

Out-of-hospital assessment and management of rape survivors by pre-hospital emergency care providers in the Western Cape.

by

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Contents

List of figures	6
List of tables.....	7
Declaration.....	8
Dedication.....	9
Acknowledgements.....	10
Abstract.....	11
List of Abbreviations.....	12
CHAPTER 1: THE PROBLEM STATEMENT	14
1.0 Introduction.....	14
1.1 Background to this research	14
1.1.1 No emergency care rape response policy in the South African polity	15
1.2 Aim of the study	17
1.3 The objectives of the study	18
1.4 Limitations and delimitations	18
1.5 Definition of terms and concepts	20
1.6 Conceptual Framework.....	21
1.7 Organization of the report	22
CHAPTER 2: LITERATURE REVIEW	23
2.0 Introduction.....	23
2.1 Incidence and reporting of rape in the Western Cape	24
2.2 The nature of rape and health care responses in South Africa.....	25
2.3 Enabling South African legislation (HPCSA Guidelines) for emergency care provider contribution to rape assessment management	26
2.4 Forensic medical care for victims of sexual assault.....	27
2.5 Emergency care response to sexual assault.....	29
2.5.1 Rape survivor and provider expectations	29
2.5.2 Diagnostic imperatives.....	30
2.6 Multi-disciplinary response to victims of rape	31
2.7 Service delivery by a Thuthuzela crisis centre.....	33
2.8 Consideration for a version of a j88 form to be used pre-hospitally	34
2.9 Rape survivors need trained providers.....	35
2.10 Significance of rape response deficits in Emergency Medicine consultant training ..	36
2.11 Human rights protection and promotion is an emergency medicine prerogative	36

2.12	Health risks and victim empowerment of rape survivors.....	37
	Conclusion	38
CHAPTER 3: METHODOLOGY		40
3.1	Study Design	40
3.2	Research Paradigm	40
3.3	Study Setting	42
3.4	Sample population	42
3.5	Exclusion Criteria	44
3.6	Data collection methods.....	45
3.7	Procedure used	46
3.8	Data collection Tools.....	46
3.9	Data Analysis.....	48
3.10	Appraisal of Trustworthiness.....	49
3.10.1	Credibility.....	49
3.10.2	Transferability	49
3.10.3	Dependability	50
3.10.4	Confirmability.....	50
3.10	Dissemination Strategy	51
CHAPTER 4: RESULTS AND ANALYSIS.....		52
A: Emergency care providers' interview results		52
4.1	Current emergency care rendered to rape victims.....	54
4.1.1	A Minimalist Emergency care approach.....	54
4.1.2	Uncertainty and imprecision of emergency care responses	56
4.1.3	Biomedical bias, triage and referral limitations	56
4.1.4	Call taking and dispatch.....	58
4.1.5	Engendered Emergency care responses to victims of rape.....	58
4.1.6	Disproportionate emergency care provider's exposure to rape relative to rape incidence.....	59
4.1.7	Lack of community of practice amongst emergency care workers.....	60
4.2	Victim's response to EMS personnel and influence on continuity of care	62
4.2.1	EMS personnel reflect on "sure cases of rape"	62
4.2.2	EMS personnel feel ill-equipped to deal with rape victims	62
4.3	Perceptions of organizational and individual role and influence in cases of rape.....	63
4.3.1	EMS personnel rely heavily on the assistance of SAPS in sexual assault cases..	63

4.3.2	Referral and facility of choice for further treatment of victims of rape	64
4.3.3	Pre-hospital need for bundling of care for rape victims.....	65
4.3.4	Organizational role directly impacts service delivery and patient care	67
4.4	Organizational and individual responsivity to rape victims through emergency care education.....	68
4.4.1	Legal and ethical implications for EMS personnel	68
4.4.2	Poor EMS-hospital relationships	69
4.4.3	Current practice and beliefs in the pre-hospital setting	69
4.4.3	Succinct paper work is required to ensure uniformity and awareness around evidence preservation is essential.....	71
4.5	Change needed to improve emergency care rape responsivity	72
4.5.1	Education imperatives.....	72
4.5.2	Promotion of continuity of care and community of practice.....	74
B: Interview results from Thuthuzela Care Centre and Rape Crisis Clinical Forensic Medical Practitioners		75
1.1	Urban versus Rural resources and infrastructure	77
1.2	Difference in composition between the Thuthuzela crisis centre and the Rape crisis centre	79
1.3	Insufficiency of rape response training	80
1.4	EC role and scope in cases of rape	82
2.1	Legal implications for medical providers treating rape survivors.....	82
2.2	Tension between caregiver rights and the survivor rights and clinical/forensic needs	83
3.1	Expert perspectives on the EMS role in the management of victims of rape	85
3.2	EMS education is needed to promote ‘continuity of care’ and ‘community of practice’ from pre-hospital to in hospital care of rape survivors to improve the health care response.....	86
3.3	Medical Provider reflections for integrated health sector responses to extremely violent rape cases.....	89
C: Emergency care consultants focus group results		90
1.1	ED responses to rape cases and referral processes	91
1.2	Emergency care personnel (paramedics) scope of practice is explored when looking at treating/responding to rape victims and the possibility of additional treatment such as PEP to be added to the curricula-scope.....	92
1.3	Rape response deficiencies in Emergency care consultant training	95
1.4	Emergency care consultants feel that basic knowledge and awareness are required for Dr’s working in the ED	96
Summary		97

CHAPTER 5: DISCUSSION	98
5.0 Introduction.....	98
5.1 A simplistic Emergency care approach taken by EMS due to the indistinctness and inappropriateness of emergency care responses	99
5.2 False dichotomies exist between male versus female (engendered) Emergency care responses to victims of rape	102
5.3 Disparate emergency care provider exposure to rape relative to rape incidence.....	103
5.4 Lack of Referral and facility policy in conjunction with a lack of policy for treatment of victims of rape in the pre-hospital setting	104
5.5 Succinct medical record keeping is required to ensure EMS personnel are safeguarded against legal and ethical implications.....	105
5.6 EMS education is obligatory from pre-hospital to in hospital care of rape survivors to improve the health system response.	106
5.8 Emergency Department current responses to rape cases and referral processes.....	107
Summary	109
CHAPTER 6: CONCLUSION & RECOMMENDATIONS	110
Emergency care providers – Emergency Medical Care Personnel:	110
6.1. Place rape and sexual assault on the EMS agenda.....	110
6.2. Promote a community of practice for rape/sexual assault health care responses ..	111
Clinical forensic medical practitioners	111
6.3. Crux of treatment and management of rape victims	111
Emergency Medicine Consultants	113
6.4. Address deficiencies within the Emergency Department	113
Recommendations for future studies:	114
Bibliography	115
Appendix A: One on one interview discussion guide	123
Appendix B: Permission to conduct research within EMS	126
Appendix B: Permission to conduct research within Rape Centre’s situated in Cape Town	127
Appendix C: Consent Form	128
Appendix D: Participant information sheet.....	129
Appendix E: Ethics letter of approval (UCT)	132
Appendix F: Ethics Letter of approval (UCT) - Extended	133
Appendix G: Approved request to conduct research in EMS	134
Appendix H: Ethics letter of approval (DOH)	135

List of figures

Figure 1: Conceptual frame for understanding emergency care responses to rape cases.....	22
Figure 2: The Thuthuzela model	33
Figure 3: The aftermath of rape	34
Figure 4: Triangulation of methods toward a gap analysis of emergency medicine rape responses	43
Figure 5: Interviews conducted	45
Figure 6: Core elements for motivational interviewing	47
Figure 7: Convergent Themes: Paramedic interview results.....	53
Figure 8: Convergent Themes: Clinical Forensic Medical Practitioners interview results.....	76
Figure 9: Convergent Themes: Emergency medicine specialist's interview results.....	91

List of tables

Table 1: Sexual Assault Survivors Therapeutic Message	32
Table 2: Hierarchy of qualifications	44

Declaration

I, Raina Tara Gihwala, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Signed by candidate

Signature:

Date: ...15 February 2015.....

Dedication

This thesis is dedicated to my beloved father, the late Harish Gihwala

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Abstract

South African incidence of rape ranks amongst the highest worldwide. No direct policy exists for the emergency care provider management of rape victims in the pre-hospital setting. The pre-hospital exposure to rape cases is unknown as its health information system is not gender-based violence sensitive. In the absence of a clearly defined protocol, indiscretion in the emergency care treatment of rape victims remains undocumented. As a particularly vulnerable group globally, victims of rape are deserving of focused intervention.

A qualitative, descriptive approach guided the research in which nine semi-structured voluntary interviews were held with emergency care providers, forensic medical practitioners and emergency consultants. Through a critical theory lens thematic content analysis was employed. University of Cape Town ethics approval was attained.

The study found that pre-hospital providers lack knowledge and skills of rape victim identification and management but are desirous of evidence-informed guidelines for treatment and referral in a multidisciplinary approach. Educational and policy deficiencies are documented.

The recommendations support a community of practice that is mutually inclusive of specialist rape-care centres, emergency department and pre-hospital providers in the interest of forensic emergency medicine. Due regard must be had for needs of practitioners at risk of vicarious traumatization from sexual assault management. Transformative curricula and responsive clinical guidelines are likely to redress any complicity of the health sector non-response to rape/sexual assault. This study is likely to benefit emergency care regulators, educators and researchers whose professional interest is to promote responsiveness of the health system to rape.

Keywords: Rape, Emergency Care provider, emergency medical services, sexual assault clinical management guidelines, critical theory

List of Abbreviations

ABC – Airway, Breathing and Circulation

AEA – Ambulance Emergency Assistant

ALS – Advanced Life Support

BAA – Basic Ambulance Assistant

CME – Continuing Medical Education

CPD - Continuing Professional Development

DOH – Department of health

DV – Domestic Violence

ECP - Emergency Care Provider

ED - Emergency Department

EMS – Emergency Medical Service

FCS - Family Violence Child Protection and Sexual Offences Unit

FET – Further Education and Training

HET – Higher Education and Training

HIV – Human Immunodeficiency Virus

HPCSA - Health Professions Council of South Africa

MRC - Medical Research Council

NGO – Non-governmental Organization

NICRO - National Institute for Crime Prevention and Rehabilitation

NPA - National Prosecuting Authority

PBEC - Professional Board for Emergency Care

PEP – Post-Exposure Prophylaxis

PRF – Patient Report Form

PTSD - Post Traumatic Stress Disorder

RTS – Rape Trauma Syndrome

SAMJ - South African Medical Journal

SANE - Sexual Assault Nurse Examiner

SAPS – South African Police Service

SOCA - Sexual Offences and Community Affairs

SOP – Standard Operating Procedure

STD – Sexually Transmitted Disease

TCC - Thuthuzela Care Centre

CHAPTER 1: THE PROBLEM STATEMENT

1.0 Introduction

The purpose of this research was to explore the experiences emergency care providers (ECP's) have when responding to cases of rape; and the implications this has for the development of a standardized evidence-informed guideline for pre-hospital emergency care practice in South Africa toward victims of rape. It was an assumption of the researcher that emergency care providers had no rape-response policy or guideline to guide their practice. It was therefore important to examine the subjective experiences of the key service providers who assist rape survivors medico-legally.

The findings that emerged from this research would likely provide Registrars in the Emergency Department (ED), emergency care personnel and the Thuthuzela Care Centre's (TCC's) with a nuanced perspective of current management of rape victims in the Western Cape. This serves as a point of entry for potential collaborations and a revised multidisciplinary approach with regards to the management of rape victims. The value proposition here is to promote patient-centered treatment amongst all personnel involved in rape survivor care. It therefore has the potential to promote a community of practice for rape management in the acute care setting.

1.1 Background to this research

Sexual violence affects all societies worldwide but South African incidence rates of rape cases ranks amongst the highest ^[1-4]. Regarding rape... "It is a major public health problem and although it is increasingly being recognized as a human rights violation, prevention and services for survivors remain inadequate" ^[1]. Currently, no direct National or Provincial Emergency Medical Service (EMS) policy or clinical guideline exists for the emergency care provider management of rape victims in the pre-hospital setting. Policies and guidelines ^[2] on how best to prevent sexual violence from occurring and treatment of rape victims in the pre-hospital setting should form a key part of national government and civil society gender violence prevention programs. Till then, a rape treatment policy imperative for emergency medicine remains. The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 ^[3] defines rape as "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".

Although there is an element of gender-neutrality in the definition, the documented cases more frequently refer to females as victims and to males as perpetrators.

Notwithstanding the many challenges of incidence, prevalence and attrition research in cases of sexual violence, it is still probable that emergency care providers function in communities where rape is prevalent and are likely to encounter victims of rape. South African Police Service (SAPS) statistics suggest that someone is raped every 35 seconds ^[4], but according to the National Institute for Crime Prevention and Rehabilitation (NICRO) only one in 20 rape cases is reported to the SAPS ^[8-9]. Barriers to reporting the crime and health consequence of sexual assault are a lack of faith in the criminal justice system and the medical services and the secondary trauma suffered by survivors at the hands of both the South African Police and health services ^[8-9]. The EMS exposure to rape cases is unknown as its health information system is not gender-based violence sensitive.

The extent to which countries have policies on rape prevention is unknown ^[1]. Medical management of rape victims has been widely researched within the hospital milieu. Recommendations for specified responses to this cohort of patients, the correct medical and legal actions, as well as the need for nuanced care for the victim exist for many health stakeholders. There is however, a lacuna of evidence ^[1] specific to emergency medicine in the developing world, in particular, pre-hospital practice responses to cases of sexual violence. The AFEM Handbook of Acute and Emergency Care ^[5], 'the only handbook for emergency care in sub-Saharan Africa' boasts only one of one thousand pages on 'Domestic and intimate violence victims'.

1.1.1 No emergency care rape response policy in the South African polity

Unregulated and/or inconsistent practice has the potential for greater harm to rape victims and is a concern to the South African health system in the context of health and criminal justice. There are no regulatory protocols to guide emergency care personnel in the treatment of rape victims ^[6]. This is particularly worrying when the profession quality assures itself through the judicious use of its own clinical guidelines and protocols. Clinical decisions and discretion in domestic violence intervention is possibly being steered by their existing knowledge and beliefs towards victims of domestic violence ^[2]. As a male dominated vocation, these dominant societal beliefs about gender stereotypes are likely to hold true for the management of rape (as a form of

gender-based violence) as well. Van den Berg, in 'Critical Reasoning and the Art of Argumentation' asserts that "societal values, preconceived ideas and cultural attitudes cloud our perceptions and attitudes and stand in the way of clear thinking"^[7].

The Professional Board for Emergency Care (PBEC), Health Professions Council of South Africa (HPCSA) has approved the 'Domestic Violence Intervention Guidelines' by emergency care providers and has "challenged other professional boards to appraise their ethical and professional role as healthcare providers in addressing both the consequences and causes of domestic violence"^{[2], [8]}. Naidoo et al.^[2] suggests that the implied guidelines for the design and development of a pre-hospital medical protocol for domestic violence victims for emergency care providers are cogently articulated in "Screening for Domestic Violence (DV): A Policy and Management Framework for the Health Sector"^[9]. How EMS currently responds to DV in their routine work is not documented^[2]. Whilst rape may occur within the domestic context, it may also occur without, and the associated mortality and morbidity renders it deserving of particular attention by health providers. In the absence of a clearly defined protocol, indiscretion in the emergency care treatment toward victims of rape also remains undocumented and unchallenged.

There is no EMS surveillance of rape cases despite that "South Africa, in the global political economy, is increasingly acknowledged as the rape capital of the world": a statement made as early as 1995 by the Human Rights Watch^[10]. "A woman is raped every 17 seconds"^[11], with the significant incidence of rape in South Africa it would be plausible that some rape victims are encountered in the pre-hospital context and/or transported to the Emergency Department by an ambulance.

The rape incidence is disproportionate to the reporting of rape to SAPS, health care facilities and NGO's in the field. The SAPS estimate of incidence in 2010 was one every 35 seconds^[4] whilst an NGO reports 1 case every 17 seconds in 2010^[11]. Disparate estimates of rape incidence are likely to be due to differing confidence in redress and support from state and other organisations, social stigma, fear of reprisals or secondary victimisation and deliberate concealment of the rape due to the denial of the victim experience^[8-9]. Notwithstanding, the inaccuracy of the incidence data, there is consensus amongst health, social welfare and criminal justice departments that the incidence of rape burden is unacceptable, that is higher

than global averages and that there is extreme violence associated with South African cases of rape.

The follow up assumption is the potential risk of loss of evidence or evidence contamination as well as substandard treatment for the patient who requires specialised treatment by untrained personnel. “The clinician’s responsibilities include accurate reporting of the details given, examination and evidence collection, and treatment and support of the patient”^[12].

As a particularly vulnerable group globally, victims of rape are deserving of clearly defined and focused intervention, as evidenced by international best practices and human rights advocacy. As clinical care of rape victims overlaps with the forensic prerogative to document and safeguard evidence, it is central to the principle of health and human rights redress and criminal justice. Emergency care providers are bona fide clinicians operating in emergency care situations, given legal competence by the Health Professions Act 56 of 1974^[13]. Rape constitutes a medical emergency but in the context of interpersonal, sexual or gender-based violence it is an ‘epic’ violation of human rights. Given the premise that health policy is intended to guide, standardize, quality assure and promote access to health care, the absence of protocol or a guideline developed for providers treating victims of rape in the pre-hospital context is telling of a level of institutional complicity in the injustice perpetrated^{[2], [14]}.

1.2 Aim of the study

In the absence of guidelines/policy for the management of rape in the EMS setting, inconsistent (policy-free) practice has the potential for greater harm to rape victims. This is a concern to the South African health system in the context of health and criminal justice. Clinical decisions and discretion/indiscretion in sexual assault and domestic violence intervention is possibly being steered by their existing knowledge and beliefs towards victims of sexual assault and domestic violence.

Due to the shortcomings faced by the emergency care providers in this current state, this study aimed to formulate evidence-informed policy recommendations for a re-contextualised and professional emergency care response to survivors of rape.

1.3 The objectives of the study

Although numerous research articles are available with regards to rape occurrence and its impact on rape victims, no known research has been conducted in South Africa which investigates the experiences of emergency care providers as first responders to rape cases and the implications of responding to victims of rape for the emergency care platform. What might the emergency care expectations of rape victims and their care-givers be? Therefore, the study investigated the experiences emergency care providers had when responding to cases of rape; and the implications this has for the development of standardized evidence-informed guidelines for pre-hospital emergency care practice in South Africa toward victims of rape. To this end, the following sub-objectives define this study:

- 1.3.1 Describe and document the prevailing pre-hospital response and management of emergency medical service personnel toward rape survivors.
- 1.3.2 Document and describe the acute care management given to victims of rape at the hospital emergency departments and Thuthuzela Care Centre's.
- 1.3.3 Perform an emergency care practice gap analysis for missed patient-safety opportunities and potential for harm - or risk reduction - in the emergency care responses and handling of rape cases.

1.4 Limitations and delimitations

It is important to foreground the study with its limitations so as to manage expectations and promote feasibility. The delimitations that follow will explain how limitations are managed so that relevance can be maintained. The critical interpretivist nature of this study precludes the narrow quantifying of a problem; it is less about presentation of 'facts' and more about critical interpretations. This freedom places duties and obligations on the researcher to interpret within a reliability framework. To aid the reliability framework, findings from the systematic synthesis of the literature were used to corroborate or refute observations and knowledge claims emerging in the study. The review was supported by interviewing the Clinical Forensic Medical Practitioners when major contradictions between 'what is and what should be' emerged.

The researcher does not claim a critical distance as this is not a prerequisite of interpretivism, a critical presence is. By comparison, the critical paradigm was intended to promote change. This study was less about change and more about understanding the nature and scope of what needs to change to enable pre-hospital emergency medical care discourse in the medico-legal response to rape. The aim of this research was to problematize current practice in the emergency care field and to nuance future practice with what was required by hospital and Thuthuzela care centres. It therefore precedes the change desired.

Epistemological limitations included narrowness of the pre-hospital emergency care setting and provider. The study was not powered to include in-hospital and criminal justice approaches to the problem but does inform and was informed by the latter. A case in point is protection of the chain of evidence. The classification of rape may also offer limitations in terms of diagnosis and intervention.

An expectation of factual data cannot be upheld by this study. The data collected allowed at face value, a thin textual description of the phenomena under the study, but an exposition of the data in the analysis presents thick descriptions, with theoretical underpinnings and is nuanced by the researcher's insider status in the emergency care profession. The researcher noted the complexity of the issue around the treatment towards victims of rape within the pre-hospital context. The fact that there is currently no direct procedure in situ by the Health Professional Council South Africa made it difficult to analyse and benchmark policies and processes. The absence thereof was telling of the health systems lack of responsivity to victims of rape. Whether further research and larger sampling will be needed to support the need to nationalise standard treatment and care towards victims of rape in the pre-hospital context is unknown, but is likely to be informed by this study.

Critical theory allows the researcher to be an advocate for rape victims (they have a right to health care that is conditioned to help them in their time of need), because in order for these personnel to treat the patient to the best of their ability, they need protocols or guidelines in place. The researcher aimed to inform policy or guidelines for the emergency pre-hospital setting, this would be a result of the researcher actively using data captured.

1.5 Definition of terms and concepts

- 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^[3].
- Survivor: Is a person that survives, or a person who continues to function or prosper in spite of opposition, hardships or setbacks^[15]. For all intents and purposes, 'survivor' will be used interchangeably with the words "patient" and "rape victim".
- Emergency Care Provider (ECP): This is a health care professional trained in emergency medical care and/or rescue at basic, intermediate and advanced levels, and is registered with the Health Professions Council of South Africa (HPCSA). ECP, for the purpose of this study, will include all individuals on the registers of the Professional Board for Emergency Care Personnel (PBECP) of the HPCSA.
- Critical theory: critical theory is a foundational perspective from which analysis of social action, politics, science, and other human endeavors can proceed. Research drawing from critical theory has critique (assessment of the current state and the requirements to reach a desired state) at its center^[16]. As such it values a change proposition. In this report the researcher will use small letters when referring to the paradigm of critical theory.
- Perpetrator: a person who perpetrates, or commits, an illegal, criminal, or evil act^[17].
- Victim: Any person alleging that a sexual offence has been perpetrated against him or her. Victims can survive a rape incident rendering them as de facto survivors but post-rape health sequelae promote a victim status^[3].
- EMS: Is the acronym for Emergency Medical Services. This term refers to the treatment and transport of people in crisis health situations that may be life threatening or carry high morbidity^[18].
- Emergency department (ED): The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. This is the reception of the hospital phase and ends the pre-hospital phase^[19].
- Clinical guidelines and Protocol: Guidelines are designed to support the decision-making processes in patient care. The content of a guideline is based on a systematic review of clinical evidence - the main source for evidence-based care^[20].

For the purpose of this project, the researcher will use 'survivor' and 'victim' interchangeably to reflect the shifting and multiple circumstances of those who have experienced rape. "Although there are different connotations attached to these terms, the use of the more conventional term, 'victim', has been subject to the criticism that it denies agency to the raped woman and hence that the term 'survivor' should be used instead to take account of her actions"^[21].

