pattern of presentation of victims of sexual assault at Odi Hospital.

The objectives were the following:

- To describe the demography of sexual assault victims.
- To gain a deeper insight into the experiences and feelings of sexual assault victims.
- To assess quality of care for sexual assault victims at Odi Hospital.
- To ascertain the perception of all parties involved in the management of rape cases at Odi Hospital.
- To make the necessary recommendations to all parties involved in the management of sexual assault victims at Odi Hospital.

The casualty register at Odi Hospital was checked daily for sexual assault victims. This study included all consecutive patients (213 in total) who presented at Odi Hospital over a six-month period for alleged sexual assault between 1 March 2001 and 31 August 2001. In most cases, the nurse who provided pretest counselling for HIV testing completed the closed-ended questionnaire for all the victims who presented at the hospital. The questionnaire was translated into Tswana and back into English. A pilot study was conducted to assist in the development of the questionnaire, develop content validity and deal with logistical problems that may arise.

Method triangulation was used for the purpose of confirmation of results, and for this an additional random sample of 15 rape victims was selected. They were asked to participate in focus group discussions or were individually interviewed if they could not be present at the focus group discussion. Casualty department nurses and rape crisis counsellors were interviewed and participated in separate focus group discussions. The medical doctors were interviewed individually as due to their extremely busy schedules focus group discussions were not feasible.

Ethics approval was received from the Ethics Committee, Faculty of Health Sciences, Stellenbosch University. The purpose of the study was explained to all participants. The anonymity of the patients and confidentiality of the information were ensured. Informed consent for the interview was obtained from all the rape victims or their guardians as well as from all victims who completed the questionnaires. Information leaflets explained the purpose of the study. Informed consent was obtained from all doctors (6), nurses (12) and rape counsellors (6) who participated in the study, before the onset of the interviews and focus group discussions. A session debriefing was done two weeks later to assess how interviewees were coping.

Statistical analysis

Results were analysed using the Microsoft Excel Program. Quantitative data were presented in tables and simple pie charts. Categorical variables were compared by means of the chi-square test. P-values of less than 0,05 were regarded as statistically significant. Ninety-five per cent confidence intervals were not calculated as a consecutive sample of all patients presenting at the hospital was selected. The qualitative analysis was done from recorded data that were transcribed and coded, and central themes were developed.

Results: the numbers

In this study, the victims' age, race, gender, occupation, marital status and possible substance abuse (drugs and/or alcohol) were considered as social and demographic characteristics. The assailant's estimated age, his modus operandi (whether he operated alone or in a gang), whether he was known or unknown to the victim and whether he was under the influence of a substance (drugs and/or alcohol) were also analysed.

Of the 213 subjects, 211 were black and two coloured. The victims were aged between two and 70 years. The findings show a peak incidence of sexual assault in the age group 11 to 25 years, with the highest incidence in the age group 16 to 20 years.

About 14% of the victims were employed while 26% were unemployed. More than half of the victims (52%) were students. This makes sense as the peak incidence happened in the age group 11 to 25 years. A total of seven infants were allegedly raped.

In terms of marital status, single people made up about 24% of the sample group while married people made up 7%, cohabiting people about 9% and sex workers 0%. Seeing that most of the victims were below 20 years of age, it is normal that the "Other" group represents more than half of the victims. Only a minority of victims were under the influence of alcohol and/or drugs at the time of their assault, and most of them were assaulted at a party or in their home over the weekend.

The age of the assailant was estimated by the victims. The results show that almost half the assailants were in the age group 16 to 20 years (48%). The next highest group is the one of 21 to 25 years (21%). Together, these two groups constitute 70% of the assailants. Condoms were used in 12 (5.6%) cases only.

About 80% of the assailants operated on their own. There were times when a gang would come to rob but only one person would rape. The biggest gang in this study consisted of four robbers. In most cases where assailants operated as a gang, they were under the influence of a substance and they had weapons (guns or knives) because their main motive was robbery.