1.6 Conceptual Framework

The conceptual framework as depicted in Figure 1 was a compilation of three major factors that was considered during this research. Firstly, the researcher looked at what literature had proven to be the best practice with regard to the pre-hospital management of rape victims. The literature used was not only national studies but also an international perspective on management worldwide. This allowed the researcher to gain a perspective on what standard of care these victims required – and would be desirous of - to be treated optimally in this environment.

The researcher then explored the current practice at a national level of management toward victims of rape by collecting data from three sources, namely Emergency Care Providers from the Provincial Emergency Services, Thuthuzela Care Centre representatives and the Emergency Registrars/ Medical officers from the secondary hospitals in Cape Town.

Lastly, the researcher performed a gap analysis on what the literature depicted as best practice and what the current management practice were in the three sites used in the data collection. The outcomes of the two intersecting areas were used to conclude on the similarities but also to elevate the discourse on the different and omitted clinical management practices.

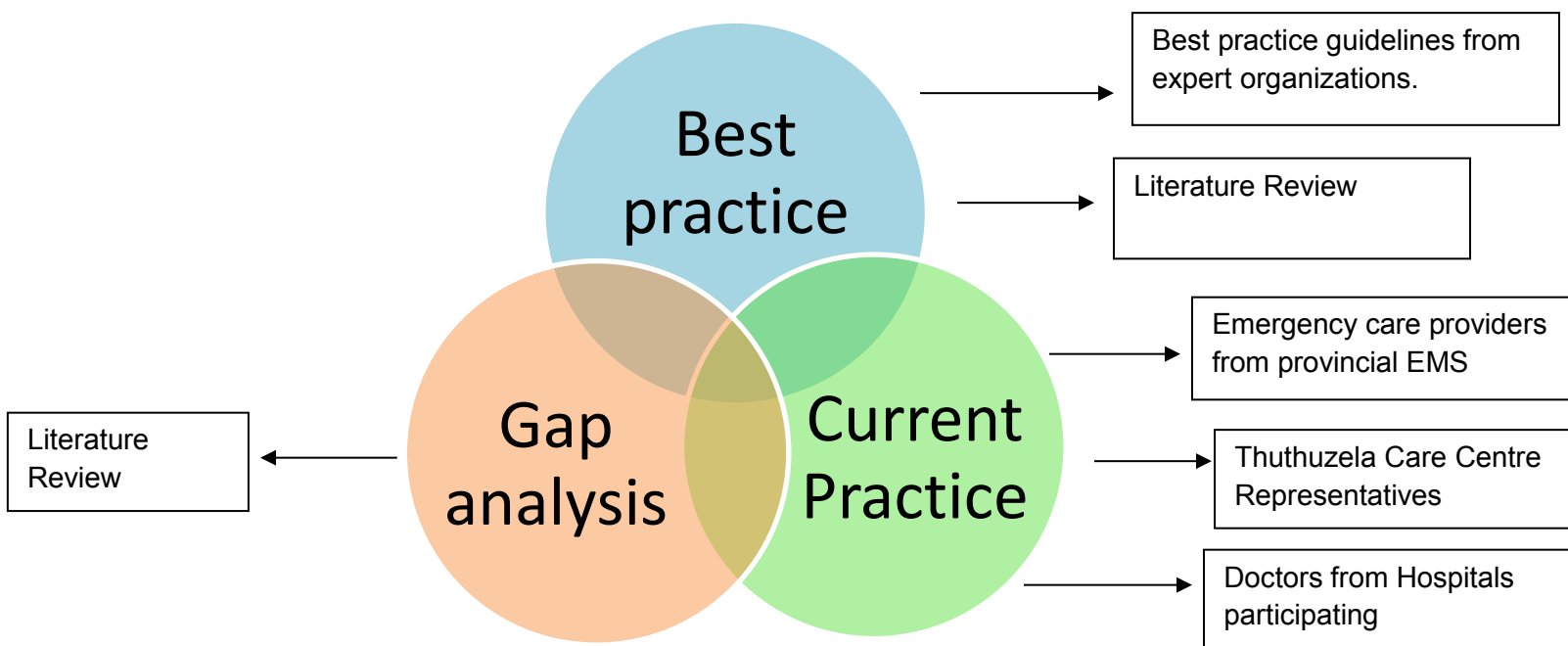


Figure 1: Conceptual frame for understanding emergency care responses to rape cases

1.7 Organization of the report

Chapter one introduced the problem being studied and includes a background to the study aims as well as definitions. Chapter two presents the literature review that contextualizes the study in the knowledge economy. Chapter three addresses the study methodology with regard to design, paradigm and population choice, data handling, and the methodology. It also addresses research ethics and shows how ethical obligations have been met. Chapter four is a compilation of results with respect to the objectives above. Descriptive themes are looked for in the transcription and then interpreted using thematic content analysis. Chapter five deals with the discussion of the results and attempts to provide a theoretical analysis. Finally, concluding recommendations may be found in Chapter six. References and appendices follow. The referencing style used was Vancouver.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This dissertation in the field of emergency medicine intends to explicate the out-of-hospital assessment and management of rape survivors by pre-hospital emergency care providers in the Western Cape. This endeavour required that the out-of-hospital assessment and management, as a clinical practice, be understood in terms of current literature, spanning emergency and forensic medicine. The phenomena of the rape survivor and the role, scope and practices of the emergency care providers are also discussed in the context of a health sector response to post-rape care. This review considered what is known about the above topic, delineates what is not well documented through a critical lens and then positioned this study's relative contribution to the field of research.

The literature review aims to address the following major topics: Incidence and reporting of rape in the Western Cape; The nature of rape and health care responses in South Africa; Enabling South African Legislation (HPCSA Guidelines) for Emergency Care Provider contribution to rape assessment and management; Forensic-medical care for victims of sexual assault; Emergency care response to sexual assault; Multi-disciplinary response to victims of rape; Consideration for a re-contextualised version of a J88¹ form to be used pre-hospitally; Why rape survivors need trained providers; Human rights protection and promotion as an emergency medicine prerogative; and Health risks and victim empowerment of rape survivors.

South African emergency care practice, through Emergency Medical Services (EMSs) and under the regulation of the Health Professional Council of South Africa (HPCSA)² currently have no known direct policies in place that could assist emergency care personnel to make evidence-informed decisions when treating victims of rape. Clinical and other guidelines or systematic approaches have yet to be established ^[2]. Consequently, the lack of standardized practice in rape survivor management is the object of this study. This is of scholarly interest as it is in the interest of rape survivors that the health system responds in a cohesive and complimentary manner and that the health care organizations are not complicit in the secondary victimization of

¹ J88 Form: The J88 details all physical injuries sustained during any attack and must be filled out by a medical doctor, or a forensic nurse along with a rape kit. This form is designed to leave no evidence unreported, resulting in an extensive and invasive examination. There is a detailed questionnaire around the victim's sexual history – including previous pregnancies, date and time of last intercourse with consent and questions on menstruation.

² As enabled by the: Health Professions Act 56 OF 1974

survivors. The legal, health and ethical arguments of post-rape care management will be intersected in the context of out-of-hospital emergency medicine in the Western Cape. To avoid parochial demarcations, evidence in the global knowledge economy will be considered. This review is likely to be of relevance to the HPCSA, EMS's and their staff as well as EMS educators and researchers.

2.1 Incidence and reporting of rape in the Western Cape

In September 2012 the South African Police Services released rape statistics for the period of 2011/2012 for the Western Cape. An estimate of 27 sexual offence cases per day was reported^[22]. These estimates may not be a true reflection of the incidence of rape, as it is likely that a high number of incidents go unreported due to the trauma, secondary victimization and stigma that victims face^[22]. There has been a decrease in sexual offences as recorded in the 2014 published crime statistics which shows a 11.2% decrease from 2008/9 when 70,514 cases were recorded, compared to 2013/14 when 62,649 cases were recorded^[23]. Reported cases of rape saw a slight decrease of 3%, since 2008/9 from 47,588 to 46,253 in 2013/14^[23]. The decrease above might signal a considerable success if it were true that rape reporting was proportionate with rape incidence.

The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007^[3] expanded the definition of rape and nature of sexual offences. The statistics does not separate each offence; these statistics include a combination of offences which range from sex work to rape^[23]. Still, the lack of justice by the South African Criminal Justice System is evidenced by a low conviction rate for rape and a disproportionately high rape incidence^[24]. An estimation of one-in-nine rapes is reported to the police according to the Medical Research Council (MRC)^[24]. This is an alarming statistic that needs to be addressed by the legal and health systems, in particular, as societal institutions. After-all, rape is a gross violation of human rights^[25].

In response the Criminal Justice System "...offers her [the victim] services, to protect her, to treat her with dignity and respect, and above all, to support her claim to justice and to act as a deterrent to rapists"^[24]. South Africa is considered the 'rape capital' of the world^[25]. The criminal justice system needs to take serious action if it is to fulfil its mandate. However, success is not reliant on the criminal justice system solely, but on all key societal role players required to see the process through from prevention of the incident, the incident, the

prosecution of the case and beyond. Conviction rates are reported to be currently at 7% in the Western Cape compared to 4% in Gauteng^[24]. The pre-hospital care system is fragmented, lacking cohesive links between one service provider and another in the overall service chain – from the police services, EMS personnel, to the forensic medical examiners to the courtroom.

Government departments responsible for state service providers are unable to collaborate effectively to tackle the problem at higher levels of influence^[26]. This is worrisome as victims are left unprotected and vulnerable. This is a health burden that is perpetuated if prevention and response is mal-aligned. The resulting culture of impunity can only serve to drive the number of rape incidents upwards, thereby seriously denying women their right to live free from violence^[27]. The state (through provincial EMS organisations) is the largest EMS provider in the country and has the potential to be the most accessible pre-hospital health resource for rape victims.

2.2 The nature of rape and health care responses in South Africa

Rape is considered an act of violence^[28] and can culminate in murder^[29], but it is not only the purview of criminologists and feminists alone. The health and emergency medicine burden of rape is understood in relation to its mortality risk, morbidity and nature of injuries. Survivors are physically assaulted and present with injuries such as head injuries and penetrating organ injuries that the patient may never fully recover from. The physical and emotional scarring remains. The South African Medical Journal (SAMJ) reported that doctors are hesitant to engage in medico-legal work, due to the lack of training and time constraints imposed by an already high workload^[30]. In spite of all medical personnel having a statutory duty to provide emergency care to rape survivors; it is only undertaken as a duty of care by some. “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”^[30]. Health professionals are the cornerstone role players in ensuring the health care needs of the survivors are met, but their roles extend well beyond the ‘doctor-patient’ relationship to the other roles such as advocacy required to ensure a multidisciplinary approach.

2.3 Enabling South African legislation (HPCSA Guidelines) for emergency care provider contribution to rape assessment management

Kim et al. performed a study in 2009 which showed that it is possible to improve the quality of care to rape survivors in a rural setting by training nurses to be the primary providers of this care^[31]. The possibility raised is the training of EMS personnel to improve the quality of care of rape survivors. This possibility becomes opportune when considering that often emergency care personnel may be the first medical contact with rape victim's in the pre-hospital milieu. It is of vital importance that the regulatory bodies in SA use evidenced-based research to implement emergency care practice strategies that would bridge the gap between pre-hospital to in-hospital care of rape victims. This could result in improved patient outcomes thereby strengthening pre-hospital management and comprehensive range of health care. It is crucial in ensuring the best possible standards in clinical care are achieved^[32].

The United States uses the Sexual Assault Nurse Examiner (SANE) to promote the psychological wellbeing of victims and to provide all-inclusive post-rape care which includes the documentation of evidence. This has resulted in the increase of sexual offences being prosecuted, allowing a synergy of multiple services in the community^[33]. To implement a clinical protocol involving the emergency care providers in South Africa a number of changes are required. The HPCSA would have to recognize this as a sub-specialty and/or integrate the practice of rape response into provider scope; and the legal system will have to recognize the EMS as qualified and legally competent forensic providers in respect of the diagnostic clinical reasoning, emergency forensic care and documentation of medico-legal evidence gathered at the scene or in the ambulance.

In terms of enabling legislation, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007^[3] (Section 66(3) (a)) instructs the Director General of Health to develop training courses with the vision of ensuring that as many medical personnel and other relevant persons as probable are able to deal with sexual offences in a manner that is justified to the survivor^[33], a notion supported by the Criminal Law (Sexual Offences and Related Matters) Regulations, 2008. Apart from the acknowledgement to develop training courses as stipulated in the Criminal Law Amendment act of 2007, other directives such as the National Sexual Assault Policy of 2005^[34], the National Instruction 3/2008 on Sexual Offences^[35] as well as the National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence

Cases, 2009^[36]; do not address the pre-hospital management of rape victims by emergency care providers directly. A general health care approach/management of the rape victim is covered in these policies detailing the use of SAPS for scene preservation and evidence collection as well as the physical examination and medical care required by the victim, as it stands, is beyond the scope of emergency care providers. Thus the policy gap exists for this training with emergency care providers to be initiated in order to achieve a multidisciplinary management approach that involves all health care providers that may come into contact with rape victims.

2.4 Forensic medical care for victims of sexual assault

Forensic medical care with respect to post-rape care/management is a broad term that encompasses identifying the care needs required by the victim to collection of evidence. Emergency Care Provider's when faced with victims of rape are limited to symptomatic treatment delivery due to the lack of policy/guidelines^[6] or comprehensive care bundles. Not only are they ill-equipped to deal with the psychology of these cases they also do not have the proficiencies to perform specific treatments regimes on/for these victims.

Rape is an atrocity in our society, affecting males and females of all ages. "Sexual assault is defined as (1) A person ('A') who unlawfully and intentionally sexually violates a complainant ('B'), without the consent of B, is guilty of the offence of sexual assault. (2) A person ('A') who unlawfully and intentionally inspires the belief in a complainant ('B') that B will be sexually violated, is guilty of the offence of sexual assault"^[3]. Compelled sexual assault is defined as A person ('A') who unlawfully and intentionally compels a third person ('C'), without the consent of C, to commit an act of sexual violation with a complainant ('B'), without the consent of B, is guilty of the offence of compelled sexual assault^[3].

"As a healthcare provider you have a dual responsibility towards these victims, it is not only physical wounds you have to deal with, but a psychological nature that is accompanied to these victims. It is crucial that we are able to identify these survivors in order to give them the best care possible, as every patient requires a specific treatment at that point in time"^[31].

Health-care providers that are ill equipped to deal with victims of rape can negatively impact the patient. An insensitive encounter along with the health-care worker not being very knowledgeable about the care required may have an effect on the mental health aftermath of

rape. Post rape incident, the victim can experience an array of emotions that could range anywhere from self-blame, helplessness to intense fear or a high level of anxiety ^[39-42].

It is crucial that health care providers are trained to be vigilant for signs of Rape Trauma Syndrome which is defined as “the stress response pattern of a person who has experienced sexual violence” ^[31], which takes place in two phases; Phase 1 – known as the acute phase / phase of disorganization: The victim struggles to comprehend what they have just been through, they cannot acknowledge the experience. They may initially react in one of two ways – a) they may convey signs of anger, anxiety, fear and often cries. b) Alternately in an organized manner, the patient stays calm and shows little outward emotion, as if an introvert. This phase can last from 6 weeks to a few months. During this time, they may display feelings of shock and emotional numbness ^[37].

Should the victim display other signs and symptoms not mentioned in phase 1, the health care provider should consider Phase 2 – known as the long-term / reorganization phase: This phase usually starts 2-3 weeks after the event. In this phase the survivor tries to reorganize his/her lifestyle, which may be either adaptive or maladaptive. However, in this phase one would require specialised training with these cases as it is an ongoing process in order to diagnose this population of patients ^[37]. By identifying these two phases, health care providers will be able to treat the patient in a manner that best suits him or her in that exact moment. Due to rape not only being a physical encounter but a psychological and emotional invasion as well, each patient will require a certain approach/package of care for their specific needs apart from the basic/ routine medical interventions that are important for these victims.

In sexual assault/rape cases forensic medical procedures/examinations are required. ECP's only treat in the emergency context ^[13]. Anything else has been assumed to be “outside of the scope of practice” and should be completed in hospital. The above has major implications for the survivor, as ECP's are ill equipped to deal with these patients potentially destroys evidence. This could result in no justice for the survivor. Understanding that the first 72 hours is crucial for these patients with regards to evidence preservation and collection, it is imperative that ECP's are trained to initiate some of the assessments from the initial point of contact ^[37].

“It is yet to be determined what can and should be done in the pre-hospital setting; it is however a safe assumption that it would be the non-invasive assessments and evidence collection of the scene you have found the patient in” ^[31].

Effects seen after sexual assault differs significantly from female to male. Since intimidation can be a more predominant factor in female assault, physical injuries may be more understated ^[38]. In male patients, severe physical injuries are seen. Awareness of differences in injuries between male and female is of utmost importance in the above regard, this would enable judicious treatment and clinical decision making.

2.5 Emergency care response to sexual assault

2.5.1 Rape survivor and provider expectations

Emergency care providers, as a professional cadre, should treat victims of sexual assault with the greatest consideration. Victims have expectations when it comes to the treatment they receive from EMS personnel. They wish to be protected from harm, treated and comforted in their time of need. EMS personnel are also expected by the health system to preserve all evidence, no matter how insignificant it may seem and document all findings, procedures and assessments in meticulous detail ^[38].

Emergency care personnel have a specific role and function in the pre-hospital context. It is their duty to create a safe environment for patients, provide rapid care and transport as well as medical procedures in an emergency care situation as needed ^[45-46]. Their roles are predominantly medical but in the event the patient is “medically stable” they can become involved in an emotional way (or be indifferent), when they are sent to a patient that has been sexually assaulted. This kind of care required is relatively unfamiliar to emergency care personnel who are trained to operate in the ‘rescue mode’. This however poses a threat to the victim’s interests and preservation of evidence, as the EMS personnel have not been trained in this regard ^[39].

Physical injuries that are common in sexual assault should be taught to trained personnel dealing with rape survivors. Emergency medical personnel are *de facto* pre-hospital clinicians. This would allow clinicians to make decisions with a medical and legal basis. Training should also include the know-how of what the survivor should or should not do, as to not contaminate evidence. It is of vital importance that no assessment or treatment is given without informed consent. Should a patient not be *compus mentis*, unconscious or present with a life threatening injury, implied consent should be considered ^[38].

2.5.2 Diagnostic imperatives

EMS personnel rely heavily on what they see in their diagnostic approach to the patient. In terms of the chief complaint, rape victims may not necessarily have physical injury hence training is required for EMS personnel to screen for overt and covert signs and symptoms. The absence of injury does not preclude the occurrence of the rape, nor the need for emergency care. Invasive skills such as intravenous therapy should be avoided at all cost until the need arises; however, this should never compromise required treatment of that patient's condition at that time^[38]. All procedures that could be delayed till the hospital are advised as this will prevent unnecessary repeat of procedures^[38]. Transporting the patient to a medical facility capable of performing evidence collection is prudent. Not all emergency departments can perform this function, so the onus lies on the provider to know the facilities that are equipped in their area of operations to deal with the patients as an act of responsible referral.

This could be seen as an unfair expectation when one considers the lack of training of the emergency care personnel treating these victims. Emergency care providers are not considered as essential health care workers in the treatment of rape/sexual assault^[40]. This is highlighted in the National Guidelines for Sexual assault where the treatment procedures are focused at in-hospital treatment and in-hospital health care providers.

Emergency care providers are the victim's first impression of medical assistance at a vulnerable time of disclosure or denial. They have the potential to make the patient's transition to hospital or rape centre a safe and empowering experience. Rape victims are required to answer certain questions asked by EMS personnel. This directly impacts the health care they receive and the apprehension of the perpetrator. Questions to be asked are related to the description of the perpetrator, a description of the event and where/when it took place^[39]. The sensitive nature of the questions suggests all EMS personnel should receive training in this regard.

The EMS documentation, if contradictory to the police version, has the potential to undermine the prosecution of rape cases. The chief complaint recorded by the medical personnel should just focus on material and substantive findings. The police role must be acknowledged^[12],^[41] and the medical information recorded should not be used to corroborate legal questions, but to safeguard the patient in terms of correct and just medical treatment. According to Hogan and Uyenishi^[12] it is also extremely important that the language used in this paper work shows that the provider is confident in his/her diagnosis and not show any signs of doubt: "patient alleged

sexual assault” should be stated as “sexual assault/ rape”^[12]. After all, patients are not thought to have ‘alleged’ chest pain or any other condition. It may suggest disbelief.

It is important that when an attempt is made to obtain a history from the patient, that the patient is allowed to control the interaction, giving her a sense of power. This welcoming environment is fostered by a focused and non-judgemental approach from the provider showing her support in this time of overwhelming need^[12]. Sexual assault or rape patients should always be triaged as ‘red’, and should not stay on scene too long, the provider should keep the interval between scene and hospital very short, in efforts to preserve as much evidence as possible, and to limit the trauma imposed by the presence on scene.

Rape and its sequelae can leave a profound effect on the emotional and physical well-being of the victim for years after the incident. This effect is usually referred to as the “*Rape Trauma Syndrome*” (RTS), which was first theorised by Burgess and Holstrom^[42]. RTS has many similarities to Post Traumatic Stress Disorder (PTSD)^[12], which has been shown to develop in a third of rape victims^[48-49]. The emergency physician plays a key role in the treatment of sexual assault. Competent and compassionate emergency care can ease the transition of sexual assault victims to sexual assault survivors who can function adaptively well despite the tragedy.

2.6 Multi-disciplinary response to victims of rape

In order for survivors to receive optimal care a multidisciplinary approach is required. The team approach has been piloted in the United States^{[39], [12]} where patients only get treatment by trained teams that are based at a “sexual assault treatment centre”. In the Western Cape (Cape Town specifically) there are National resources based on the National Prosecuting Authority (NPA) Sexual Offences and Community Affairs (SOCA) unit identification and support programs which has enabled treatment centres called “Thuthuzela Centres”. South Africa introduced these centres as a part of the anti-rape strategy. These are intended to be ‘one-stop’ facilities that help the survivors in every aspect of care, ranging from medical treatment to the evidence provision in the prosecution of their cases. The centre also aims at reducing secondary trauma in rape survivors. The team should consist of police, EMS personnel, prosecutors, mental health care providers, nurses and doctors amongst other crucial personnel^{[39], [12]}. This centre should aim at providing the patient with an approach that is unified and interconnected allowing each role to be focused preventing undue harm to patients.

A community of medico-legal practice like this intends that the victim does not perceive seeking medical attention as a risk. It portrays a safe and supportive environment for the victim to make his/her transition to survivor. Throughout the encounter with victims one should emphasise the “Sexual Assault Survivors Therapeutic Message” (Table 1) ^[12] because care that follows the rape incident has the potential to reduce long term secondary trauma that these survivors may encounter along with possible victimisation.

Table 1: Sexual Assault Survivors Therapeutic Message ^[12]

1. The victim is not at fault. No one ever deserves to be raped. The perpetrator, not the victim, is responsible for the assault.

2. Millions of others have experienced similar pain. The victim is not alone.

3. The victim is now a survivor. She (or he) made the right choices to get through the assault alive. She (or he) is to be congratulated for surviving and for the courage to seek help.