The majority of assailants (68%) were known by the victims. This is in contradiction of the common advice given to children to beware of strangers. It was disturbing to find that most of the sexual assaults took place in the victim's home (about 36%).

Table I: Percentage of assaults per location

Locations	Percentage of assaults	Number of assaults
Victim's home	36.2	77
Assailant's home	14.1	30
School/college ground	6.6	14
Street	13.1	28
Friend's home	8.5	18
Open veld	10.3	22
Bus/train station	3.8	8
Party	7.5	16
Total	**100.0**	**213**

Although sexual assault is considered an act of violence, visible injuries were reported in only one-third of the cases. Information about the injuries was obtained from the patients' files, from the J88 form or from the participant during the HIV pretest counselling session.

For the sake of simplicity, all injuries of genitalia, anus, mouth, breasts, thighs and buttocks were considered as "genital injuries"; injuries elsewhere were classified as "extra-genital". When injuries were present, they were mostly in the genital area (59%). The most common mode of intercourse was vaginal (91%).

Injuries varied from skin irritation to deep stab wounds, thus the classification of minor (62.3%), moderate (29.0%) and severe injuries (8.7%).

The majority of sexual assaults (30%) in this study took place between 20:00 and midnight and then between 16:00 and 20:00 (19%).

Table II: Time of occurrence of assaults

Time of occurrence	Percentage	Number of assaults
08:00–12:00	13.1	28
12:00–16:00	16.9	36
16:00–20:00	19.2	41
20:00–00:00	30.0	64
00:00–04:00	9.9	21
04:00–08:00	8.9	19
Couldn't tell	1.9	4
Total	**100.0**	**213**

Sexual assaults were committed more often on a Saturday (25.4%), followed by a Sunday (21.6%) and Friday (18.8). In 67% of cases, the assailant did not use any form of restraint. When restraint was used, guns (66.7%) were the preferred method.

Rape victims consulted for medical treatment of their injuries but also for legal reasons as the collection of specimens would form evidence against the assailant. The results of this study show that the majority of participants (about 96%) consulted in the first 24 hours.

Results: the perceptions

We interviewed the rape victims, the rape crisis counsellors, the nursing staff working in the casualty department and the doctors.

In terms of the quality of service offered by rape crisis counsellors, rape victims were satisfied with the service offered by rape crisis counsellors on the day of the assault and long after that. They said that the counsellors were "nice" and "caring" and "helped" them to overcome their trauma.

The waiting time at the police station and at the hospital was apparently too long. The older group of rape victims interviewed (20 to 38 years) complained about the police officers taking "too much time" before attending to them. The younger group thought that the waiting time at the police station and hospital was reasonable.

All parties involved agreed that the waiting area was not appropriate and that rape victims should be separated from other patients. As for the consulting room, except for the younger group of victims, all parties agreed that it wasn't suitable for the interview and examination of rape victims.

There were mixed feelings about the attitude of nurses and doctors attending to rape victims. Some patients said that they were treated nicely by both doctors and nurses. Others said they had the impression that doctors and nurses did not believe they were really raped. Nurses and doctors complained about the impatience of police officers and rape crisis counsellors. According to some of the nurses and doctors, police officers and rape crisis counsellors expected them (the doctors and nurses) to attend to their patients immediately without realising that emergencies had to be triaged and prioritised as in some instances a gunshot wound to the chest was more urgent than the less serious injuries of a rape victim.

There was also the issue of examining rape victims in a busy casualty department. On weekdays, rape victims could easily be managed in the casualty department, but over weekends this posed a serious problem because the casualty department was packed with other patients with stab or gunshot wounds or acute medical conditions such as asthma, and there was only one doctor on duty. The doctors asked why forensic sisters could not attend to rape victims on weekends as the examination of a rape victim could easily take up to 60 minutes.

Discussion

The results showed that females were the most likely to consult for sexual assault. These findings are consistent with those of an earlier study by JK Mein et al who found that most victims of reported sexual assault are women.[2]

The results showed that women were vulnerable at any age, but the highest risk group was between 16 and 20 years, followed by those between 11 and 15 years and those between 21 and 25 years. Together, these three groups constituted more than half (55.9%) of the subjects of this study. Furthermore, the results indicated that more than half (52.1%) of the participants were students and that only 11.3% were under the influence of alcohol or drugs at the time of the assault.