4. Medical care can help with the transition from victim to survivor. Appropriate medical care will speed recovery, ease pain, and help her (or him) move on with a normal life.

In the few cases of sexual assault that are transported by EMS, personnel should be instructed to leave the sheet on which the patient is transported at the receiving facility, as this may contain vital evidence. If possible, they should avoid cutting off clothing. EMS personnel can begin sending the therapeutic message once they understand that the complaint of sexual assault has been made.

This team approach allows for evidence collection and prophylactic treatment to happen in the time frames it should; for instance, preventative treatment for HIV has a 72 hour cut off time as well as the morning after pill which has 120 hours/5day time period. It is of vital importance to provide immediate counselling in what is deemed a safe environment by trained professionals, should we get to these patients as soon as possible after the incident has occurred. Protocols should be established by team players including EMS to take all local considerations into account to develop care practices that draw on international practices but can be implemented locally. This may indicate different approaches for all different scenarios; e.g. attending to rape

survivors within a 24/36/72-hour period post incident versus after the incident when certain limitations are faced.

2.7 Service delivery by a Thuthuzela crisis centre

South Africa has an anti-rape strategy targeted at reducing secondary trauma for the rape victim; help improve conviction rates and turnaround time (Figure 2). In order to achieve these goals, Thuthuzela Care Centres (TCC) was envisioned as one-stop facilities to ensure the aforesaid goals took place without a run-around for the patient ^[43].

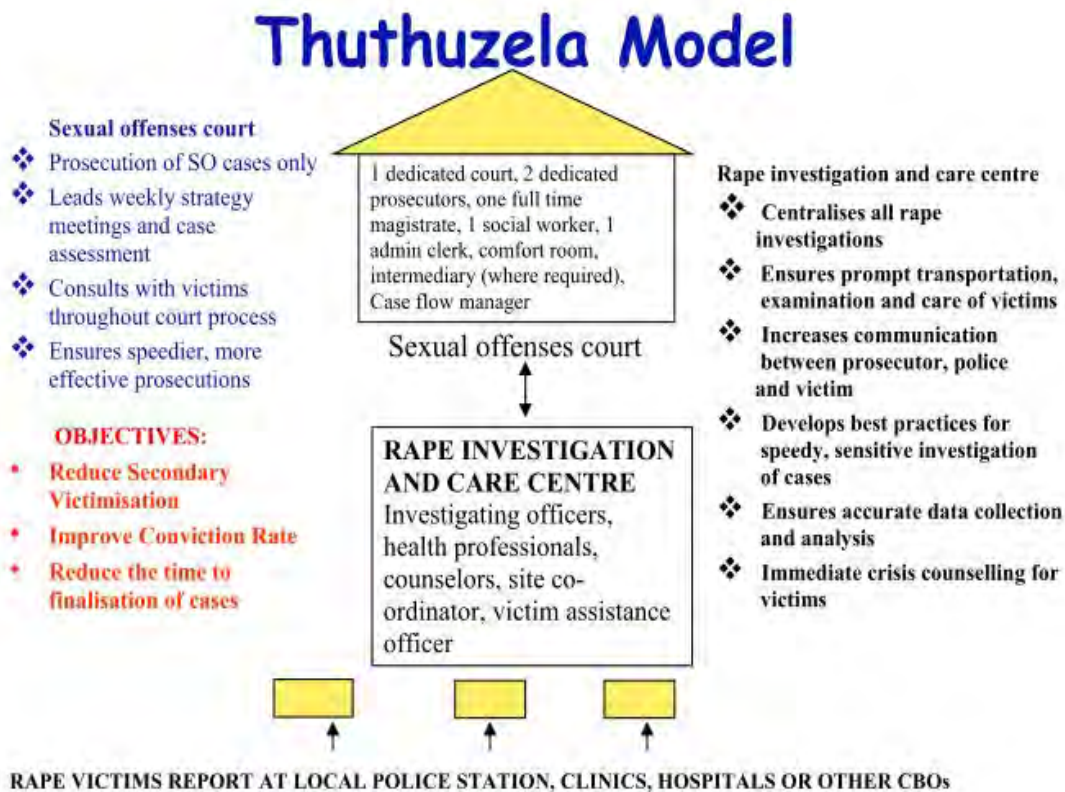


Figure 2: The Thuthuzela model ^[43]

In contrast to the Rape Crisis Centre, the Thuthuzela Care Centre's are led by the NPA's Sexual Offences and Community Affairs Unit (SOCA), in partnership with an assortment of donors to support victims of rape ^[43]. The unit aims to develop best practices in areas of sexual offences, domestic violence, child justice and maintenance as well as to help exterminate victimization of

all rape victims irrespective of gender or age^[43]. One of the TCC's objectives was to try and eliminate the victim from having to encounter multiple personnel having to relive the encounter over and over, taking into consideration what the rape victim may experience and consequences that may follow (Refer to Figure 3).

The context: Rape is complex and has a wide impact in society ...

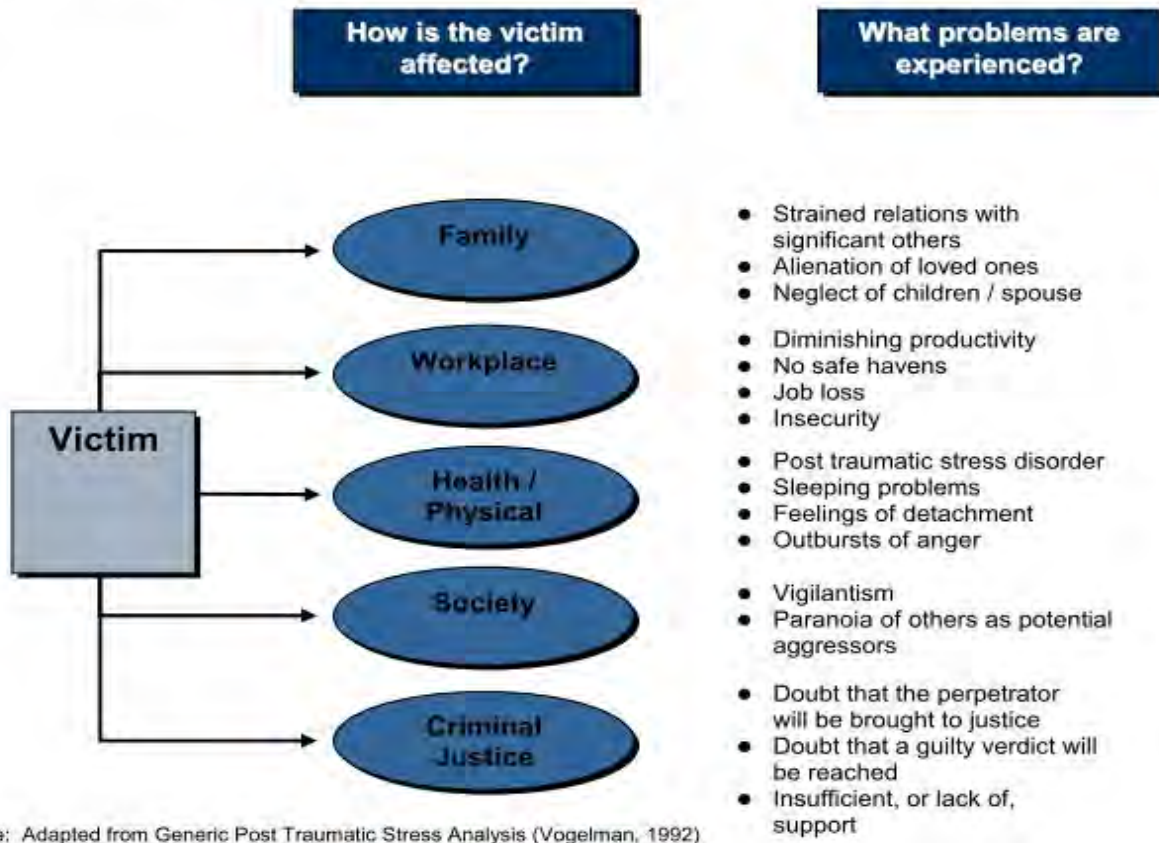


Figure 3: The aftermath of rape^[43]

2.8 Consideration for a version of a J88 form to be used pre-hospitally

The J88 form is an official legal document used by medical professionals to record physical injuries as well as the emotional state of a patient upon examination. The cases that require the use of a J88 form are sexual violence cases that may require legal proceedings for criminal cases post hospital care visit and treatment. Observation of bodily injuries and most importantly

injuries that involve the ano-genital region must be noted accurately; including various DNA samples taken in all cases and forms of sexual assault ^[50-51].

According to Artz and Pithey 2010 ^[44], during health assessments, medical personnel are obliged to complete a full primary and secondary survey on the rape survivor, documenting all they see, smell, hear and touch ^[44], all relating to the patient in question. Its purpose serves to deliver precise explanations provided the J88 form is documented impartially and honestly by all health care professionals ^[45].

For legality purposes for both survivor and provider, a suitable custodian should be present during all examinations.

2.9 Rape survivors need trained providers

Rape survivors have reported that their needs during this time consists of a non-judgmental approach from personnel, a coordinated service delivery system which provides access to HIV and STD treatment and counselling as well as the required information they need to help navigate the legal system for the prosecution of their cases ^[25]. Many factors affect what services the rape survivor may seek at any given time, therefore it is paramount that emergency medical personnel understand that each rape case is unique and should be treated using a sensitive approach aimed at reducing victimization of the survivor ^[46].

Pre-hospital emergency medical care personnel in South Africa are ill equipped to treat the rape victims according to international norms, due to the paucity of policy/protocol that exist for these personnel. The professional naivety has ramifications for the victim. The lack in education and experience may result in incorrect information given to rape survivors post incident, which could impede timed care required for these patients to try and prevent pregnancy from rape and sexually transmitted infections ^[46].

With untrained personnel treating rape survivors as first point of contact, it has been documented that woman experience 'secondary victimization' at the hand of health professionals. A study has shown that medical services were amongst the few that rated as more 'hurtful, than helpful'. "Our inadequacies as pre-hospital health care providers to victims of rape have caused patients more harm, and some never recover in their life time" ^[46]. An

educational change moving forward is inescapable as rape is becoming more overt every day with various health sectors having to face the challenges in treating these victims, but this change is required to happen sooner rather than later^[46].

Given the aftermath these victims are faced with, it is desirable that a comprehensive response delivered by trained personnel that are knowledgeable about patient's health care needs both physically and emotionally, are essential in supporting the patient in making his/her transition from victim to survivor. This is hindered by a fragmented implementation of policy that undermines services for rape survivors in South Africa. This claim is supported by a study that suggested women who have been raped would most value services delivered by personnel who have had training in the health needs of these patients after rape^[47].

2.10 Significance of rape response deficits in Emergency Medicine consultant training

Sexual assault/rape should be considered a medical emergency, and treatment should be prioritized accordingly. Despite the growing incidence of rape, Doctor's working in the primary health care sector is hesitant to engage in medico-legal work. This is mostly likely the result of lack of specialist training, time constraint and high workload^[48]. Notwithstanding that "medical personnel have a statutory duty to provide emergency care to rape survivors, as required by the Constitution^[49] and the National Health Act^[50] and an ethical duty of care stipulated by the HPCSA", the implementation of this principle leaves much to be desired from a practitioner perspective^[51]. Despite the high incidence of rape in South Africa, 32.6 % of health practitioners did not acknowledge rape to be 'serious medical condition'^[52].

2.11 Human rights protection and promotion is an emergency medicine prerogative

"Members of the medical and health professions become involved in four major ways: as victims, as perpetrators, as bystanders (a powerful role), and as protectors and defenders of human rights"^[53]. Education in the field of sexual assault is required in the pre-hospital setting to allow the health care provider to decide which of the four areas of involvement mentioned

above they will become a part of, as the lack of awareness highly impacts not only the victim but the health care provider too.

“Health professionals continue to play a role in human rights, in one way or another. Today, health professionals continue to be complicit in the face of human rights violations. Being complicit in the face of violations makes doctors bystanders, and implies that they are failing to protect these basic human rights”^[54].

It is vitally important that the health care provider become self-aware of the role they play in the bundles of care delivered to rape victims and the type of interaction and encounters they have with the victims. This conduct is emphasised in the General Ethical Guidelines for Reproductive Health (Booklet 13) of the HPCSA which highlights the ethical guidelines for key issues of reproductive health. “The HPCSA condemns violence against women, whether it occurs in a societal setting (such as virginity testing) or a domestic setting (such as spousal abuse). It is not a private or family matter. Violence against women is not acceptable whatever the setting^[55]...” Health care providers are responsible for information distribution for the community, informing them of their rights as well as health care options that would give the patients and/or victims the best possible outcome for survival^[55]. This could not be emphasized enough as a negative encounter could have detrimental effects on victims which could lead to health care being aborted for various reasons, vice versa could be said when the victim has a positive encounter.

When dealing with the victim medical files which could later be used as evidence in a prosecution, it is paramount that medical reports are accurately recorded and kept confidential. One should not overlook evidence that may favour the suspect, and medical reports should not be manipulated for the benefit of law enforcement organizations^[54]. These actions both disrespect and fail to promote human rights, turning medical personnel into perpetrators of human rights violations. Should the regulations of just reporting be adhered to, these actions will promote the survivors right to a fair trial^[54].

2.12 Health risks and victim empowerment of rape survivors

Health care providers in the pre-hospital setting in South Africa do not receive any training on post rape management, including post- (HIV) exposure prophylaxis (PEP). This has major consequences for the patient, as many of them are eligible for PEP within the required time frame when they call for an ambulance. The treatments that are given to victims of rape in South Africa are amongst preventative treatments for HIV, if not given in time a preventable

illness is not being prevented. This incoherent approach is not patient-centred leaving the patient to his/her own devices, having to consult with many people, if any. The lack of awareness leaves the patient essentially untreated and open to HIV, pregnancy risk, secondary trauma and PTSD^[56].

Introducing a strengthened referral system between all services is beneficial to the patients, be it legal or health related. This is a minimum standard for service delivery in victim empowerment: “It should be ensured that victims have received effective developmental assessment, referral and support services, enabling the victim/witness to effectively participate in court proceedings”^[57]. “Such referrals to social support services are the responsibility of health workers, police officers and social workers”^[58].

Conclusion

Emergency care providers are the pre-hospital acute care component of emergency medicine, thus requiring trained providers in the treatment and management of rape victims. Emergency medicine is the specialisation in medicine that intersects with all other specialisations, supporting the platform for a multi-disciplinary response to victims of rape. As such, it carries a moral imperative to protect and protect human rights as an emergency medicine prerogative. This is nuanced when one considers that emergencies by their sudden and indiscriminate nature; renders people vulnerable and can create situations that undermine their human rights^[59]. Rape as an act of violence is a global phenomenon but South African incidence ranks amongst the highest in the world.

“Health professionals have a large role to play in supporting the victims of sexual assault- medically and psychologically- and collecting evidence to assist prosecutions. The health sector is considerably more effective in countries where there are protocols and guidelines managing cases and collecting evidence, where staff is well-trained and where there is good collaboration with the judicial system. Ultimately, the strong commitment and involvement of governments and civil society, along with a coordinated response across a range of sectors, are required to end sexual violence”^[60].

There are best medico-legal practices for rape thus opening the platform to inform South African legislation and policy for emergency care provider contribution to rape assessment management. It is unclear which of the post-rape care-bundle is relevant, feasible and appropriate for pre-hospital emergency care practice in South Africa. This is the very clarity that the study aims to provide. This review is likely to be of relevance to the HPCSA, EMS's and

their staff as well as EMS educators and researchers to promote the need for uniform emergency care responses to sexual assault. It intends to inform practice change in emergency care. The potential areas for consideration would focus around identifications, treatment and referral of rape victims as well as the health risks and victim empowerment of rape survivors.

CHAPTER 3: METHODOLOGY

This chapter aims to discuss the research methodology used in this study as well as a summary of the research design. The study adopted the qualitative approach to answer the questions pertaining to the treatment of rape victims in the pre-hospital setting, with the purpose of describing and understanding the phenomena from the participant's lived experience.

Consideration has been given for the research prerequisite of coherence- best achieved through the constructive alignment of the methodology below using the paradigmatic lens of critical theory. Critical theory is a kind of social theory focused on critiquing and changing society as a whole, in dissimilarity to traditional theory concerned with understanding or explaining it. Critical theories intend to dig beneath the surface of social life and uncover the assumptions that keep us from a full and true understanding of how the world works.

3.1 Study Design

Through a qualitative, descriptive design, the study aimed to document thick descriptions of provider responses in the acute care settings. Strong elements from evidence-informed practice methodology influence the study, namely observation and analysis as well as a 'questioning approach to the current practice'.

"Qualitative research is a form of inquiry in which the researcher makes an interpretation of what they see, hear and understand. Qualitative researchers try to develop a complex and holistic view of social phenomena"^[61].

3.2 Research Paradigm

Critical Theory is the paradigmatic lens through which the data will be collected, analysed and reported on.

The researcher used Critical theory to use voice in addition to the textual data to be collected from participants. This allowed the researcher to triangulate data from different access points, taking into consideration the paucity of data that exists in the South African pre-hospital setting

with regard to management of rape. This gave the researcher the ability to engage actively in the research as an insider, allowing the two to be mixed (researcher and participant).

The researcher's aim for this proposed study was to enable policy recommendations by documenting an understanding of current practices toward victims of rape in the pre-hospital and institutional setting, and through comparative analysis identify the gaps. This required the researcher to dig deep into the emotional wellbeing of the participants, as well as physical constraints that were being faced with regard to this sensitive topic. A superficial look at the surface would not suffice as the phenomenon of rape is a growing emergency care burden. Taking the above context into consideration the researcher felt that a qualitative lens was best suited to yield data specific to the questions at hand^[62].

"The aim of interpersonal violence prevention and medical treatment of these victims are consistent with that of critical theory: critique and transformation, restitution and social emancipation"^[62]. The researcher needed to be critical of current processes, informing policy and promoting the change for guidelines to be established for emergency medical personnel in the pre-hospital setting with the guidance of the four key principles mentioned above.

Critical theory was the paradigm of choice for this study on rape management as Naidoo, N and Knight, SE and Martin, LJ articulates...

"The emergency care provider, like any health care provider, has the potential to be an agent of change, and the power to uphold or violate human rights in respect of violence and the health response. Critical Theory provides an ideological perspective (with explanatory power) that may facilitate the understanding of such concepts and their potential to promote a team of emergency health workers that are forensically accountable, clinically sound and responsive to public health and forensic needs"^[62].

Currently, in South Africa, we have no guideline or definitive policy in place that allows a designated team of emergency care providers to be specially trained in the care required to treat this patient population: there-in lies the practice problem.

"Structural and historical insights constitute the critical theory nature of knowledge which may be generalized by similarity. The quality criteria include: historical situatedness and an erosion of ignorance and misapprehension as well as stimulus to action/change"^[63]. This study was aimed to draw focus to the lack of guidelines or policy^[6] currently existing in the pre-hospital management toward rape victims, and by using the critical theory approach this will allow the

researcher to advocate for future policy to be considered in this regard without the criticism of undue researcher bias.

3.3 Study Setting

This research takes the form of a qualitative study with triangulation of methods. Individual interviews with representatives of the Thuthuzela Care Centres in Cape Town and emergency care providers were conducted separately as well as a focus group interview with the emergency medicine consultants/registrars.

3.4 Sample population

The following participants were invited to voluntarily participate in this study:

3.4.1. The most senior representative from the Thuthuzela Care Centre (a minimum of 1 participant from each centre) in Cape Town. Thuthuzela Care Centre personnel were used due to the fact that they are a point of entry for Emergency care personnel that treated potential rape victims. They played an important role in informing what role Emergency care providers play not only with regard to medical care but to emotional well-being of the victim.

Thuthuzela Care Centres (TCC) included in this study were the TCC based in GF Jooste Hospital (Since moved to the Mitchell's Plain Hospital) and the TCC based in Karl Bremmer hospital. They have 5 functional staff (which comprises of a Doctor, nurse, psychology co-ordinator, councillor and victim unit (legal team)), resulting in two who are eligible to participate in this study from each centre.

3.4.2. Emergency Medical Care personnel (1 participant from each provincial ambulance base in Cape Town). Emergency Care Provider's (ECP) were chosen for this study as they are the highest qualified advanced life support provider's (they have a 4-year degree) and limits the confounding variable of medical curriculum limitations. This was the preferred participant, however taking into consideration that this was still a young profession with a large portion of its population taking job opportunities abroad, provision was made to include advanced life support personnel that obtained a National Diploma and had more than two years working experience,

on the basis that they were the highest qualified pre-hospital provider available to rape victims in a locale.

Metro Ambulance bases included were: Pinelands, Tygerberg, Lenteguur, Khayalitsha, Paarl and Stellenbosch base.

3.4.3. One representative (a consultant) from the emergency department for secondary hospitals in Cape Town: Emergency Care physicians are the links between Emergency Medical personnel and the rape crisis centres and are both the receivers and referrers of rape cases.

Emergency centres (EC) included were Karl Bremmer, Mitchell's Plain since the closure of GF Jooste, New Somerset and Victoria Hospital. False Bay was excluded as they had no Emergency Specialist based at this hospital.

It is fundamental to triangulate the activities of the three entities to be able to identify what is being done for the victims of rape and if they are consistent with what is required.



Figure 4: Triangulation of methods toward a gap analysis of emergency medicine rape responses

As the participation was voluntary, size of sample was estimated to be between 9-18 participants. This would consist of 3-6 Thuthuzela Care Centre Representatives, 3-6 emergency care providers who dealt with rape in the past and 3-6 Emergency Care physicians' consultants.

The sampling method used was purposive sampling, as the population sought needed to be involved in or associated with the treatment and ethical obligations toward victims of rape. The actual sample size resulted in 13 participants due to GF Jooste hospital being closed and False Bay hospital not having an emergency consultant based at the hospital.

Statistical analysis was not intended by the PI in this study as qualitative thematic analysis was. The PI was concerned for paradigmatic incoherence at the level of the methodology at all times. Whilst it is true that the sample size is 'small' (13), a sub-group analysis of the sample was not intended. The EMS sample could not be larger as there were no other EMS staff that satisfied the inclusion criteria. To abate the concern for generalizability, however, the findings are not generalised toward a population, but toward theoretical propositions.

3.5 Exclusion Criteria

Table one shows the hierarchy of advanced qualifications.

- Any BTech provider working for the provincial government not registered with HPCSA currently as an ECP, as well as <1 year of experience.
- Any National Diploma provider working for the provincial government not registered with HPCSA currently as an advanced life support provider (ALS), as well as <2 years' experience.
- Thuthuzela Care Centre personnel that do not have permission by the organisation to be a participant, as they must have the authority to correctly represent the organisation.
- Emergency Care consultants/registrars that have been at the participating hospital for <1 years.

Table 2: Hierarchy of qualifications

Hierarchy of qualifications (Advanced life support providers)	BTech (ECP)- 4 year study period
	National Diploma- 3 year study period Vs
	Critical Care assistant (CCA)- 9 month study period.
	Emergency Care Technician (ECT)- 2 year study period

3.6 Data collection methods

The qualitative method used to collect data in this study was the interview technique. Specifically, the semi-structured interviewing method was employed. Semi-structured interviews are reasonably formal interviews which have a definite research schedule, and often employ open-ended questions as a primary means of obtaining information ^[61]. The semi-structured interview technique was selected for this study for two primary reasons. First, it was suited to explore fully the issues surrounding the management of rape in the pre-hospital setting. Second, it provided the researcher with the flexibility to establish the meaning of the answers given by the participants, by probing for more information and clarifying the answers (See Appendix A).

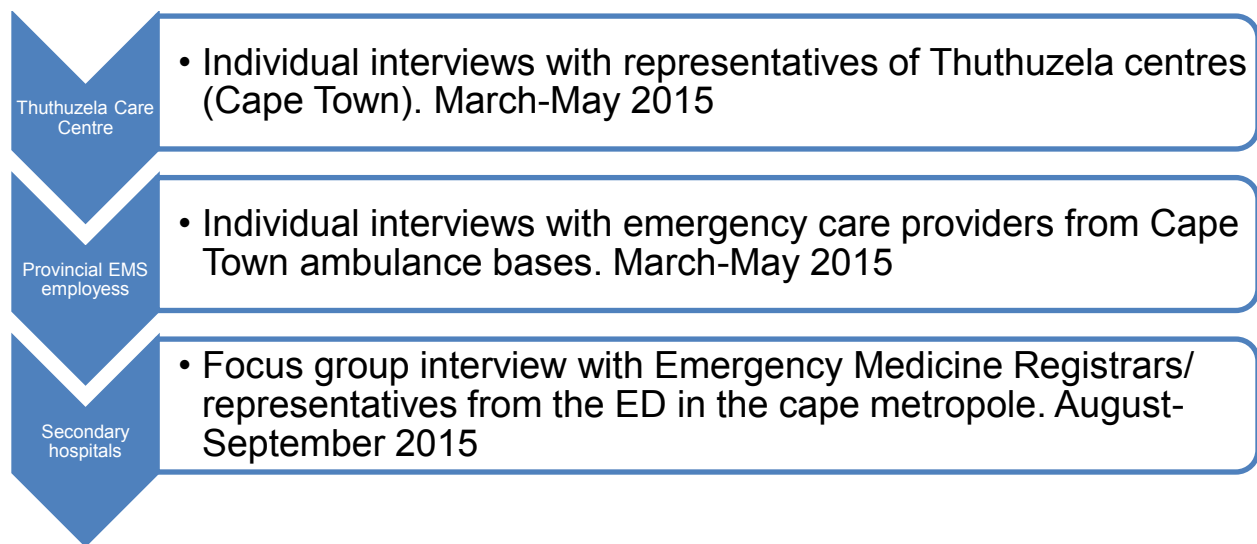


Figure 5: Interviews conducted

The focus group interviews with emergency physicians (consultants) were held according to the participants' availability. There-after the individual interviews with representatives of the Thuthuzela Care Centres in Cape Town and Emergency Medical Care personnel who have dealt with the victims of rape in the past were conducted. For the focus group interview the researcher used the individual interview themes to guide the focused questions, therefore the individual interviews were analysed and interpreted prior to conducting the focus group (Figure 5).

3.7 Procedure used

The researcher visited the Thuthuzela Care centres, hospitals and EMS Personnel (Appendix B) where the victims of rape are transported to engage with the personnel that are directly involved with the management of the rape victims (EMS personnel, Thuthuzela Care Centre representatives and ED registrars), where the researcher personally informed the staff about the study. The staff willing to participate signed the study consent form.

The consent form stressed (as well as a verbal reminder before the interviews) that they could withdraw at any point if they felt uncomfortable. The staff of the Thuthuzela care centres, hospital and EMS personnel was informed that participation was voluntary (Appendix C). Furthermore, the above mentioned participants were given a letter which explained the aims of the study and various ethical considerations, such as confidentiality and anonymity (See Appendix D).

The following initial procedures were adopted:

- The researcher approached the people responsible at the crisis centre to inform them of the commencement of the study, as well as the EMS personnel and Emergency physicians participating.
- The researcher met with EMS personnel, Emergency care physicians and Thuthuzela Care Centres staff to discuss the consent form to be signed as well the parameters of confidentiality, as tape recorders were used, and to explain the intended format of publication of the research results.
- The researcher interviewed the EMS personnel, Emergency care physicians as well as Thuthuzela Care Centres staff in order to gain insights as to what care has been given to victims of rape and the referral procedures following the identification of these victims.

3.8 Data collection Tools

The researcher used the method of semi-structured interviews. This allowed the researcher to engage with the participants in a conversational manner by using open-ended questions as a primary means of obtaining information. It was important to establish rapport with a participant in

order to achieve more in-depth data saturation on the subject at hand including the attitudes and experiences of the participants.

As the health worker's/ crisis interventionists are not immune to secondary/ vicarious trauma, the technique of motivational interviewing was employed.

Motivational interviewing was used by the researcher to conduct the interviews with open ended questions. Motivational interviewing is defined as “a collaborative, person-centred form of guiding to elicit and strengthen a motivation for change” [64]. Motivational interviewing is based on three fundamental elements between the interviewer and the participants, which consists of collaboration (between interviewer and participant), evoking or drawing out (the participant's views of their own experiences) and emphasizing the autonomy of the participant (Figure 6).

The fundamental elements mentioned above allowed the interviewer to be cognitive during the interview, refraining from the following contrasts that are very closely aligned [64]:

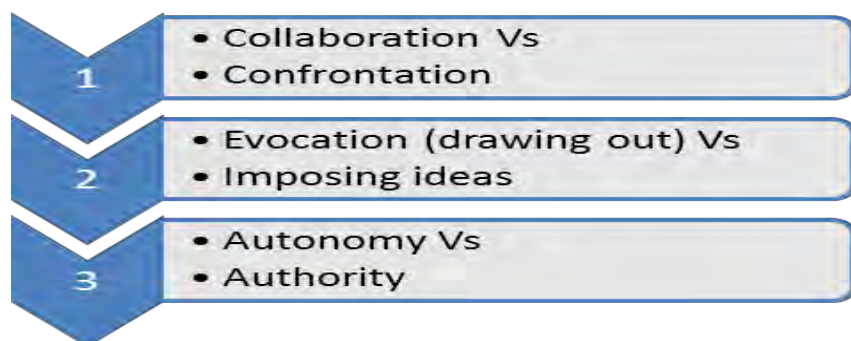


Figure 6: Core elements for motivational interviewing

Collaboration helped build a trusting relationship with the participants, allowing them to share their experiences with more ease than in a confrontational approach, causing the participants vulnerability to be exposed not having a safe environment to relive their experiences.

It was of utmost importance to draw out the experiences of these participants and not impose one's own ideas onto them, as each person's experience is different and by making their experience seem “okay” or “the norm” by assuming what they went through would be detrimental to these patients [64]. This was avoided at all costs.

Motivational interviewing identified that the true power in healing and change for these participants in question was to allow them to hold on to their autonomy, this was not only empowering to the participant but also gave them a sense of responsibility for the actions they taking. Once one resumes the role of an authoritative figure you lose this relationship and the participant refrains from participating.

Bearing in mind the three fundamental elements, there are four principles the researcher/interviewer used throughout the interview process ^[64]. They are as follows:

- Express empathy
- Support self-efficacy
- Roll with resistance
- Develop discrepancy

The combination of the four terms mentioned above allowed the interviewer to build rapport with these participants but also to maintain their trust. This was of vital importance when one communicates with participants of such nature. The above was guided by the interviewing skills and strategies that were used by the interviewer. These strategies were namely open ended questions; affirmations; reflections and summaries. These strategies were put in place to help ease the process with the participant building therapeutic alliance and stimulating discussions about their experiences.

3.9 Data Analysis

The semi-structured interviews and focus group were digitally recorded and transcribed. Data collected was transcribed for descriptive themes and then interpreted using thematic content analysis. Data analysed was compared to the existing policies and legislature so as to make recommendations to enhance treatment practice and ethical obligations toward victims of rape. The Thuthuzela Care Centre Clinical Forensic Medical Practitioners were interviewed for health system integration and oversight considerations.

The recorded files were kept in the researcher's home, in a locked safe which only the researcher had access to. There are no other occupants in this vicinity so the recorded files were not compromised at any point in time.

The researcher performed all the transcriptions and translations for this study.

3.10 Appraisal of Trustworthiness

According to Guba and Lincoln, in "Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches": trustworthiness is the equivalent term for "rigor" in qualitative research^[65]. To ensure trustworthiness was considered during the study, the researcher was guided by four principles namely; credibility, transferability, dependability and confirmability^[66]. The researcher had also gone through the process of ethical approval for the feasibility of the study, and had received approval from both the University of Cape Town and Department of Health (Appendix E, F & H). The researcher in addition to the ethics approval had received permission from the heads of department to access Thuthuzela care centre, rape crisis centre as well as the emergency medical care personnel (Appendix G).

3.10.1 Credibility

Lincoln and Guba define credibility as the "confidence in the 'truth' of the findings"^[66]. I used triangulation of sources to warrant the findings in this report and used the emergent themes in discussion that was synthesised from the literature review, interview data as well as the available evidence-informed policy guidelines. The researcher made use of peer debriefing by sharing the content of the study as it evolved with the supervisors of the research, allowing for the opportunity to read and probe the report, questioning the process and allowing the researcher to defend emergent hypotheses without bias. This provided the researcher with the opportunity for authenticity, catharsis (cleansing) and reflexivity.

3.10.2 Transferability

Lincoln and Guba define transferability as "showing that the findings have applicability in other contexts"^[66]. This qualitative descriptive study could be applicable to other gender-based violence contexts insofar as they relate to emergency care providers. Due to the paucity of data

around pre-hospital management of rape victims and the lack of policy, the researcher would advocate for further investigation around the topic at hand, to enable any generalisations toward a population to be made. Theoretical generalisation however may be made, that emergency care providers have a role to play in response to victims of gender-based violence, be it rape, domestic violence, or human trafficking. Whilst it is true that rape is a form of gender-based violence, not all gender-based violence includes rape. The extreme physical violence and bodily mutilation that has characterised rape in South Africa and as an object of war and misogyny, suggest that the context of interpersonal violence has strong linkage to this study purpose. Emergency Care Providers respond to victims of physical violence as an everyday occurrence, without considering the diagnostic, prognostic and treatment nuances of rape and sexual violence.

3.10.3 Dependability

Dependability allows the researcher to show that the findings are consistent and that it could be repeated ^[66]. The researcher achieved this by using the supervisors of the project as external auditors, as they were not involved directly in the study and served as a 'sounding board' examining the research process and product. The external auditor's role was to evaluate whether or not the findings, interpretations and conclusions are supported by the data ^[66]. Text and textual interpretations are presented in sync in the results in support of a claim of dependability.

3.10.4 Confirmability

The fourth principle is confirmability, which refers to the quality of the results produced by an analysis in terms of how well they are supported by the researcher involved in the study and by events that are independent of the inquiry. The researcher supported findings with literature to fortify confirmability of the study in addition to information and interpretations by participants other than the inquirer both from within the inquiry site ^[67] and between stakeholders (emergency care providers, Emergency consultants and clinical medical forensic practitioners).

3.10 Dissemination Strategy

Careful consideration of a dissemination strategy was guided by (a) who should receive the contents of this study, (b) where and when the information should be disseminated, and (c) what information should be disseminated. This will ensure that one maximizes the relevance of the research making it accessible to all that will benefit from this research.

a) Who should receive this research?

i. Education Institutions (FET and HET) who offer various levels of pre-hospital emergency care training

ii. The students enrolled in Emergency Medical Care

iii. Policy maker (allowing for opportunity to inform new policies) i.e. HPCSA

b) Where and when the information should be disseminated?

i) Educational committee meetings at the end of an academic year, where they have a look at the program and proposed changes there is to consider.

ii) HPCSA Boards should review this research and consider adding the findings to the EMS provider's scope of practice across the board.

iii) Thuthuzela Care Centres as well as all the ED's dealing with victims of rape

c) What information should be disseminated?

i) The results of the study, alongside the recommendations and conclusions are the most important information to disseminate.

ii) How it should be presented: (The more used the more dissemination occurs). It is important to remember that before dissemination occurs, the content needs to be prepared and tested.

iii) Academic Forums (Journals, conferences etc.)

iv) Accessible forums (open access, online, open workshops & presentations)

v) Promotional Distributions- supporting forums dealing with rape crisis interventions

vi) Organizational Interventions

vii) Networks- Research gates

CHAPTER 4: RESULTS AND ANALYSIS

This chapter presents the results of the data collection and initial analysis. It is presented in three parts: Section A is the emergency care providers' interview results, Section B is the clinical forensic medical practitioners' interview results and Section C is the emergency medicine specialists' interview results. All three sections converge themes in a joint analysis as depicted in Figure 7-9. In the interest of foregrounding participants' voices and demonstrating authenticity, the researcher's interpretations precede relevant excerpts from the transcripts of the data. This runs the risk of providing some repetitive textual representations; however, the intention is to pursue accountability as a novice researcher and to reflect ideological and behavioural alignment/malalignment amongst critical stakeholders in rape responses. The ensuing discussion of collective themes (Chapter 5) provides for a deeper analysis, not at the level of the text but at the level of what is theoretically possible and needed.

A: Emergency care providers' interview results

Participants in the Emergency Medical Personnel sample included advanced life support providers, who were either a Paramedic³ or an Emergency Care Practitioner⁴. One participant from each base in the provincial Emergency Medical Service, situated across the Metropole⁵, was sampled purposively, with a deliberate focus on the urban context as an exploration of rural limitations to care for victims of rape was not a direct study objective. Six interviews were conducted and thematic analysis was used to decipher common themes for discussion (Figure 7).

³ 'Paramedic' is a HPCSA protected professional category (in terms of regulatory nomenclature) for a holder of a 3-year National Diploma in Emergency Care, duly registered as such.

⁴ 'Emergency Care Practitioner' is a HPCSA protected professional category (in terms of nomenclature) for a holder of a 4-year Bachelor of Technology in Emergency Medical Care degree, duly registered as such.

⁵ The 'Metropole' is an urban setting.

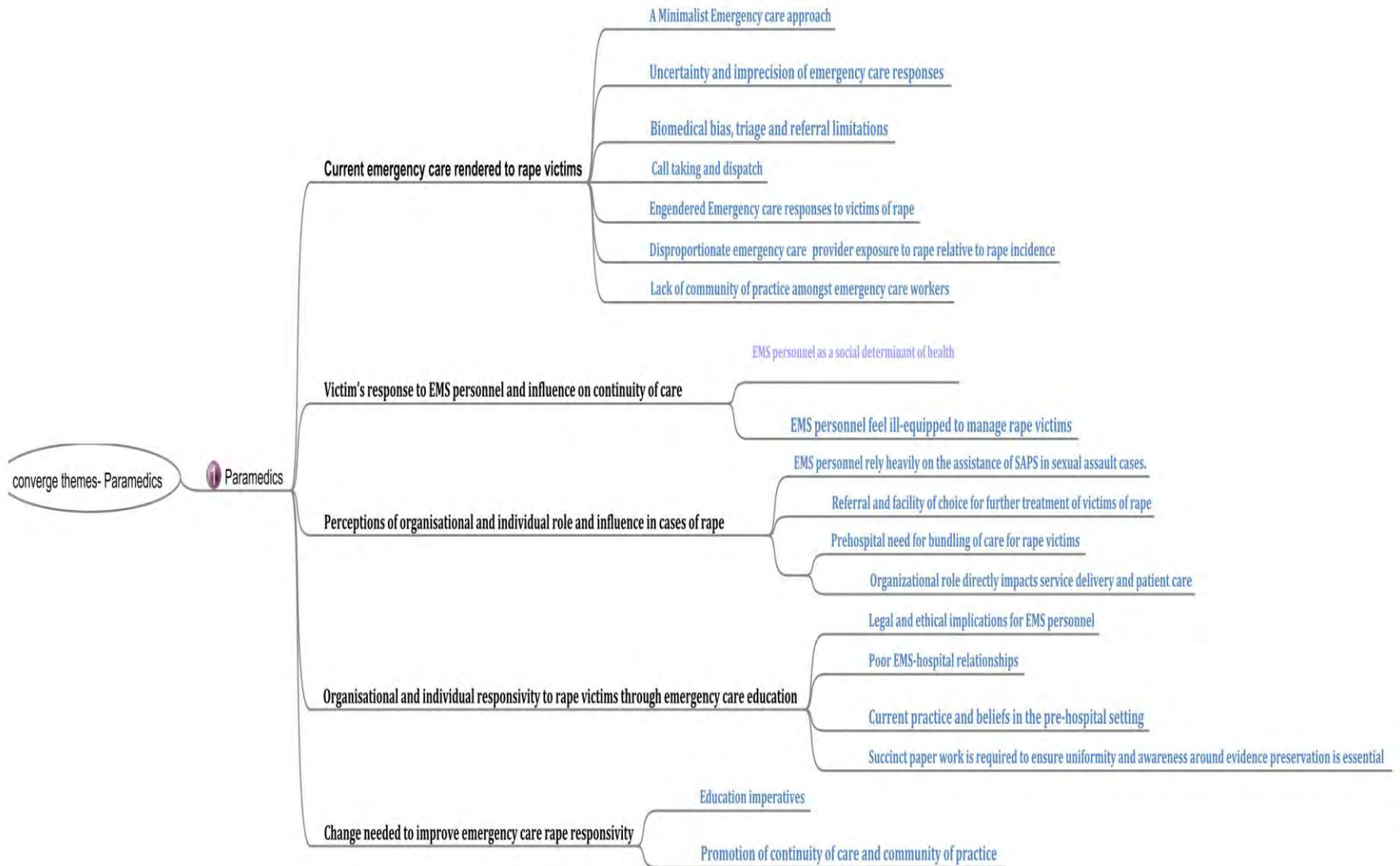


Figure 7: Convergent Themes: Paramedic interview results

4.1 Current emergency care rendered to rape victims

4.1.1 A Minimalist Emergency care approach

Participants provided convergent views that suggest a minimalist emergency care approach to victims of rape. It would appear that a highly sophisticated medical system, often mooted as the best in the country⁶, may be reduced to a transport system alone as regards the response and handling of victims of rape in the pre-hospital setting. There is also no expectation of care from emergency care providers by the South African Police Services (SAPS) that aligns with gender, health or criminal justice imperatives. Intersectoral collaboration - a mantra of the democratic dispensation - at the patient interface appears to be substantively absent. There prevails an assumption that in serious cases, the police will attend to victims in the hospital. The provision of 'comfort', albeit ill-defined, may serve as proxy for appeasing the provider conscience and a minimum standard of care. Notwithstanding, transportation is claimed as a minimum standard but participants being unaware of the specified and specialised receiving facilities for suspected or confirmed rape victims reduced emergency vehicles to "glorified taxis" (Participant 4). So, transportation or rape victims may occur, but the referral may be neither responsible nor appropriate.

PARTICIPANT 1: Basically, the treatment that we're currently doing is basically just transportation of, if we get on the scene SAPS will phone us and then we will transport patients. The idea behind the whole thing is not to really get involved. Yes, you can give the care and attention and make the comfortable as possible but don't interfere, don't ask questions or really get involved.

PARTICIPANT 2: Usually, we do transport to the, what's it – I know in Somerset West they have a what do you call that? I think it's a rape counsellors'... a rape crisis centre....Ja⁷. So usually we transport them to there or if they have serious medical conditions like lacerations that need sutures and stuff, we usually first take them to the hospital and then the police will follow up with them there...

PARTICIPANT 4: You know, in a lot of cases we are just glorified taxis you know but to be able to actually start the care right from then would be a good thing. I think that would be definitely something to look into.

Participant 2 qualified the notion of 'care by proxy' in that in cases where the advanced providers were not available the Basic and Intermediate qualified provider would be tasked with

⁶ Dr S de Vries. 2015. EMS Director's inaugural lecture to final year ECP students. Cape Peninsula University of Technology, Cape Town

⁷ "Ja" is an Afrikaans word literally meaning 'Yes'. In the context above it indicates agreement with the preceding statement/s.

the patient assessment and the relay of information. The rationale of not wanting “to intimidate the patient too much” raises questions about why paramedic intervention would be perceived as intimidating or intrusive and if so, what would constitute an acceptability scale for ‘intimidation’? Would rape victims not be expectant of the most qualified professional?

PARTICIPANT 2: Well, we don’t really experience them often but when we do it’s usually just the basic medical care. What I’ve experienced is that usually because I’m a male the females don’t really want to be assessed by a male. So usually, if there’s no paramedic that is available that can offer assessment then I usually get [BAA or AEA?] to come in and then assess and then just relay the assessment to me because obviously, I don’t want to intrude or don’t want to make a – I don’t want to intimidate the patient too much.

Reported experience by the emergency care worker was that basic assessment and care was provided on the basis of a language barrier. The act of providing minimal care was seemingly justified by the language barrier. Such an explanation of inaction, tantamount to a deflection of responsibility, may have deleterious consequences for completeness of care - most of the time - on the one hand and assumption of responsibility for care on the other.

PARTICIPANT 2: I’ve had one instance of a boy but it wasn’t totally confirmed that he had [sexual assault] suspicion. But ja, then again also, [I] just did the basic assessment, trauma assessment, didn’t really do any counselling, anything like that. But that could also be because of the language barrier. He was an African boy and he didn’t speak so well English. So that was also one of the barriers that I’ve identified at the scene.

A general consensus with regard to the treatment rendered to victims of rape amongst all emergency care providers interviewed, was that of supportive care. Despite case specific experiences, the bundle of care of choice seemed to be basic/supportive care unless a traumatic physical injury occurred in which case participants will perform their emergency treatment en route to the emergency department. However, should the victim have no physical injuries, the emergency care providers that are aware of the individual rape centres (Thuthuzela/rape crisis) would transport to the specific facility within their area, but this practice has some areas of concern due to the lack of education and awareness around the required treatment for victims of rape ranging from medical care to referral to the correct facility. These areas of concern emerged from the reported experiences of the emergency care providers.

4.1.2 Uncertainty and imprecision of emergency care responses

EMS personnel in many cases are the link between initial treatment and definitive care for victims of rape. As the first responder in any medical/trauma emergency, should not be grappling with sentiments such as "...at the moment... I don't really know what I'm supposed to do. So I phone my dispatch and say please tell what am I doing..." This is alarming as treatment and management of victims of rape requires one to be sure of management; require personnel to call for specified assistance such as the police for example and require EMS personnel to possess both the hard skills (physical management of victims) and the soft skills (ability to converse with a patient that has been emotionally affected that may display an array of emotional outbursts). In the absence of this, you open the patient up to experiencing secondary victimization and trauma which has been shown to directly impact the patient's ability to heal and move past the act of rape. Participants have also claimed in their responses that "...our main function is to treat medically first". What is it to treat medically? Can treat in any other way?

PARTICIPANT 4: ...treatment would be... compassionate but also not trying to, I don't want to use the word pity... I don't want to make them feel worse about the situation you know...also not trying to smother them with my presence...