As for the assailants, their estimated age showed a peak in the 16–20-year-old group (48.1%) (same as for the victim), followed by the 21–25-year-old group. These two groups together formed 69.4% of the assailants.

In most cases (79.8%), the assailants operated alone. The majority of the assailants were known by their victims (68.1%). This is consistent with Diane K Beebe's study that found that approximately 80% of all rapes involve an acquaintance.[19] Culprit number one was a neighbour or stepfather for victims in the age group 0 to 10 years. The number-one culprits for victims in the age group 11 to 25 years were schoolmates, ex-boyfriends and boyfriends. For the victims older than 25, when the assailant was known to them, husbands, ex-husbands, boyfriends and ex-boyfriends were equally the culprits.

In many cases of violence, alcohol and/or drugs are thought to be contributing factors. This was not the case in this study as only in 21.2% of cases could the victim confirm that the assailant was under the influence of a substance. In 63.6% of cases, the victim could not tell whether her assailant was under the influence of a substance or not.

The results further indicated that most sexual assaults took place in the victim's home (36.2%), followed by the assailant's home (14.1%). In 67.6% of cases, there were no visible injuries. When injuries were visible, they were over the genitalia (59.9%) and were minor (62.3%). The most likely time of sexual assault was between 20:00 and midnight (30%) and between 16:00 and 20:00 (19.2%). Most sexual assaults took place over the weekend (65.8%), from Friday to Sunday, with Saturday being the day when most assaults (25.4%) took place.

The assailant did not use restraint in about 67% of the cases reported in this study. This is probably because women were advised to comply with their assailants in order to avoid more severe harm. When restraint was used, guns were the preferred method of restraint. Most of the victims consulted in the first 24 hours (96.2%).

The fact that rape victims were being seen in the emergency department of the hospital caused frustration among all parties concerned: The police officers and rape crisis counsellors became impatient, and the nurses and doctors vented their frustration by showing an inappropriate attitude towards the rape victims and by not giving the rape victims the full attention they deserved. This problem could have been solved by allocating separate waiting and consulting rooms as well as a dedicated forensic nurse or doctor to rape victims.

The lack of equipment was also frustrating to the examining doctors. If doctors are expected to play a part in convicting rape perpetrators, they should have the necessary equipment to help collect the specimens needed to trace the perpetrators.

Conclusion

The quality of care of sexual assault victims presenting at Odi Hospital can be improved. The waiting time of sexual assault victims is too long and attempts should be made to provide dedicated rooms and staff to assist in the care of sexual assault victims. Further, attention needs to be focused on ongoing educational activities as part of a holistic approach to management. Such education may assist in informing potential victims of the general modus operandi of perpetrators, encouraging victims to come forward without fear of victimisation and assisting them in becoming survivors of sexual assault.

Recommendations

This research highlighted the problem areas in the current management of sexual assault victims and it is hoped that the ensuing recommendations will assist in improving the quality of care of sexual assault victims at Odi Hospital:

- User-friendly waiting and consulting rooms should be made available for victims of sexual assault.
- The management of the hospital could allocate a dedicated

forensic nurse to be on call for rape victims only. A dedicated doctor (e.g. district surgeon) could also be appointed although this would be accompanied by an increase in cost.

- Patient education is essential to inform patients about sexual assault and the modus operandi of assailants.
- Ongoing relevant training should be provided to members of staff to assist them in dealing with sexual assault victims.
- Police officers and rape crisis counsellors accompanying rape victims should exercise patience when presenting sexual assault victims to busy hospital staff.
- Doctors and nurses should continue to be empathic, caring and compassionate at all times in an attempt to assist sexual assault victims in coping with the trauma

Declaration

We declare that we have no financial or personal relationship(s) which may have inappropriately influenced us in writing this paper

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