PARTICIPANT 5: ...basically, at this stage it is more supportive [care] ...as far as giving advice that is the difficult part ...We just try and make them as comfortable as possible on the bed, covering them with blankets... There are people who are way more capable than I am of doing that...

PARTICIPANT 6: ...our main function is to treat medically first.

4.1.3 Biomedical bias, triage and referral limitations

What is the meaning of the system labelling a traumatic and gross violation of personal rights as a mere medical type 29 or 5? Does it point to the normative regard toward rape, because it seems that no one is even certain of the call type or what it means, it's just been grouped into a category with no specific reference and priority. It is as normal as asthma? These codes are not specific to sexual abuse, there is no specific triage score that has been developed for victims of rape, which has intern resulted in the absence of nuanced care. They are generic and ignore the distinction of sexual abuse, with or without visible injury. Uncertainty of priority coding, despite age, high index of suspicion for rape has influence over attitudes and responses

such as “ ...I mean usually it’s the same ABC you know kind of assessments, secondary assessments and no real changing process or anything that goes with that. So it’s just purely of getting the call, being dispatched, arriving, assessing and taking the patient to wherever they need... to go.” EMS personnel should be well equipped to treat victims of rape so that victims of rape do not continue to suffer abuse of their human rights.

PARTICIPANT 1: We’ve got a call sign...I think its type 5, it is a possible rape victim... We normally take them to the closest hospital... and their triage colour is supposed to be red

PARTICIPANT 2: ...it depends on the area that we’re working in...they were always taken to the Rape Crisis Centre. We do our assessments. If there’s no further medical treatment needed, we take them to the Rape Crisis Centre...I have absolutely no idea. What we worked on a long time ago is that if you get a rape victim or a suspected rape victim then - and there’s no medical emergency that’s going to kill the patient now, we take them to the space in Karl Bremer that little blokkie outside M5...

PARTICIPANT 6: No specific call sign. It’s just medical so for example, if the patient – they won’t rate it under trauma. So it’s a medical [type 29?] case and then we take the patient as per triage score...Not specifically to maybe the Thuthuzela we have at the district you see.

The management of rape victims is experienced as unknown territory where the providers become vulnerable and exposed and often experience defensive behaviour and vicarious trauma such as Participant 3 “I really don’t want to think about that call but any case”.

Participant 3 below, as case in point, felt comfortable to treat the unconscious female in comparison to the conscious patient that would have questions he/she could possibly not be able to answer and would have to face examination and treatment that is vastly intuitive and case-experience dependent.

PARTICIPANT 3: So, I mean, obviously the one lady was completely out of it. She ended up being intubated and ventilated. So at least I could look and see, okay but here is this and that and all the other and then we tried, we carried her, she was far away. They left her on a dump. I really don’t want to think about that call but any case. So we carried her, when we moved her over we moved her into a sheet, to a sheet and a, like around her and another sheet and then we put her onto the trauma board so we can carry her, on the [scoop?] so we can carry her out. So we left her like that tied up with all the bits that came with her when we rolled her and took her to hospital like that. And then I also explained there, when I handed the patient over that this is how we tried to at least contain whatever is containable. So what they did after that, I don’t know.

4.1.4 Call taking and dispatch

In the absence of policy and training, the emergency care providers rely on basic tools of assessment for these patients that creates the false dichotomy of trauma cases and medical cases. A step forward has been taken by allocating a call sign in efforts to identify these victims/patients however this is not well known and emergency care providers rely strongly on the advice of control and dispatch as to what to do with these patients require and where to take them. This role is misaligned to roles and responsibilities of a control/dispatch centre. Therefore, role definition and treatment policies to avoid these patients being mistreated may mitigate misaligned roles and responsibilities.

PARTICIPANT 1: We've just got a call sign...like I think its type 5, it is a possible rape victim...We normally take them to the closest hospital....But the control room normally if we ask them they would know where to take the patient...there's no policy in place as far as I know for us and for the victims.

PARTICIPANT 3: Never transfers, only primary pickups...Well the treatment would depend on what was done to the rape victim before we got there. So if its trauma related, obviously fix that and then take them to a trauma centre first. If there's no visible trauma, then usually we're supposed to take them to Karl Bremer Hospital. They have a centre, rape victim or rape crisis centre. I've had some really bad experiences there. So I've taken four patients there in total ever since I've been working in the northern division and three of them, I had lots of issues with. So at the moment we don't, I don't really know what I'm supposed to do. So phone my dispatch and say please tell what am I doing. At least now Karl Bremer's got a trauma unit so you can take them there now and they can sort out both trauma and the, what w

PARTICIPANT 2: At the moment I mean it's not really differentiated because I mean a call comes through which is a call is a call... You must go... and do the call. I know the only way they like over the radio they will say a Type 5, I think is a Type 5 or a Type 7, one of the two. Obviously, it depends on the area that we're working in...If there's no further medical treatment needed we take them to the Rape Crisis Centre and then there they will – I'm not sure what they do there but we hand them over. But as for relaying that message over the dispatch, there's no real process or anything that goes with that. So it's just purely of getting the call, being dispatched, arriving, assessing and taking the patient to wherever they need to wherever they need to go.

4.1.5 Engendered Emergency care responses to victims of rape

Dichotomies created on false premises exist in the community of EMS regarding perceived female care-giver preference toward victims of rape. A better understanding amongst emergency care personnel and what their thoughts around rape are would help identify the root

cause of such responses. Awareness and education around what rape victims need from emergency care personnel when seeking help and assistance need more unpacking as the balance between what current practice and beliefs are and what they should be requires more understanding.

Further, no participant identified male rape victims as patients, and this too has major implications for both health care providers and patients. Male rape victims do exist and require providers to be knowledgeable of their circumstances and the specified rape management required to treat optimally avoiding secondary trauma or victimization. It is a common misconception that only women fall prey to rape and not men, such myths are damaging to the population resulting in missed opportunities in seeking health care and conviction of the perpetrators. A change in mindset is required.

4.1.6 Disproportionate emergency care provider's exposure to rape relative to rape incidence

Notwithstanding, the participant claim of uncommon experiences of rape patients, the anecdotal finding in support of a perception of female caregiver preference is acted upon. This perception is not critically reflected upon by participants. Neither is the professional conduct of male caregivers that may drive such perceptions. Still, the perceptions remain untested and serve as an indictment against male emergency care responses. If a hijacker is of white race, does this preclude all white paramedics from treating hijack victims? What of short people, tall people, people with facial hair? Can there be no healing potential in acknowledging violent acts as violent acts, perpetrated mostly by men, but counterbalanced by non-violent men, caring and empathic men, in friendly uniform and non-threatening? There seems to be a need to delineate that which is actually and perceptually needed by the rape victim from that which is actually and perceptually needed by the emergency care provider. The assumptions of engendered preferences may be provider guilt-laden and counter-productive to the progressive positioning of men as solution-oriented.

PARTICIPANT 2: ...I'm a male; the females don't really want to be assessed by a male. ...I don't want to intrude or ...don't want to intimidate the patient too much. From what I've experienced being a male, coming into a patient that has just been raped by a male, it is a bit more upsetting to the patient. But if there's nothing else you can do, I mean, I always try and make sure there's a female present at all times. But I think it would be

advantageous to have a female assessor, a female that has been raped, just to avoid that anxiety and the stress that could possibly happen.

PARTICIPANT 5: Minimal touch, reassuring her, ensuring that she understands that she's safe and that is basically the majority..., in the sense that if we're male and female on the vehicle, then I will sit in the back, trying to make it as comfortable for her as possible. When we get into the hospital or even in the back of the ambulance we don't use the word rape or verkragting [Afrikaans word meaning rape] for that matter. We basically just try to establish what has happened and as soon as we get the suspicion or they tell you that they've been raped then we don't dwell on that... there is nobody that can tell him the procedure. This includes me. I don't know why it felt different towards a male but it did.

The uncertainty and value judgement of provider gender preference is present above and below. Participant 1 appeared surprised that the male partner "actually spoke very well and very nicely to the lady [rape victim]". The addition by participant 4 that men are also victims lend credence to the need for gender neutrality in care-giving.

PARTICIPANT 1: ...SAPS normally call us query rape or whatever. Send a female crew out, a little thing like that. I just think being a female you would have more empathy with the patient. I actually don't know. I mean I worked with a male partner the one time as well where he actually spoke very well and very nicely to the lady.

PARTICIPANT 4: ...it's not just women who get raped, it's men as well and it's something that is kind of overlooked a bit... But, ja, just the awareness that, you know it does happen and that it's not something that should be ignored because I feel from what I've heard and what I've read a lot of, it's more predominant for a male rape victim to kind of try to hide the fact that they have been raped because they don't want to expose that because it's somehow a sign of weakness you know...which is bizarre. I mean, rape is rape. You don't, there's, nothing of it is your fault... I mean, you think of sexual assault you immediately think of a female patient. You don't think of a male patient.

4.1.7 Lack of community of practice amongst emergency care workers

It is apparent that the structures that are currently in place (Thuthuzela and rape crisis centers) are not being used for its intended purpose by emergency care providers. Emergency care providers have interacted and transported patients from Thuthuzela and did not even know that it was a Thuthuzela Care Center and did not know what service it is that they deliver until a patient had told them. Have providers become so robotic in their care, that they see themselves as taxi drivers in a transport service? On the other end of the spectrum, this could be due to many reasons, such as lack of awareness and exposure, inadequate training in this area of

expertise as well as within their own structure, referrals are lacking and are not being identified. Doctors and nurses that emergency care providers encounter on a daily basis are not raising awareness in this pre-hospital community by directing EMS personnel to the centers on their premises. No one seems to think it is their responsibility to treat and care for victims of rape, in fact Participant 5 went as far as to say “there are way more capable people of doing that” than myself.

PARTICIPANT 2: I've heard about them but I've never really had a – no, we've never taken – I know at Helderberg Hospital, I'm not sure if that is a Thuthuzela Centre or if that's a Rape Crisis Centre or whatever.

PARTICIPANT 3: Well the treatment would depend on what was done to the rape victim before we got there. So if its trauma related, obviously fix that and then take them to a trauma centre first. If there's no visible trauma, then usually we're supposed to take them to Karl Bremer Hospital. They have a centre, rape victim or rape crisis centre. I've had some really bad experiences there. So I've taken four patients there and three of them, I had lots of issues with. So at the moment we don't, I don't really know what I'm supposed to do. So phone my dispatch and say please tell what am I doing. At least now Karl Bremer's got a trauma unit so you can take them there now and they can sort out both trauma and the rape victim...

PARTICIPANT 5: ... I went there a lot and I didn't even know what it was. I saw the name and then eventually I realized when this lady started speaking to me, you know that this is what's happened and that's like safe house for them and ja... Ja, that's fantastic and I didn't even know and I've fetched multiple patients there. So that would then actually be the place where the system gets activated immediately and everything. Okay, so that's there I just didn't know... There are people who are way more capable than I am of doing that...

Perhaps Participant 3 provides the summary position: The current responses are without evidentiary basis or considerably outdated. The triage system in place is not sensitive or specific to rape victims (unless they are in cardiac arrest) and the referral system is poorly understood or appreciated. The consequence is likely to result in poor emergency care responses to victims of rape.

PARTICIPANT 3: I have absolutely no idea. What we worked on a long time ago is that if you get a rape victim or a suspected rape victim then - and there's no medical emergency that's going to kill the patient now, we take them to the space in Karl Bremer that little blokkie outside M5. Is it called M5?

4.2 Victim's response to EMS personnel and influence on continuity of care

4.2.1 EMS personnel reflect on "sure cases of rape"

It would appear that with experience, EMS personnel are able to detect if a patient scenario or scene appears to be dubious, however, providers are not willing to take responsibility for the unknown and would rather sacrifice ethical obligations, health and social justice and appropriate health care by not asking the patient/victim those vital questions screening for what would most likely provide the "dreaded answers". This is alarming, and has life-changing consequences for these victims, and the pre-hospital health care provider does not appear to take ownership in the professional role they are entrusted with by the society through the HPCSA and Department of Health, the custodianship of which deserves deeper analysis. One may induce that this denial of responsibility could accrue from a lack of education and awareness and is structurally embedded by an EMS system that is not sufficiently responsive to rape victims. On the other hand, one should be cognisant of the social causes of violence and its responses, as the very community this resides in is where our health professionals are embedded in.

PARTICIPANT 4: Or told one of the providers on the scene which would then, been relayed to me through confidentiality but, ja there have been some cases where you, kind of just get a bit of a feeling that something's not quite right. But, ja it's not a question that I really want to ask them because you know if they don't want to share that information with me then I don't want to force it out of them...I think for the most case[s] it's been a case of the patient has told me.

PARTICIPANT 2: ...So I remember there was this one case where the lady was just frantic, you know just didn't want... – and as I walked into the room and she freaked out. And then that case I couldn't do any assessment. I just put her in the back of the ambulance with the police, female police officer and then we just drove to hospital and then the female doctor at the hospital assessed her.

4.2.2 EMS personnel feel ill-equipped to deal with rape victims

As if the thought of caring for one patient wasn't daunting enough, some emergency care providers reflect on cases where they were faced with multiple patients with different aetiologies. Not all required physical care due to physical injuries, but some required emotional support and treatment. With the lack of training, policy and procedure in place, this is cause for chaos on scene and may result in provider experiencing vicarious trauma as they too become

victims in this cycle of inadequacy. However, one has to question if there is desire from the EMS personnel to seek this knowledge to be able to provide better care for rape victims?

PARTICIPANT 1: ... And then with the other one was where the mother's daughter was actually raped by the father and I didn't know how to handle that because there's two patients at the end of the day. Because it was the mother being traumatised by this whole thing. She felt like her daughter was, I can't think of all the words now. I don't know what the Afrikaans word is. She actually felt betrayed by the daughter although the daughter didn't have anything because this was an ongoing thing for years already. So it was very difficult handling that because there were two patients. There was the one side from the mother's side, not knowing how to handle the mother because the daughter is actually the rape victim. So – and the daughter was just sitting there. I mean I felt like crying for them.

PARTICIPANT 5: ...I'm not here to question the patient...

It seems unimaginable that EMS personnel are sent to assist and treat victims of sexual assault when they lack the very basic awareness and education around this very serious condition. It is unethical in every aspect, to respond to a patient that has been violated/sexually assaulted with: "I don't know what the procedure is". Should the care being rendered be altered by the sex of the patient? If we are all equal and deserve equal care, how can EMS organisations promote or negate this?

PARTICIPANT 5: I'm sure he was in shock because what had happened and there is nobody that can tell him the procedure. This includes me. I don't know why it felt different towards a male but it did.

4.3 Perceptions of organizational and individual role and influence in cases of rape

4.3.1 EMS personnel rely heavily on the assistance of SAPS in sexual assault cases

In the absence of policy and/or guidelines the EMS personnel rely on SAPS for assistance with victims of rape and rely on them for support when dealing and treating the victims. According to the emergency care providers, the feeling of discomfort when assessing the female patient as a male provider is masked in the presence of a female police officer. This has been seen by participants as a safety net for male personnel. In contrast to the above statement, in the absence of SAPS and policy, the personnel resort to transporting the patient to the police

station for assistance or straight to the emergency department, with no escort or consideration for the chain of evidence.

PARTICIPANT 1: ...the dealings with SAPS that I've had before was specifically with this one child that was raped by another school child, where SAPS just said "oh well, these things happen". And she didn't show any support, anything. She didn't even want to help me of when the call was logged, when the child had to go back to hospital or anything like that. I mean so I wonder if they actually themselves, know about this system or what's actually happening in this whole system...

PARTICIPANT 2: Usually, the SAPS police members are there and usually they bring...a female officer with – I don't feel comfortable especially assessing a female. I don't feel comfortable being alone whenever I assess a female patient. So usually when I get instances of rape there's usually a female police officer with.

PARTICIPANT 5: I had a suspicion, called the Control Centre, told them what I'm suspecting, said to them that they can please ask the SAP to come out, this is what I'm suspecting. We sat there for more than an hour, SAP never pitched. [I] told the Control Room again, listen then the next step is I'm going to take the child in the ambulance to the SAP... I've encountered police, normal constables and those people on the scenes but in my personal experience they have not been helpful at all. As a matter of a fact, at the end I felt like I was the offender rather than trying to assist...my experience with that has been bad...[when] SAP... [is] non-existent, makes you feel like a perpetrator, ja.

4.3.2 Referral and facility of choice for further treatment of victims of rape

It is encouraging to hear that some of the participants understood the sensitivity and urgency when dealing with the victims of rape – however this is predicated on the provisional diagnosis of rape - and that the participants acknowledged treatment to be urgent and separate from everyone else where possible in the emergency department. However, it is concerning that this depends on which staff emergency care providers encounter on the day, if you get empathetic staff the patient will receive optimal supportive care but if it's a bad day where staff are desensitized and 'cold' the patient could go as far as to experience secondary trauma with such engagement/ lack thereof.

PARTICIPANT 5: So to be quite honest with you, normally I take them to the resus area because I see it as time limited, critical, needs to be a separate kind of patient and if there isn't a doctor available to hand over then obviously, to the sister who is in charge of the resus area. Now that depends on what shift is working. So there are some sisters in there that are very empathetic and they express their sympathy and whatever and they will try to make the patient as comfortable as possible. But in other cases it's just another patient. So that kind of ties my hands, there's not a lot that I can do about that.....

EMS personnel may be doing a great disservice to all the victims of rape they encounter in the pre-hospital setting by not having policy and referrals in place. Vital time frames and windows of opportunities are missed with time wasting when EMS personnel take patients that are not physically harmed with life threatening injuries to the ED. The emergency care providers are not aware of the rape crisis centres and Thuthuzela centres, and have not been trained on what services these facilities offer. This naivety has major consequences for patients and their quality of life post treatment.

PARTICIPANT 1: I know there is something at Karl Bremer. If we take rape victims to Karl Bremer they're supposed to go to a specific area there... Ja, but I mean there's a lot of stuff that's lacking but I mean yes, there must be a policy in place regarding these patients because it's very important, definitely.

PARTICIPANT 4: It's just kind of one of those things that you're not made aware of... I should be doing a hell of a lot more than I am, you know...

PARTICIPANT 5: There is a centre in Paarl that I know of but I'm not sure how the referral of that works. We normally take all of them whether it's emotional or physical we take them to the hospital. So to be honest with you I'm not really sure about exactly what the process is or the procedures are in place for that. Over the weekends there's a social worker that is very visible in the hospital and sometimes I will go and talk to her about what their processes are. However, I've not really gotten from the ambulance's side a policy of saying this is what you do, this is where you take them and so that is quite a hazy part.

4.3.3 Pre-hospital need for bundling of care for rape victims

Providers experience feelings of complicity and can be seen as perpetrators, this is an indictment on the profession and on the prevailing systems. "I felt like I was the perpetrator", is a strong statement to make, and not one to overlook. In the absence of direct training and policy, EMS personnel are left in situations where they are vulnerable, with no debrief in place and support from SAPS in certain aspects, not only are patients receiving sub-standard care but the personnel themselves are being affected (physically, emotionally and mentally). Feeling of helplessness has been a general consensus due to the "non-existing" role that is being played currently by all role players. In the absence of training, it has been raised as a concern that the EMS personnel should receive training on how to deal with victims of rape, both the emotional and physical training is required as the current practice differs from provider to provider.

PARTICIPANT 5: But I felt like I was the perpetrator. The whole system was – I was actually scared as to how to proceed to actually get this thing out...I wasn't sure whether SAP was supposed to come with us...personally, I felt that somebody had to escort us from the scene all the way to the hospital to make sure number one that no evidence gets lost.

PARTICIPANT 3: Well, currently there is non, a non-existing role. I would ideally like to see that we get training...we do need to know what do I do for you and what don't I do. I remember one of the other crews had a lady that wanted to go shower first. So obviously, you can't do that because then the rape kit is going to be not really helpful... What are we not supposed to do and where do we take them?...

Caring for victims of rape is not only a stressful physical task but it is mentally challenging and emotionally taxing, which results in the 'untrained' EMS personnel becoming professionally and personally vulnerable. The option for immediate debrief should be made available to EMS workers without the negative stigma attached to asking for help. A healthy environment is paramount in this field and one that requires sustenance. It is shocking when a participant states that they have been working in the pre-hospital setting for 9 years and the system hasn't changed 'You do what you do and you go home and you do it again tomorrow', seems providers have no voice to be able to advocate for changes to take place.

PARTICIPANT 5: ...So it will be easier for me to see if – just say okay fine, I've got the next shift or I've got the rest of the shift till it ends where I have got the opportunity to go off, say yes, I want whoever it is to come and speak to me, or to de-brief me or whatever the case may be. You deal with it and you can move on. It's not that thing about oh you, how can you feel so sad about this? Because honestly, with Anina's it did affect me... she asked me have I spoken to anybody, do I want to speak to somebody? Now you know the whole stigma in Metro you're weak when you do this. I try to promote it...

PARTICIPANT 3: ... We just don't think about it. You do what you do and you go home and you do it again tomorrow... [we need] some emotional support because I mean, I've been a paramedic now for what, going on nine years and those two particular calls, it still haunts me. Even now when I have to talk about it, it makes me upset. So I need to know how to deal with it myself and I need to know how to deal with the patient....

EMS personnel have identified that victims of rape should be cared for immediately, they feel that despite the victim not having physical injuries they should still not be triaged (sorted) as green. However due to the different role players encountered on the platform, and no policies and training in this area, they are left with no choice but to triage these victims the same as they would a 'normal' case. In the cases where EMS personnel look up to senior medical personnel, they are not assisted with correct procedure and referral as not all senior medical personnel

themselves are aware of the structures in place surrounding them. This is a shocking reality, but one that has been reported as a common experience by EMS personnel in this study.

PARAMEDIC 2: they were triaged as either green or yellow. So and they were made to wait in a waiting room, which was really not ideal but there's nothing that I could have done about it...And a lot of the times the nurses don't know that you know it's a rape crisis patient and there's a certain protocol that needs to take place, one needs to follow.

PARTICIPANT 4: I think it depends from patient to patient on their state and etcetera. I certainly would want to triage them at least orange or above, just for the sake of not handling another patient at the same time... This is a patient that needs to be sorted out. It's not just an external thing that's happened to them. This is definitely something that's happened mentally, physically and emotionally etcetera. So they need to be dealt with now. Their care needs to start as soon as we can get the care to them. So in that, yes, going to red or to orange would be, you know, probably my go to...

PARTICIPANT 5: So they are being triaged as every other patient unless there is physical damage.

PARTICIPANT 6: ...But he himself [Doctor] didn't know there was a Thuthuzela facility at the hospital, he's working, so you see? ... the male, no, you know. Medically, I don't the doctors will too, you know kosher with me taking a stable green, physically green patient to a secondary hospital. Because some other patients are green or orange, sorry, yellow medically but they would ask me why am I taking a patient to a secondary facility?

4.3.4 Organizational role directly impacts service delivery and patient care

EMS personnel feel inadequately prepared for the types of patients they deal with on a daily basis, the main focus in this analysis being rape victims. The participants, as insider EMS personnel, acknowledge that training during studies were insufficient in some areas, such as treatment and management of sexual assault victims as a whole, thereby not exposing future providers to the identification and management of rape victims as well as the psychology that accompanies this training. In addition to the interpersonal violence content deficiency their employer organisations have not made use of safety nets for their staff with regards to referrals which are unreliable and scattered. Not enough awareness and emphasis on correct facilities for specific conditions are being taught or liaised with operational staff and neither to the control room/dispatch personnel. One can assume that the reported 'distrust' is due to the above concerns, as the employees don't seem to feel protected by the organisation; they feel as if they have to fend for themselves and in doing so become vulnerable.

PARTICIPANT 5: But making it kind of a standard procedure, what you need to understand is currently the vibe out there it's about response times. How long did it take you to get there? How long are you on the scene? How long are you in the hospital? We can't take ten minutes with these patients though, that's the problem... More, definitely more because every time I encounter these patients I kind of have this – I don't know how to pinpoint the feeling but inadequate would be part of it because I'm not 100% sure of what should be done. The other side I'm also uneducated on the topic. I know about the physical injuries that there can be but I don't know enough about the psychological side as to how to approach them and actually properly support them... From Metro based that side of the thing, not really support at all. What they sometimes do is they say phone Metro. I don't know who made Metro God, because it's people who are sitting there who have not been on the road for ages, who don't have all of the policies and procedures and sometimes even with regards to other calls, what they are saying does not make sense...

PARTICIPANT 4: The organisation always counts a role in everything that you do. I do feel that they could probably play a bigger role in, you know, having the facilities a little bit more well-known...It, yes, there is unfortunately way too much that we don't know but it would be really good if we can have a direct contact person. Like a liaison between us and them. And not just, maybe not us as the crews but maybe someone in the control room or a few of the dispatchers because obviously they work shifts as well. So you'll need somebody that is there 24/7 or at least enough people that know so that at all times they would be able to communicate with this person. I think that will be very beneficial.

4.4 Organizational and individual responsivity to rape victims through emergency care education

4.4.1 Legal and ethical implications for EMS personnel

Currently EMS personnel are treating victims of rape based on personal experiences, attitudes and beliefs, uninfluenced by formal instruction. This has the potential to violate human rights, as every individual deserves to be treated by a capable health care provider. Education and training, as a requirement for addressing complex problems, is pivotal in changing current practice and essential in decreasing the vulnerability of the EMS personnel and rape victims. EMS personnel are transporting rape victims without knowing it because they lack the skill and education of case identification. When cases are identified, they lack the practice knowledge on treatment and referral of rape victims.

PARTICIPANT 2: No, usually what happens is that we'll get the call as being a rape. We don't do the vaginal, anal assessments per se. So if the patient has been raped and it hasn't been dispatched to us like that, we wouldn't know unless the patient told us and that hasn't happened to me.....

PARTICIPANT 3: what is the ethical implications of what we are doing...Are we really helping? Are we doing, not illegal but unethical things in the process? the interaction I could do but what I do with that information I don't know. And where do I take the patient to be treated properly, I don't know. And that really bothered me...

PARTICIPANT 4: So, ja I'm not going to rule out the idea that I may have missed a case.

PARTICIPANT 5: Honestly – honestly I think everybody is aware that there is major ethical dilemmas with any rape victim. It's something that you feel from inside. It's not something that you're taught...I think people are also afraid and scared to deal with these victims because they don't know what or who's protecting them....

4.4.2 Poor EMS-hospital relationships

The health care system in its current state presents with some challenges to comprehensive rape responses. The system is over-worked and requires more staff to prevent burn out and to handle the health care burden/load. However, taking the latter into consideration, not having a designated doctor or nurse to receive patient's EMS personnel bring to the ED or to assist in appropriate referrals has serious consequences for both the health care professionals and the patients. It would appear that the roles of EMS personnel are confused, ranging from what care should be given to victims of rape initially to the continuation of care when considering the facility, you take the patient too.

PARTICIPANT 1: ...I feel there should be a specialized person in a unit handling these types of patients or like take them to a specific area where they can be handled in a certain way...

PARTICIPANT 2: Ja, it is but I mean it's difficult to come into a hospital and then demand that this patient gets seen or get treated differently because obviously, it's not my you know it's not my area and not my domain that I operate. So as much as I try and relay the message over it's up to the nurses, the doctors to actually do the you know the actual caring and counselling.... So ja, so just to have the same training or to know the capabilities of whatever the other qualification can do and then the interpersonal relationship between doctors and nurses and emergency care providers that also builds the trust amongst the professions.

4.4.3 Current practice and beliefs in the pre-hospital setting

There is an expectation by the employers that care be delivered in a certain way, time frame and recorded against the forms administered to the employees (EMS Personnel). According to

the EMS personnel this is expected to be standard practice across the board and should be done for every patient but standardising rape responses comes with an array of additional complications that may involve the mental, psychological and physical state of the patient (victim of rape). Some emergency care providers based on their experiences have worked out a system when treating victims of rape and have become aware of the do's and don'ts when treating these patients. The emergency care providers do not perform the "expected care" by employees and have educated themselves in such a way that should their deviance from the norm be questioned, that they are able to justify their actions. However, this could not be said for everyone, and there-in lies the problem.

PARTICIPANT 5: In my opinion, personally, I don't go through the standard things if it is a rape victim...I only do the things or go through the motions with the whole set of vitals, there's something that sounds suspicious to me...I'm in the position to make the argument where the staff underneath me aren't in the position to make the argument they will still go through the motions.

PARTICIPANT 4: ...I don't believe in time limits on the scene. My priority is the patient care...I will rather spend the time on the scene if that's what is beneficial to the patient to, you know, not just suddenly be thrown into an ambulance and drive away.

PARTICIPANT 1: ...I want the people to actually feel what the patients are feeling because if you don't feel what they're feeling, you're not going to understand...I mean not only physical assault, like I said the sexual assault, the emotional side of their things. I think to me that is just people are not going to understand if they don't experience themselves.

There is not a lot known about the pre-hospital treatment toward victims of rape and even less known about what medications are required to be administered to victims of rape in the EMS setting. So when the EMS personnel reflected on the possibility of administering PEP and/or emergency contraceptives pre-hospitally their instinctual answer was no, because with every medication there are possible adverse effects and contra-indications and because not enough was known about the bigger scheme of things such as basic management, the consensus was first to raise awareness and to educate the EMS personnel about the management of these patients and which facilities are best for continuation of treatment. It was felt that if the latter could be corrected, that correct treatment would be given to these victims in time in a controlled environment by senior health care providers.

PARTICIPANT 2: Because obviously, if I just look at diagnosing or the indications and the adverse effects and everything like that it could be advantageous. But then again, not every paramedic will be comfortable assessing a patient that has been raped and administering those medications as the next one would. So I mean it could be

advantageous but then again, I also think that there's a place for in-hospital treatment versus emergency care and that's not really under the bracket of emergency care, so ja. If I was given the option... I wouldn't...

PARTICIPANT 3: I think we should be fiddling as little as possible...I think less is definitely more.

PARTICIPANT 4: ...in the pre-hospital setting we don't want to be doing too many invasive procedures ...We don't have ...a particularly private environment... So getting them to the appropriate care would probably be number one priority.

In reflection on current practice and case experiences, EMS participants are not opposed to scope changes and training when it comes to the identification and management toward victims of rape. EMS personnel want to do more; they do not just want to be a "transport facility". EMS personnel are not just interested in the medicine side of things, but are eager to understand the psychology behind the traumatic event and would like to be educated on how to interact with these victims and gain skills on preserving the patient to limit destroying possible evidence during management but not to over step/blur the lines between forensic policing and EMS personnel. It is also of vital importance to understand when additional assistance is required and what those additional support systems look like.

PARTICIPANT 4: ...I definitely would not be opposed to having a little bit more in my scope of practice to be able to do something rather than just being a transport facility.

PARTICIPANT 5: ...I know each and every person as individual, I know that and people deal with things differently. But to at least...theoretical training. Skills, maybe just as to how you interact with that patient...proper policy in place of what needs to happen to support these patients as much as possible...

4.4.3 Succinct paper work is required to ensure uniformity and awareness around evidence preservation is essential

EMS personnel understand that their role are to provide medical care and support in the pre-hospital setting, however they are aware that the victims of rape cannot be handled as 'ordinary' patients because they are considered '*walking evidence*'. In the absence of SAPS and the luxury of time, EMS personnel will have to treat and transport these victims alone. This has crucial implications on continuation of care and can affect prosecution of this crime if processes are hindered and not completed correctly. So awareness is vital along with paper work that can commit to the cause and what is required to maintain the care required to assist the patients'

medical needs but also to assist in the pursuit of justice later on should prosecution follow. However, EMS personnel are in favour of a simplistic version of the J88 form⁸ and not the actual J88 form itself, but training on how to fill in these forms are required before personnel can make use of such forms, due to its legal implications.

PARTICIPANT 3: Well, if we're the one that's going to pick the person up on the scene, then we should at least know to take the patient with everything like, not have them change the underwear; put it in a paper bag. If there is stuff under the fingernails try and at least protect that. Things like that, I think it, I think it constitutes as evidence collection and that is stuff that we can do because we see the scene first... If you have people that are adequately trained...Everything, from the bottom all the way up through forensics, through collection, through everything, then yes. They will be competent enough to fill in a J-88. But the rest of us, unfortunately we're not, we don't know, like you said we don't know the lingo, the proper language...no I don't think J-88's or any document of that kind of magnitude should be filled in by just everybody... paperwork is really important but not everybody is doing it correctly. So maybe to go past that obstacle have a set of document...I think that will be beneficial.

4.5 Change needed to improve emergency care rape responsivity

4.5.1 Education imperatives

EMS personnel feel that a change in education and awareness should take place as soon as possible considering their past experiences and also to provide training to every level of care, not just advanced life support because these victims will present from 'no injuries – dead and dying'. EMS personnel are also aware of their colleagues and feel that training everyone might be a difficult task, so the primary focus or main priority should focus on training key personnel first, so that they would be able to guide their team/shift and would be able to assist as a 'consultant'. As the movement progresses the other staff that were yet to be trained would receive training. It has also been made clear that the personnel are not only interested in the physical skills and training but also the psychological and emotional side of things and would want specific training in those areas as well. It is also very important to distinguish between male and female rape victims, as approach and how one cares for victims of rape could require different approaches depending on patient presentation.

⁸ J88 Form: The J-88 details all physical injuries sustained during any attack and must be filled out by a medical doctor, or a forensic nurse along with a rape kit. This form is designed to leave no evidence unreported, resulting in an extensive and invasive examination. There is a detailed questionnaire around the victim's sexual history – including previous pregnancies, date and time of last intercourse with consent and questions on menstruation.

PARTICIPANT 5: ...There is not awareness. The only time when staff talks about this – ...subject is when they've encountered a victim or a possible victim. That's the only time this gets discussed...one of those things that you will be baffled once you encounter it and you don't know what to do. It's one of those things that it stays with you. I know I should have done more but I didn't know what to do...

PARTICIPANT 4: I think definitely having specific, maybe staff that is trained in rape management and that sort of thing and knowing which facilities do offer that...maybe having counselling training for us as EMS staff to be able to start the counselling right from the get go, from there, the treatment on the scene so that we know how to approach the patient. How to assess the patient. How to speak to the patient and then, like I said then knowing where to take the patient so that we can then continue that care with someone who has that specific training as well to continue the care from that point on.

PARTICIPANT 1: ...we should be much more educated in that area because we are the first line that they get contacted with ... we don't know how to handle these people? ...from the emotional side, helping us, like for instance if there's a rape scene or something, how to deal with the scene around the whole situation. I think that is very important because we're just hindering the whole system by not doing that as well...I just think we all fail the system and of course, these rapists get away...

PARTICIPANT 3: It should be part of our training but it should not just be part of [ALS] training. It should actually start with [unclear] because unfortunately in government, we sometimes have vehicles that have [two BAA's on] and we have much more [BAA's] and [and then less ILS's] than what we have emergency care providers...

PARTICIPANT 2: Ja, I think it will just be good to have the initial counselling approach to a patient that has been a victim of rape. And then also to understand your role as an EMS on the scene...then also the differentiation between male and female rape victims. I mean I only had one male rape victim and it was totally different from the four other female.

Taking into consideration that rape is a growing phenomenon, EMS personnel could be facing rape victims daily, may it most times be unknown. Continuing medical education (CME's) should be noted as important in order to raise awareness around identification and management of victims of rape. The main objective with providing CME's is to provide the medical field with updates around new and upcoming developing areas, with the aim of maintaining competence. However, it has been reported that CME's are not as regular as one would imagine and the little CME's that have taken place in relation to anything close to the theme of rape have been evidence preservation. Albeit a step in the right direction, it becomes forgotten knowledge when EMS personnel cannot find the direct link to their daily work as it lacks context. In conjunction to regular CME's, policies should be set in place and legal documents should be implemented and training in all three areas should be a priority in the pre-hospital setting.

PARTICIPANT 2 [3, 4 & 5]: Not particularly rape victims. I know we did a DNA, CME, which was more a crime scene you know, where to walk, where to touch, not to, what to do and what not to do on the crime scene but not particularly on a rape scene.

PARTICIPANT 6: There's not really any you know, a policy specifically for that ...never has rape been emphasized and that's actually sad... I think it should be a continuous thing.

PARTICIPANT 4: Well, definitely CMEs and that sort of thing on sexual assault awareness and as well as the counselling side of things...more emphasis on the awareness side of, sort of, identifying the patients as well as treating the patients, what we should be looking for and how we should be treating the patients...We kind of treat a broad spectrum of things. But it definitely is something that needs focus. It needs to be, sort of, brought a little bit more into the limelight and something that we can be a little bit more specific about in saying, you know, this does happen. We need to identify it because it does need specific care...

4.5.2 Promotion of continuity of care and community of practice

The treatments rendered to victims of rape are as important as the handover given to the receiving facility, as it directly impacts continuation of care. If crucial observations are not made or picked up, time delays take place and the victim/patient is either taken to the wrong facility or window periods for specific care can be missed. It is also very important to acknowledge the victim's presence, so the manner in which information is given to receiving facility sets the foundation for continuation of care.

PARTICIPANT 4: It was definitely handed over with the knowledge that it was a sexual assault... it was sort of a case of trying to be discreet about the situation yet informing the doctor of what was going on so that the treatment could happen correctly...Sort of not trying to make the patient re-experience everything all over again, you know. Make things worse. But discretion, I definitely think is key but also the relevant information does need to get across without beating around the bush too much.

Regardless of patient presentation, should you suspect any form of foul play, the patient still has the right to be cared for in a respectful manner and to have their dignity protected.⁹ EMS personnel will never be able to diagnose every rape victim, so should the victim not disclose what has happened and should the EMS personnel misdiagnose, one should never be able to

⁹ Health Professions Council of South Africa. 2008. Guidelines for Good Practice in the Health Care Professions. *General Ethical Guidelines for The Health Care Professions*. Booklet 1.

question care delivered. Point of care should always focus on putting the patient first and having policies in place with credible consultant's EMS personnel can rely on, this would ensure the above is always the case.

PARTICIPANT 4 ...you know some patients don't necessarily want to reveal what's happened. They'll be all embarrassed about the situation. They feel scared about the situation, whatever the case may be and just the fact that I'm a man treating them, you know they don't want to divulge about the situation. So there definitely could be patients that I have missed the fact that they've been assaulted. So if the patient doesn't want to give me that sort of information and I do miss the fact that, hey this patient has actually been assaulted, I think that the treatment should be equally respectful anyway and therefore the handover should be done in such a way that the patient receives treatment as quickly as possible anyway.

B: Interview results from Thuthuzela Care Centre and Rape Crisis Clinical Forensic Medical Practitioners

The participants included in this study were from rape care providers and emergency care centres in Cape Town metropole which consisted only of clinical forensic medical providers. The participants were sampled by means of purposive sampling, only focusing on the urban environment, due to the limited scope and resources of this study. The interview started with the premise that post incident care of rape victims are complex or complicated. The questions in chief were: a) What are your thoughts around a multi-disciplinary approach with regards to the management and post care of victims of rape/survivors? b) Who, in your opinion should be the parties involved and what should their roles should be? The unstructured interviews were essentially an elaboration of these fundamental responses and lasted between 45-60 minutes each, this resulted in several themes emerging as depicted in Figure 8 below with discussions to follow.

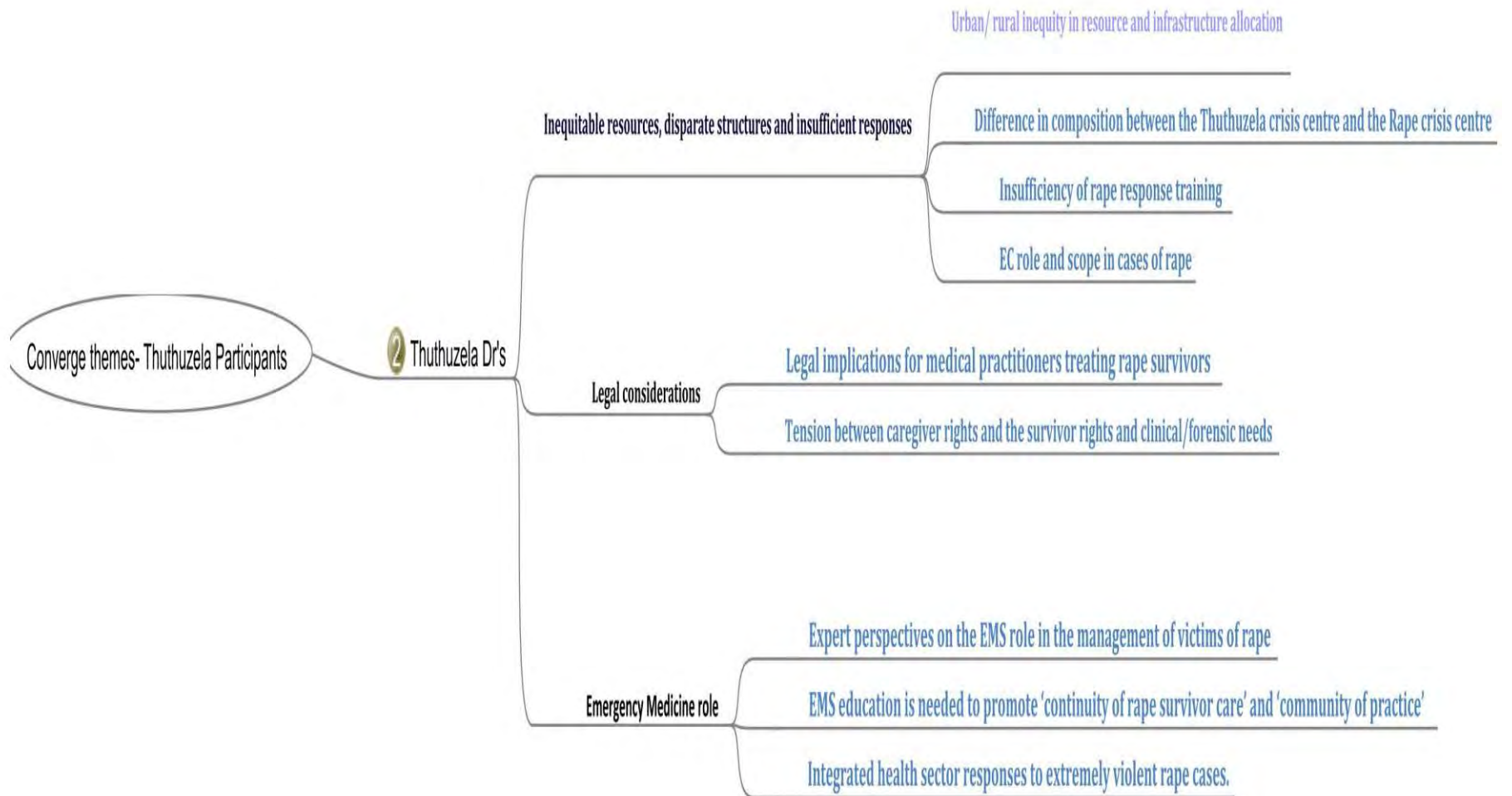


Figure 8: Convergent Themes: Clinical Forensic Medical Practitioners interview results

1.1 Urban versus Rural resources and infrastructure

Participants thought it important to note that when one proposes a change in clinical practice one has to focus on the context in which they would be applied (urban vs rural). However, important themes/ content will remain a priority notwithstanding the context, and where there is room for certain clinical procedures to be done, should the context allow, those will be tailor made for the specific health facility depending on the patient criteria and needs they face. Currently progress has been made within the urban setting, and structures such as Thuthuzela care centre and Rape crisis centres have come into existence and have been intentioned to be a 'one stop shop' for victims where they get assisted with all they require ranging from medical assistance to legal guidance. The participants valued the current model of service delivery as feasible in that they perceived the same models as being applicable to the rural setting, to the extent that a lot more victims would seek help provided that trained professionals in the area of rape management and sexual assault are the ones providing the care and examinations.

THUTHUZELA DR 1: ...the big challenges come in the rural settings where there's a lot of shortages, a lot of challenges, a lot of resource constraints. In the Metro many people would say we are over resourced...We don't have the same thing there... that needs to be established...it's a challenge ...Not enough is being done to educate survivors about that [treatment they require and where to access this care]. The general public and that is specifically true in the rural settings. When they come in here, the Thuthuzela process mandates that that gets done... That's in the Metro settings ja¹⁰ where we have all these wonderful resources and things. In the rural setting, I don't know how often that happens...

Even though participants suggested the health sector has achieved quite a lot when it comes to managing victims of rape, they also acknowledged that we still have a long way to go. There are resources we currently have no access to due to such as funds and a proper chain of evidence that requires it to be used in court. The resources range from cameras and software to urine analysis when one suspects drug facilitated rape; this is just some examples to highlight the gaps in the system. This is alarming considering the frequency of rape victims being seen on a day to day basis at these facilities.

THUTHUZELA DR 1: The camera issue – there are still little things that we need that will improve the service. You see the camera issue is an issue of resources. In order to have a camera you need to have a chain of evidence... But how commonly a photograph like that would be used in a court of law is debatable; ja, very debatable and I said it's about the question of money. And the same issue arises when we want to swab a vaginal discharge, same thing. We don't have a chain of evidence, we have the

¹⁰ "ja" is an Afrikaans word when literally translated means "Yes". It is used by bilingual (English/Afrikaans) speakers to indicate agreement.

lab facilities to do it but despite fighting for the last ten years, there's no way in this country to secure a vaginal swab as evidence in court, which means a lot of evidence is getting lost... we suspect there's drug assisted rape. So the person was drugged and then taken advantage of. That bit of evidence which is going to be urine, no chain of evidence and kits exist for all those and no chain of evidence. So in this country as we sit today in 2015 there is no way anywhere in South Africa to secure the chain of evidence... Ja, so we're losing a lot of cases...because we can't prove those things.

THUTHUZELA DR 3: ...the problem is in South Africa at the moment the forensic industry laboratory does not test for toxicology [urine¹¹ is not currently tested].

It was the participant's experience that with numerous role players involved with the management of rape victims having come from different backgrounds, not enough awareness and training on who does what and when, has resulted in a fragmented system. This has had negative consequences for both victim and the provider that made first contact with the victim, because correct timely referrals are key to reducing secondary victimization and allows the patient to get the best possible outcome. Consequently, the role players that are not well informed should not function within this system until everyone on board has sufficient awareness and training.

THUTHUZELA DR 3: ...management is complex because there are different role players involved and that's why a multi-disciplinary approach is absolutely vital in order to give the survivor everything that is needed. So depending on where the person presents for the first time, whether it's a police van passing by or a police station or a local clinic or day hospital, or private GP, that first person must, from the first point, ideally, the patient should be treated in an empathetic way and to try and cause as least as possible secondary trauma...a multi-disciplinary way is the only way to really effectively manage this. But the service as it currently is fragmented... it's difficult to say who's not, who shouldn't be involved...it's not necessarily that they shouldn't form part but they should be educated about what to do. Then they can actually play a very vital role...

Each role player mentioned below has been identified as integral stakeholders in this multidisciplinary approach (service delivery model) focusing on patient-centred care. Various variables such as education and training should be considered to achieve great success in the medico-legal aspect with regards to the management of victims of rape. The lack of policy and standard operating procedures (SOP) has also negatively impacted the success this model intends to achieve.

THUTHUZELA DR 1: ...EMS, the police, our rural counterparts, our Chief Director, doctors, nursing representatives, the National Prosecuting Authority (NPA) specifically sexual assaults. And then of course, there's other stuff that you do that needs other

¹¹ Urine collection and analysis can aid in the detection of recreational drugs that may have been used to alter the level of consciousness of the victims amongst other effects and is used to determine if the victim is pregnant/have become pregnant due to the assault; however, the latter should be tested within 5 days of the assault.

stakeholders also like the Traffic Department, who do drunken drivers and the correctional facilities because we see offenders, specifically sexual offences the issue of just sectoral collaboration [is what needs to be worked on] ... We have conducted training with them...The problem is that needs to be ongoing because you obviously have a turnover of staff...Standard Operating Procedures need to be drawn up and written and signed off between both parties. That's what needs to get done because these things get forgotten...SOP's need to be developed; constantly updated...

THUTHUZELA DR 2: I think the approach or the multi-disciplinary team is a bit of service delivery [model?] because the – it speaks to patient centred care. So that the health care providers and the police and civil society through NGO's go to the patient then the patient moving between these groups to access services. That's why the initiative or the Thuthuzela Rape Centre is so important to the whole issue because that's the service delivery model that all the services that the rape victim needs are provided under one roof.

When drawing focus to the Emergency Medical Personnel and considering that management of rape is not taught within the curriculum, the participants' have only their own experiences to fall back on, this information gap can have severe consequences as most often the emergency care worker takes on the approach of "I don't see anything wrong with this patient, so I'll just drop he patient at the ED". This approach of "it's not my area of expertise" results in many cases going undetected, and with these incorrect referrals are taking place.

THUTHUZELA DR 2: The information gap, because even though that you may have the information that the patient that they have in addition to the injuries, they were raped; they just get numbed or paralysed by not knowing what to do. So because of being paralysed, you just pretend not to deal with this thing. Let's deal with the issues. I remember some years back, one of the worst cases I have seen where these two couples were involved in an accident and five guys on that R-300 [arterial road], five guys approach them. They thought, hey, there comes the help. These guys raped the woman. She had a pelvic fractured and a femur fracture they still raped the woman, all the five ...Now imagine that scenario. I don't know who brought them. Ja, it was an ambulance. But now I didn't talk to the guys because they had, I don't know they were not even aware...You see, they were not even aware [of the rape, they only treated the fractures].

1.2 Difference in composition between the Thuthuzela crisis centre and the Rape crisis centre

There is a nuanced importance of awareness and education when making decisions around the best care a patient needs at the first point of contact. This decision is impaired when not all information is known, results in no or poor advice given to the victim and poor clinical decisions are made. If the patient wanted to lay a criminal charge, or had no physical injuries and required

to see a provider to perform a rape kit, without the correct education and training no EMS provider would know these facilities exist and they would not know what services are offered and where. It is pivotal to understand what a Thuthuzela care centre offers compared to a Rape Crisis centre, Thuthuzela Dr 2 explains:

“The difference is the composition. Here [Rape Crisis Centre] there’s no presence of NPA [National Prosecuting Authority] because the Thuthuzela service delivery module is a baby of NPA..., [they] concerned with the legal aspect... Here [Rape Crisis Centre] we are not linked to that system. So here we just do the hard line clinical forensics, but with a close association with the FCS [Family Violence, child protection and sexual offences unit]”

This has major ramifications for the victim as they may lose any chance of laying a charge and getting required treatments in the specified time frames should they land up in the wrong hands. In this way, EMS serves as the point of entry to the broader health *and* criminal justice systems.

THUTHUZELA DR 2: I think it should start from the very beginning. You see the biggest problem that we have especially with clinical forensic services; it’s a very poorly defined service within the Department of Health. It doesn’t have a directorate; it doesn’t have anything. It sort of gets carried by forensic pathology, which is clearly different. Forensic pathology concerns itself with issues over the dead. Clinical forensic medicine concerns itself with issues over the living which means if you look you will see that the medical school ... [It’s a non-accredited module].

1.3 Insufficiency of rape response training

How could it be that in a medical degree of 6/7 years of study would only have a “one liner” on sexual assault/rape within their curriculum? When handing over patients to Doctors there is a large amount of frustration between the different health care workers, but this is hardly their fault if the system is deficient. We live in a country where rape is the highest in comparison to the rest of the world and it would appear that the training received is disproportionate to the scale of the incidence and health sequelae of rape. The same could be said for the emergency medical personnel, that has almost no training on sexual assault/rape within the 4years of emergency care study. It is pivotal to note that some cases will be brought to the EC/Rape Crisis centre/Thuthuzela Care centre by EMS personnel, and with this comes a responsibility by the health care provider to provide a service where clinical decisions and referrals are made based on a strong foundation and training when it comes to the management of rape victims as the first responder or as a provider that continues care between one facility to the other.

In the absence of training and guidelines the victim is put at a higher risk of experiencing secondary trauma due to the uncertainty in the treatment toward/of the victim of rape. Training the health care worker in the management of rape victims also requires one to acknowledge that the male versus the female victim may present in different ways and the health care worker needs to be equipped on how to manage and treat the different presenting victims. Even though rape is rape, how these victims perceive the encounter may differ and will need a tailored response that is only possible with training and experience.

THUTHUZELA DR 2: If you look at the student's undergraduate programme [MBCHB] it's probably [a] one liner that is there. That's why I'm saying going back to the beginning. You will find as a result when people come – graduate as doctors they have very, very little knowledge and this cascades into not wanting to have anything to do with this thing. You go to nursing, same story. There's nothing here. You go to EMS, so it's not a strange EMS phenomenon...If you don't ask [if the victim was raped], you'll not be told... specialised police unit where the members are specifically trained around issues of sexual violence, so that you have a group of policemen who have the correct approach...one of the bigger aims is reduce secondary victimisation and if you have trained police that would be less. If you have trained EMS that would be less, the doctors, that would be less. And those are the things that eventually lead to very bad outcomes in terms of mental health because the journey to recovery starts at the point of contact...mental health; it's actually a very, very big thing.

THUTHUZELA DR 3: ...constant communication between all the different role players because everybody just wants to wash their hands...And there's a very good chance that you're going to see this. It's not *maybe*, you *will* see it.

THUTHUZELA DR 2: ...looking at the way the EMS is structured, the EMS take patients to emergency centres. Emergency centres are linked to these Thuthuzela Centres or clinical forensic units. And then those clinical forensic units are linked to the FCS. So on paper it looks good... Nobody should fall through the cracks. But they do... for me it's the information gap...we have got a sort of disproportionate response...

THUTHUZELA DR 2: There's no Master's Programme, there's nothing. That's why also it explains why the doctors gravitate away because there is no career [path]. Most people don't just want to do a Diploma. So until that time when you do a change where they can now create specialists posts and with an appropriate post-graduate Master's Programme then things will start changing and I think it will change for the better because really it's a problem because in most cases, rape is closely tied to domestic violence. You can't talk about one without the other. So it's a huge society or community problem, which everybody looks the other way. I mean I was listening to this American actor, Jolie. She was talking to African leaders in Sandton last week and she was addressing the issue of rape in conflict areas because those soldiers they actually use rape as a weapon of war.

So, not only are the undergraduate and postgraduate opportunities deficient, there seems to be poorly orchestrated career-pathing and planning in the area of health sector responses to

interpersonal violence. Given the complexity and longevity of sexual violence complications, it would be prudent to develop a human resource supply chain to respond effectively.

1.4 EC role and scope in cases of rape

It would appear from the participant's sentiments, that education and training around emergency medications such as Post-exposure prophylaxis (PEP) and emergency contraceptive should be given to all health care providers. Knowledge and awareness is as important as the actual dispensing of the medication, because you would be able to direct the patient to the correct health facility for further management. Some participants even went as far as to state that the sooner the PEP is administered, the better the outcome/results, which is why the participant's felt strongly about EMS personnel being allowed to administer PEP.

THUTHUZELA DR 2: ...giving PEP is a top priority...in my view looking at how rape is so common; it should be part of the medications that should be on the ambulance. Because now if you ask and you find that the person you are transporting was also raped, the sooner you give PEP the better the results...

THUTHUZELA DR 3: I think it's good that they [EMS] be informed about what's given after a case but I don't think they will be providing it [PEP or EC] unless if it's a very [cold case-old case]. I mean because you can get it within 72 hours...So I think just as an overview...to form a comprehensive picture for them what will be done at the unit... I don't think they will be in a position where they have to prescribe it.

When one encounters a rape victim, there is a dual responsibility that needs to take place: one is the medical aspect (i.e. provision of medical care) and the other is the legal implications for both provider (in respect of forensic roles) and victim (as integral to the crime/scene).

2.1 Legal implications for medical providers treating rape survivors

Participants thought it is imperative to understand the constitution and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 when treating victims of rape, regardless of the role played. If providers are unaware of the do's and don'ts and what happens in our local context versus the international context; the victim, it was purported, will not receive the appropriate care. It was deemed important that training in this regard takes place so that there is uniformity in language usage and treatment. Participants sought common

understandings of the difference between a fresh case and a cold case and how to we go about treating these victims. It is also thought to be the responsibility of the health care provider treating the victims of rape to make sure to call the Family Violence Child Protection and Sexual Offences (FCS) unit to alert them about the situation. The FCS unit is a specialised unit that forms part of the South African Police Service, which has trained personnel that assist and advise an array of victims about their rights as a victim, what their options are legally and are there to expedite the investigation procedure. As far as a chain of evidence is concerned, this should happen immediately. If this does not take place and the providers treating these victims are uneducated about the forensic and emergency needs or rape victims these patients are likely to get lost in the system and justice is thwarted.

THUTHUZELA DR 1: Well we take specimens of the victims and we treat them holistically with counselling and provide HIV prevention and pregnancy prevention. And obviously change of clothing and being able to wash. And then after all that is done we then go to court to testify in these matters and then of course victims can be fresh cases if it happened within 72 hours. Or old cases if it happened after 72 hours in which case we won't take specimens in this country according to the national protocol. Other countries it differs like for example, in the UK they take specimens up until seven days according to their national protocols...

THUTHUZELA DR 3: ...[EMS] should be doing more you know...include it in the curriculum... they need to know... do you preserve the evidence? What are important things to look out for? ... how to prevent secondary trauma. What is the referral route, what's the multi-disciplinary approach you know because maybe on the way the patient may ask them what's going to happen to me when I get there? You know just to have an idea what does the comprehensive management [consist of] ... and they need to know ...the rights of the patient. If they do not wish to lay a charge you should inform them it's in their best interest to maybe have the evidence collected in case they change their mind. But they do not forfeit their right to receive medical advice and treatment just because they do not wish to lay a charge and that's so important you know but it doesn't ...always happen like that.

2.2 Tension between caregiver rights and the survivor rights and clinical/forensic needs

Education and community awareness plays a vital role on the rights of both patient and health care providers. Expectations exist, but one can argue: Is it unfairly so? It would appear that there is a disproportionate response to rape as a social and health burden. There seems to be a systems bias toward TB and HIV responses and a denial of the alarming incidence, consequences of rape and the need for unprecedented resource allocation.

THUTHUZELA DR 1: ...There's very little that's been done to educate the general public about those procedures [management of a rape victim] and what they should and shouldn't do. And more needs to be done...for one person, you eventually begin to realize that it's too big a task for one person to handle...There actually needs to be a budget allocated specifically for community outreach and I know the NPA for example, have road show but not, I don't think enough you know. And ja, it's a matter of resource allocation where the money's going and it's a problem because obviously there are other priorities. There's TB, there's HIV and health care and community awareness is something that I think is often neglected in most aspects of health care, ja.

When dealing with victims of rape it is paramount that providers are well informed on an array of things ranging from legal requirements to health care within their appropriate time frames. When any of the above is lacking, the victim experiences a disservice by health care personnel to whom they entrusted their wellbeing, after such a traumatic experience. If medical provider cannot advise the victims to help ensure they make a well-informed decision, the victim is exposed to secondary trauma and might decide to not seek medical and legal advice and goes undetected. Such a fragmented system results in a preventable denial of care. One also has to be trained on accepting whatever decision the victim may make with regards to laying a charge to refusing treatment in a non-judgmental manner, provided that all necessary information was given and explained to the patient and that the patient acknowledges they understand but their decision remains unchanged. The coercive nature of the rape behavioral pathology undermines autonomy of the victim but providers are also at risk of violating autonomy.

THUTHUZELA DR 2: ...to respecting the wish of the survivor and that is – manifests itself by you not exacting undue influence on what the survivor should do. Some survivors come here and they state upfront, I want, I don't want to lay a charge. My concerns are around pregnancy, HIV, STI prevention. So if the person says that, my duty is to provide them sufficient information so that they make a well informed decision. That's all, for example, if somebody tells me that then I can say look that's fine but there is also an option that you might want to exercise like you allow me to perform a forensic examination, collect the evidence and we will keep it here for six weeks during which time, if you have changed your mind, you can still come back to us, we'll still have the stuff. Because you only have one chance to have evidence collected. If it's not collected today it's gone and if the person still says, I fully understand then you go by their decision. So it's about providing information so that the person can make a well informed decision and you respect whatever decision they have made. You may not like it but that's about it. You don't coerce, you don't treat people into doing certain things because you have decided that this is how it's going to be...

Treating victims of rape one has to understand exactly what that role entails, this is only possible with education and training. Nowhere during the interaction with patients should you

resume the role of judge or prosecutor. Providers should understand that their role is to treat the patient with dignity and respect and be the best witness for the patient. When one refers to witness, it means that everything noted during history taking and everything seen during the examination should be reported-and *honestly* so, and make sure that during no time is the chain of evidence is weakened so as to give the victim the best possible chance of moving forward with the criminal justice system. When in consultation with victims of rape, one has to be aware of the mental state at all times as well as the influence of mental and physical age. This is required knowledge as it will guide the provider on the way forward keeping in mind the statutory guidelines that exist around the age (what constitutes a consenting adult and vice versa). Lacking knowledge about legislation places providers in a potential legal dilemma.

THUTHUZELA DR 3: Yes, you have to remember that you are a witness to [signs?]. So you can only report on what you see and what evidence you can collect at that point in time. You listen to the history that the patient gives you but you don't take a formal statement of the patient or the survivor. That will be done by the police... whatever I see on the body, bruises or lack of bruises, fluid collection, things like that, that's what I can report on in my affidavits on the [J-88?], you know what I mean? If I can't see any injuries, then I will say I can't exclude or confirm the history. It doesn't mean it didn't happen...obviously you have to care for the patient but at the same time you have to be an objective witness... anybody below the age of 12, yes, cannot give consent to sexual intercourse...it will always be statutory rape. It doesn't matter what the age of the perpetrator is. Now, with a Teddy Bear Clinic case it's controversial and it may be challenged again, but for now, if the child and the partner is between the age of 12 and 16 years, both of them. And the age gap between is not more than two years and they both gave consent, then the State will not prosecute... But if the age gap is more than two years or if one of the parties are older than 16 years then it's still seen as statutory rape...

3.1 Expert perspectives on the EMS role in the management of victims of rape

Rape victims or any patient advocate call EMS personnel usually when the traumatic experience has left the victim physically hurt and in need of immediate medical intervention. The participants felt that the EMS core function and role in cases of rape should remain unchanged-EMS should keep their focus on emergency care and stabilization of rape victims. However, this does not exclude 'management of the rape victim'. EMS personnel should still be trained on identification of these cases, what treatment is required after stabilization and what to be mindful of when focusing on preserving any evidence.

The awareness and training should emphasise that at no point does any of the rape management take over priority of emergency patient care- it is still the main focus, because you can't preserve evidence at the expense of human life. The difference is made when there is correct referral and the EMS personnel know where to take what patient, depending on what the patient presents with, and would have been more aware of the scene, so if they could bring any evidence along with them, that they would do so.

THUTHUZELA DR 2: ...if you look at rape by vast the majority is in the middle where they don't actually require any treatment and contact with EMS is...less. Now, which means by the time that you guys get involved, it's because the priorities are around health care provision... your core function still remains what it is, emergency care and at no time should this be compromised because you want to collect evidence or you want to preserve evidence. And the aspect of law is actually outside your scope because you need, if you are going to worry yourself with collecting of evidence, then you literally have to move with a crime kit and it has got its own rules, which means you are opening up EMS personnel to standing, to sitting at the courts on the bench to explain what you did. How did you collect this evidence? So collecting evidence completely out. Preserving evidence, yes...

THUTHUZELA DR 3: Yes, no, I think it's very important because what happens now is that often the patient doesn't know where to go...But if they maybe phone an ambulance to ask for help because they've been raped or they find somebody next to the road who's been raped and an ambulance is the first person to respond to that and this person can find out what happened. Then they can bring them through to one of the dedicated centres immediately... it can speed up the process... they need to be informed to tell the survivor what not to do...if they also know how to deal with these patients you know, in a way that doesn't cause secondary trauma. I think it's very valuable and I really hope that we can bring EMS in the multi-disciplinary management as well because I think it's an underutilized source at present...

3.2 EMS education is needed to promote 'continuity of care' and 'community of practice' from pre-hospital to in hospital care of rape survivors to improve the health care response.

There is consensus amongst the participants when speaking about what should be incorporated into the curriculum and what roles different health personnel have. Two major roles and responsibilities that should be defined came through as doctors and EMS personnel. However, both of these professions are deficient in this area due to lack of education and training. Clinical forensics should not be excluded or a minimised in their education, but instead should form a core module to ensure the victims get the health response they deserve.

Notwithstanding that emergency medical personnel work in the emergent environment with life threatening injuries, there are and will be times they deal with patients that are not 'dead or dying'. When these victims are sought after the EMS personnel require to be proficient in their knowledge around rape and its management as well as evidence preservation, triage of these patients and referral to centres where they will receive required medications and legal advice should they meet the criteria (fresh vs cold case).

There should also be considerable changes around paper work, and maybe look at designing a simplified version of the J88 for emergency personnel to complete along with any evidence collected and the treatment and management provided to the victim. This is important for chain of evidence and for legal purposes, should you be called to court. If this is considered, adequate training is crucial before implementation.

THUTHUZELA DR 1: Because they have the same problem with medical students and we've been fighting for years for that to be improved in the curriculum. Right now, it's a non-accredited training module that should really be accredited in your as you said a bachelor's training. And importantly, that the paramedics obviously know about triage. They need to know that injuries in a sexual offences victim takes priority over anything that we do in this building here. So if there are any life or limb threatening injuries that's the first thing that needs to be attended to...they need to know about securing DNA...then to know about the 72-hour window period for the dispensing the [PEP?], that's very important. And those three things are very important when it comes to what they would do because it's terrible for the victim of course, if they get referred inappropriately... that needs to be ingrained in every emergency personnel person and as you said, included in their training because it's really, it's not that difficult... It's just the standard operating procedures everyone needs to know...there should be a module with sexual offences in it. Clinical Forensics in fact, in general because you must remember drunken drivers is also something that they're going to deal with. So it should be a Clinical Forensic Module dealing with offenders, dealing with drunken drivers, dealing with sexual offences. It should be part of their [EMS] training most definitely.

THUTHUZELA DR 1: If they [EMS] had some kind of standardized material that they could use even if it's in the form of a smaller kit, a simpler version of the sexual assault [one?] to take a urine specimen even. Because if that survivor wants to go the toilet they can collect that first urine specimen in a jar and keep it safe for us and seal it and sign it off that would help. Ja and biological evidence. If they had a simplified version of the kit to secure that for us that would help a lot.

THUTHUZELA DR 2: Ja, it's that kind of thing. So I think the value would be to look at that form [PRF] and see how it can capture certain elements around rape or sex offences even if just a few ticks. Because once your tick is there that re-enforces the awareness that we've been talking about.

THUTHUZELA DR 3: Yes, ja and also, as long as they are trained properly on how to use [simplified version of a sexual assault PRF], you know how to word it. You know don't put specific names and dates and times. Say alleged, you know things like that you know because for the same reasons that I've just explained now, I'm just a little bit

scared that they may become a weapon of the defence. You know so they need to be sure they know how to word the thing; you know say [alleged with consistent with?] things like that. But that's, ja, I think it's important.

It is important to understand the capabilities of the resources/hospitals that surround you within a defined area. One needs to accept that private hospitals have pros and cons and the same could be said for state facilities. However due to the limited resources when it comes to clinical forensic medicine, the best choice for medical and legal care for victims of rape would be the designated state facilities that are geared to deliver these services by specialists in this field. Stigmas that negatively impact people to make good informed decisions need to be changed, and the likely way to achieve that is community and provider awareness.

THUTHUZELA DR 3: ...The private sectors are often not geared to see these cases. I've had a couple of cases seen at various private hospitals around Cape Town where the patients prefer to go to the private trauma unit because they do not want to go to a State hospital or whatever the case may be and they end up sitting there waiting for hours. The doctor who sees them has maybe never ever collected evidence; has never completed the [J-88?] and this will ultimately influence their case you know. So my experience from private practice is that the doctors are not experienced because they do not see these cases all that often. Most of the time the police or the detectives in this area in any case, will really try to tell the patient it's better for you to come to the place. They've got everything there. You can get all the medication free of charge. Obviously, in private you're also going to pay whereas in the State you get everything for free... And the problem is also often, that the patient gets sent around in circles because they maybe go to the nearest private hospital and then the doctors said well no, we don't do those cases. And then they try to find out where to go. So even the communication between them and us is not good. So that's another thing that should be improved.

THUTHUZELA DR 1: Ja, and I think partly it's a media issue you know where you get the scary stories being splashed over the media. Woman gives birth in corridor of a hospital, that kind of thing you know. So I can't even say that enough isn't being done. There is nothing being done as far as the private EMT guys go. I don't even know what they're telling the patient you know. When they come to a scene, they suspect the sexual offences because those guys they don't rock up here. They don't rock up here so I don't know where they're going. So we definitely need to find a way to – and those are businesses. So there are CEO's that need to be spoken to on that level and the owners of those companies, those private companies, to educate them about the fact that unfortunately medi-clinic is not going to do a Thuthuzela type job.

3.3 Medical Provider reflections for integrated health sector responses to extremely violent rape cases.

The participants all agree that emergency medical personnel should be doing more. However more does not necessarily mean a physical response but more of a passive response with regards to awareness and education, so that advice given to the patient is correct and helpful for the patient when making important life changing decisions. When the victims come into contact with emergency medical personnel the expectation is that they are in 'good hands' and will be looked after, but in all honesty that is not the case when it comes to management of rape, as earlier mentioned it is not even taught in their education and training. The lack in training has major legal implications for the emergency medical personnel, as well as chain of evidence not activated when emergency medical personnel has collected some, opens the grey area and puts the personnel in an ethical dilemma.

THUTHUZELA DR 2: ...court need information as detailed as it can be...they work on the premise of beyond reasonable doubt. Now, if you transported the patient who was a victim of rape and by way of reason you were expected to do certain things and you didn't do them that starts weakening, if one would say the case. Because you will do something that comes to compromise for example, the chain of evidence ...if during that process, you are able to capture information that raises the so-called red flags. Your response will be different...You see, one piece and that might be all that was need to secure a conviction. But if it's off the radar you see a handkerchief, you're so what? Dismiss and probably that was going to be the only thing that was going to assist in the investigation.

To broaden the knowledge and experience of emergency medical care personnel, the participants had suggested that shifts in the rape crisis centre should be considered as part of the practical exposure to coincide with the theory taught around the management of victim's pf rape. As we know the management of rape victims is a wide spectrum of various approaches and treatment, which unless you're exposed and get experience will not be able to identify it in the pre-hospital setting and would not have the tools to treat them. This also allows the emergency medical personnel to build networks and relationships with these facilities that would open up the door to consultations and referral opportunities.

THUTHUZELA DR 3: [Consider job shadow at rape crisis centres and Thuthuzelas] Maybe if they're not even present with the genital examination, the evidence collection but just for – to see the management of the patient, what happens. You know because that will also prepare them, if they need to inform people what's going to happen at the hospital and also they can see what's the medication that we do, what are the tests that we do. How long does it take? You know what – how do the patients react. You know

because it's very stressful and people become very emotional sometimes. And maybe they can learn on how to deal with these things and also, you know to build up a network, get to know the staff who's working here...it's good for networking, getting contact between us and them...it can be quite daunting especially, not any case, I mean some cases are surprising unemotional. And for you just to see that you know the spectrum of how people present because people are very biased when it comes to the management of rape survivors and you have to see – even if you sometimes have doubts in your mind whether the patient is telling the truth or not. You know you're not there to make a judgement. You're not the judge or the magistrate. You're a witness. You're there to assist with this - whatever the motive is behind, whoever is telling the story; you're not there to judge. You need to give every patient the benefit of the doubt, so to speak and to treat them in the same way...Whatever the case is – you know you need to learn how to be non-judgemental and to treat everybody the same... I think that it's very good to expose people [EMS] to that...

This section reviewed and discussed the findings of this research study, and identified and described the views and needs of the participants. Important themes emerged through the analysis and raised many questions concerning the role of EMS in the pre-hospital management toward rape victims and where EMS is located in a multidiscipline approach to the holistic bundle of care of victims of rape. Differences with resources and infrastructure were scrutinized when it came to urban versus rural context as well as the private sector in comparison to provisional hospital care systems. The gap in training and education in both the Emergency department and within the pre-hospital system were highlighted as a deficiency of appropriate care of the victim which directly impacts both patient and provider when looking through an ethical and legal lens. The themes discussed in this section will be explored in Chapter 5-Discussion.

C: Emergency care consultants focus group results

The participants that made up the Emergency Care Consultants sample came from New Somerset, Mitchell's Plain, Karl Bremmer and Victoria hospitals. The participants were sampled by means of purposive sampling, only focusing on the urban environment. Focus groups were conducted and common themes were extracted from the results (Figure 9), discussion and analyses below were used to explore the emergent themes.

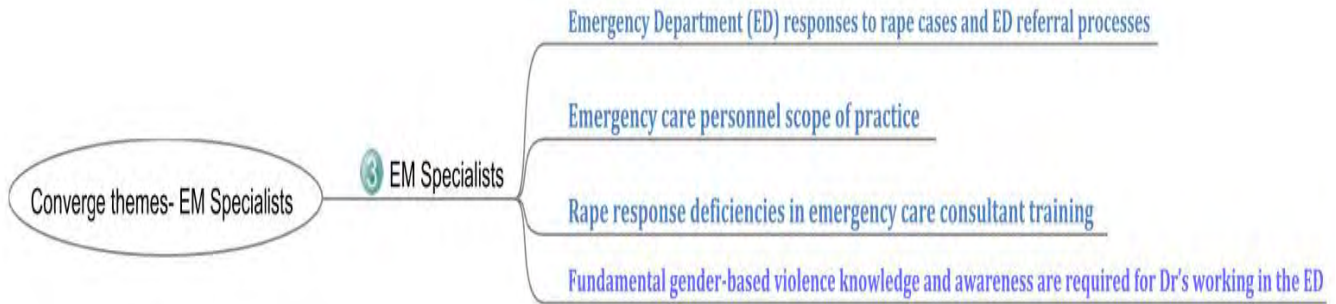


Figure 9: Convergent Themes: Emergency medicine specialist's interview results

1.1 ED responses to rape cases and referral processes

Consensuses amongst all the participants, as emergency care consultants, were that victims of rape are not seen in the Emergency Department (ED). However, should victims of rape be brought to the ED and they present with no 'physical' injuries, the doctor would not accept the patient. The personnel that brought the patient to the ED would be told to take the patient to the Thuthuzela/ Rape crises centre. On the other hand, should the patient present with physical injuries in the ED, the participants would treat the patient medically-then refer to the forensic unit if the patient is stable. In the event that the patient is unstable, the Dr in the ED would call the clinical forensic medical provider to come assess the patient in ED and to perform the rape kit in the ED in a private room to maintain patient privacy. This has been documented in a form of a policy, so the criteria for referral versus care in the ED is available for all staff working in the unit.

EMERGENCY CONSULTANT 1: They're [rape victims are] not [seen in the ED], is the answer...We have a Rape Centre, so they don't ever get seen in the Emergency Department. It's not appropriate...it's never happened in my unit...So in the event that a patient is too unstable or they're on a ventilator or there's a reason why we can't move them, then we have an agreement that that rape kit examination will be done in the EC...So that's the one policy that we do have here...There's no-one here that's qualified to manage them and I say that- I've done the course. I am technically qualified but I've never done a rape kit in my career and I plan for that to not change...

EMERGENCY CONSULTANT 2: ...So we don't see victims at all here. All victims that come, go directly to the Rape Centre...The only time a patient would come to us would be if a patient had been battered quite severely and required emergency medical care from our side like suturing or whatever else it may be. So then the patient would be seen by the sexual, by the Thuthuzela [unclear] and then managed by us but referred back to them as well...

The participants expressed quite strongly that treatment of rape victims is not likely to take place in the ED, they feel they are the emergency specialists and that victims of rape should be seen by a clinical forensic medical provider. However, there might be that one case where they will be faced with treating a rape victim and if it were to happen, they have made provision to treat the victim by having an emergency rape kit/pack available. The required treatment regimens would be administered to the victims of rape-this included PEP and emergency contraception. The participants are also not inclined to complete the J88 form in the ED, unless one of the EC Dr's are going to complete the rape kit, they would rather refrain to complete the J88 form and would send the patient with police officer to the rape crisis centre/Thuthuzela care centre. Should the J88 form be completed, they would need to make sure there is a case number and that there is a police officer with the patient, as the chain of evidence cannot be broken.

EMERGENCY CONSULTANT 1: ...I don't want to be involved with it. If I wanted to do rape examinations, I would take job in a Thuthuzela and I don't want to do that. I want to be as far away from it as possible and I think that that's quite a pervasive feeling because people are threatened by it. It's horrible. It's not a nice type of work to be doing... there's no doubt that information needs to be shared and that knowledge needs to be gained and that the language needs to be learnt. So that when they take the patient to the appropriate venue, they can say this is Mrs So and So, this has happened, this is why she's here and then there shouldn't be a problem.

EMERGENCY CONSULTANT 4: ...So we've got a PEP pack as well as emergency contraception [in the ED] ...if the patient is not stable enough to transfer... if the J-88 is complete with the case number and the police are with the patient...then the doctor receiving and assessing the patient obviously fills in the physical injuries. But that's never given to the patient. That must be handed to police to not break the chain of evidence. The forensic kit and that is done at Forensics.

EMERGENCY CONSULTANT 3: Most of the time we do not have the J-88 immediately available with the police forms. So in that case everything is fully documented into the clinical notes until either a J-88 arrives or the police officers arrive and the forensic kit – if we do, do it here, it's released only to the police officers.

1.2 Emergency care personnel (paramedics) scope of practice is explored when looking at treating/responding to rape victims and the possibility of additional treatment such as PEP to be added to the curricula-scope.

Some participants feel that due to the nature of EMS and what the job entails, that the medical care they offer to victims of rape should not being very detailed and invasive. The participants feel that the surroundings in which they find rape victims are not very conducive for such intricate examinations and are not suitable for the level of care. Instead EMS personnel should

identify what kinds of patients they have –rape or no rape, stable or unstable rape patients and transfer them to the most appropriate facility for further management. The participants feel strongly that the training of EMS personnel around rape victims and the care they need should be required to ensure that all victims get the best possible care. However, the participants don't feel that it is necessary to increase scope with medication, as it requires extensive training and understanding and feel those decisions should best be made by the clinical forensic medical practitioner.

EMERGENCY CONSULTANT 1: ...when you get a call for EMS it's an undifferentiated call... So the response part of it is not an issue. In terms of the treatment part, it's a tough one because... my opinion is that they should be able to...I think that it is imperative that they get some training on, oh my goodness what do I do? I've got a male or a female that's been raped. What do I do? What do I touch? What don't I touch? But even better than that would be ability on the part of the paramedics to recognize that this either a, a rape or b, a rape plus other injuries or c, only other injuries because which one of those it is will determine where they take that patient. So the giving of PEP and all of that is lekker, it will be wonderful if everyone got it within the right time windows but actually, the most important thing is to get that patient to the right point of care...They're [EMS] going to be called to a one hour old rape or one that happened two hours ago...So they're going to get fresh cases, where your window of opportunity is still wide ahead of you. Then it's actually more important that that person gets to the right point of care because there are still many hours in which they can be given the relevant drugs that they need.... If you're telling me that the paramedics don't know where the Thuthuzelas are, that's a massive problem. That's actually a crisis.

EMERGENCY CONSULTANT 2: No, absolutely, if you consider the burden of disease and lifestyle that we have in the Western Cape and especially with the drug utilization and crimes associated with it, you know, it obviously becomes of paramount importance that people are able to handle the situation be able to identify firstly, that you know that could be somebody that has been compromised. So they should be equipped with the appropriate tools to be able to identify and manage this appropriately without compromising the patients and maintaining the patient's integrity and being comforting to the patient because these people are in a very vulnerable state and as you say, it's quite important to be too able to handle it professionally and appropriately.

EMERGENCY CONSULTANT 3: Just from that point of view, I agree with [EMERGENCY CONSULTANT 4] that PEP should not be prescribed on the road-side. I think that is inappropriate in that there needs to be a full assessment of the case and a risk benefits scenario discussed with the patient. Also, there needs to be some investigations done prior the commencement of the PEP...

EMERGENCY CONSULTANT 4: ...The reason, we are sort of reluctant about it is because there needs to be consent. The patient needs to be taught the risks about PEP. The patient might be on ARV's already, you know, it's not just a simple yes, no, answer...

Contrary to some of the participant's beliefs, the other participants felt that EMS personnel are not doing nearly enough when it comes to victims of rape. To qualify the discordance, EMS responses are totally context dependant, and EMS should be trained accordingly. Some of the participants felt that the administration of PEP is a 'benign' act, but where the consequences come in is when not all the information is gathered prior to administration and this could negatively impact the patient. With this taken into account, in the urban setting the EMS personnel should get the victim to the appropriate setting in time for all the required treatments, unless faced with cases that are out of the norm that would get considered for such medications; but when it comes to the rural setting, administration of such medications could become standard practice. However, participants felt that they could not make such decisions and that the HPCSA is the only forum that could propose these changes to scope and training.

EMERGENCY CONSULTANT 1: ...It's not a drug the paramedics carry and I think it's a seemingly benign act to give the PEP or the post-coital contraception or the whatever. But all of those drugs happen in a context. They all have interactions with every other drug that the patient's either already taking or is going to take and there are questions that need to be asked and answered prior to starting. I mean a patient might already be on ARV drugs, in which case we don't give PEP. So I think that's an issue of law...there's lot of things that I think paramedics could be doing that they don't currently do but that's not my decision to make. And this would be one of them... I think that there is definitely a place to explore that and a phone call to a Doctor to get permission from a supervising medical officer is definitely something that could happen. But like you say, there's got to be a basic understanding. There's got to be some groundwork that's done before that happens.

EMERGENCY CONSULTANT 2: ...I think the issue is also not just the lack of knowledge but it's also a lack of protocols from EMS's side. You know and I think if that's [unclear] then the EMS personnel and the paramedics would know how to go about managing these situations. You know take the patient directly to Thuthuzela, if there's co-injuries then they would EC and Thuthuzela and [unclear]. And they'd be able to vouch for the patient and stand up, as you say, stand up for the patient's rights as well. So the patient doesn't get battered around. I mean I think the worst thing that can happen is if you're violated emotionally, physically and however else and now you're being given the run around.

Making the case for a change in scope has pros and cons, and some of the cons the participants are worried about are the concerns about giving these medications to the EMS personnel, because once they have it to their disposal, it would be really difficult to control the dispensing of these medications. In hospital there are policies in place to control when and how these medications are administered, so before any considerations are taken to implement this for EMS personnel, training and policies should be mandatory. There should also be training for

all levels of care in the pre-hospital with policies detailing the scope of care for each level of worker.

EMERGENCY CONSULTANT 1: ...I mean that also implies that they need to be carrying those drugs... that open... a whole new can of worms... So now they've got the equipment...they phone and they say, I've got this guy. Now, what do I say? Do I take the risk that they'll kill the patient...or do I guide them through...? And so the minute stuff is there, people will use it usually. So they've got to have the PEP to give and then they've got to have a system in place and so we've got to cascade it backwards to where you were saying, create the awareness, bring the training in at whatever level you can bring it in and I think that the way things to go is that inevitably, over time, that training will create a desire for more training and for more comprehensive training and that will turn, create a need for the treatment side of things and slowly it will go.

EMERGENCY CONSULTANT 4: No, the paramedics should be called out for an ALS transfer. You know that depends on the victim's injuries. That's where they [PEP] should be used you know, accepting that resources are limited, any qualified professional should be able to deal with the emotional stuff of the rape victim... If you're talking about further training whether it's emotional, social and all those things together, one should ask the question do you need an ALS paramedic or should we go down a different scale you know, a basic life support person who has got maybe a different training of education to deal with these things, might be just as effective and not using your resources appropriately...

1.3 Rape response deficiencies in Emergency care consultant training

Majority of the participants received no training specifically to the treatment and management of rape victims, for both undergraduate and post graduate studies. Not even in-service training in the management and treatment of rape victims occurred, suggesting a failure in the CPD system to address gaps. The minority that had received formal training have certification to do these examinations but have never completed a rape kit. However, the minority that have received training feel that the little training they had received is sufficient as they don't encounter these victims in the ED, so they feel that if your context requires it of you, then more extensive training would be appropriate. One has to ask the question, if EMS personnel have no training on the management of rape victims, and the EC Doctors receive no formal training, how can one rely on the system we entrust so much when such crucial gaps exist?

EMERGENCY CONSULTANT 2: ...I haven't even attended the course but I used to do them in Thabazimbi there was probably a course I did ten years ago as a Cosmo but nothing else for that. I mean I didn't, haven't done a rape kit in ten years.

EMERGENCY CONSULTANT 1: Okay, I've never done a rape kit but I've done the course. So I've got a certificate, I'm qualified. But I've never – I have never done a [rape kit] ... I think that in a resource limited environment such as the one in which we

work, we have to divide the load and that's been done. And so Thuthuzelas have been created and you get those wonderful, crazy people that want to work there and who give excellent service to these people and thank heavens for that because the EC guys are literally too busy doing emergency medicine to be able to do that as well. So we've diversified it because otherwise we wouldn't cop

EMERGENCY CONSULTANT 4: Additional, except additional through our FCEM Training, like a special course or something, no, none.... it depends on what setting you were – for me, obviously, we don't see – we see the physical injuries of the rape victims and its covered by the Forensic Unit filling in the rape kit and that. I do feel that if you're working in a setting where you are going to be encountering a lot, that you know, one day course, how to fill it in correctly is probably more paramount.... I did do a Forensic Block but to be honest, I never saw a J-88 until I reached my internship.

EMERGENCY CONSULTANT 3: Okay, so the training with [unclear] in Gauteng and the forensic services offered say six monthly training updates to our staff with regards to the completion of the forensic kits etcetera, to ensure chain of custodies etcetera. So when you say formal teaching, it's not that we got certificates at the end of this but we have the specific training by the Forensic Services and I can tell that our Registrars do receive a specific training as well in the Western Cape...With regards to J-88 training was really an in Service type of scenario where one person showed another person how to do it. And that was at an intern level and then with regards to the rape kit, so it was again, initially done on a peer type of teaching point of view until the various specialized rape centres came online...

1.4 Emergency care consultants feel that basic knowledge and awareness are required for Dr's working in the ED

The participants feel that extensive knowledge around treatment and management of rape victims are not really required by emergency care doctors/consultants. They feel that the Thuthuzela/Rape crisis centres are robust enough to treat all victims of rape that are stable and do not have life threatening injuries. The participants feel that awareness around rape and basic training around what PEP and emergency drugs are used for is all they need, as in the time of need, they are able to administer the drugs under the correct circumstances.

EMERGENCY CONSULTANT 2: Look, I don't think it's an issue to give PEP to somebody that's been a victim but I still stand that you know what, the Thuthuzela System in Cape Town is very robust and it's very supported ...if any of them go on leave, they cover for each other as well...We need to know basically, we need to have an understanding of rape survivors and initial management.... There is always a unit open and there's a Doctor on call 24/7 at quite an exorbitant cost to the state... so I don't think it's a necessarily all incumbent on EC providers within the EC to be trained on completing the kits firstly. Secondly, you know I think the patient comes in day 3 there is some medical condition that needs to be addressed well and good and needs to be

addressed. And I really don't have an issue if you need to administer the first dose of PEPs at day 3...

EMERGENCY CONSULTANT 1: No, I was going to say I think that is really actually part of basic medical training, certainly for Doctors. I mean every Doctor that's trained in this country now knows something about HIV. And so I think that that first dose of PEP and the post-coital contraceptive and something for sexually transmitted infections. I don't think that's a big ask because those aren't – they aren't fancy drugs for us. They're everyday drugs... The question regarding the paramedics is a little bit more complex because – because there's no training they need to know as I said, which questions to ask, how to recognize these people, how to look at the situation and think hang on, there's more going on here than meets the eye. Could this be a case of sexual assault? Know where to take them to and then just know how to preserve the chain of evidence. Not that there's really anything that a paramedic is likely to do that's going interfere with the evidence per se because what you guys do is very seldom going to involve working near the perineum... I think that creating the awareness with – means that sometimes in the training phase we give more information than the person necessarily needs to use on a practical day to day basis. But it provides a context within which they can work...

Summary

This section identified and described the views and needs of the participants when it came to identifying the difference between care rendered in the emergency department compared to care rendered at a designated 'rape unit'. Important themes emerged through the analysis which highlighted deficiencies in the emergency department with regards to the training of Doctor's in the management of rape victims as well as questioning the role of EMS personnel in the management of rape victims and whether their scope should be revised to include rape management such as PEP and emergency contraceptives etc. The themes discussed in this section will be explored in Chapter 5- Discussion.

CHAPTER 5: DISCUSSION

5.0 Introduction

In order to ground this discussion with the study purpose, the aim and fundamental assumptions are presented below. In the absence of guidelines/policy for the management of rape in the EMS setting, inconsistent practice has the potential for greater harm to the population of rape victims. This is a concern to the South African health system in the context of health provision and criminal justice. Clinical decisions and discretion in sexual assault and domestic violence intervention is possibly steered by existing knowledge and beliefs towards victims of sexual assault and domestic violence. Due to the shortcomings faced by the emergency care providers in this current state, this study aimed to formulate evidence-informed policy recommendations for a re-contextualised and professional emergency care response to survivors of rape.

Although numerous research articles are available with regards to rape occurrence and its impact on rape victims, no known research has been conducted in South Africa that investigates the experiences of emergency care providers as first responders to rape cases and the implications of responding to victims of rape for the emergency care discipline. What might the emergency care expectations of rape victims and their care-givers be? Therefore, the study investigated the experiences emergency care providers had when responding to cases of rape; and the implications this has for the development of standardized guidelines for pre-hospital emergency care practice toward victims of rape in South Africa.

Convergent themes and prominent statements emerged in chapter four highlighting key areas of treatment and teaching practices of relevance to this study's aim. It also documented 'absences' of treatment in certain pre-hospital and hospital environments as normative - due to various health care provider and health system factors.

The following themes for discussion will be engaged with in this chapter with a view to further abstraction: A simplistic Emergency care approach was taken by EMS due to the indistinctness and inappropriateness of emergency care responses. False dichotomies exist between male versus female (engendered) Emergency care responses to victims of rape. This creates an engendered response. Disparate emergency care provider exposure to rape relative to rape incidence was also documented. A lack of Referral and facility policy in conjunction with a lack of policy for treatment of victims of rape in the pre-hospital setting was also found. Succinct medical record keeping is required to ensure EMS personnel are safeguarded against legal and

ethical implications. EMS education is obligatory for pre-hospital to in hospital care of rape survivors to improve the health system response. Service delivery by a Thuthuzela crisis centre in comparison to a Rape crisis centre provided some contrast. Emergency Department current responses to rape cases and referral processes and the significance of rape response deficits in Emergency Medicine consultant training are also included in the summary findings. This section is completed by an appraisal of trustworthiness of the study.

5.1 A simplistic Emergency care approach taken by EMS due to the indistinctness and inappropriateness of emergency care responses

The results and initial analysis strongly suggests that rape is still a sensitive topic that health care providers, emergency medicine consultants and pre-hospital care providers alike, are not willing to engage with notwithstanding their emergency forensic knowledge skill set. For health care providers in the pre-hospital and in hospital environment, sexual assault and post-rape management is an emerging priority^[68] that obligates optimum health care for men and woman. Whilst the phenomenon of rape was acknowledged as a public health and emergency medicine problem by the participants, the critical emergency and forensic role that practitioners could play was only partially acknowledged. Health care providers seem to be complacent with their current role in the health system, and have taken a nonchalant approach to rape and what it means for pre-hospital care. Emergency care providers view themselves as a transport medium that delivers 'supportive' care to victims of rape, such as basic assessment of the primary survey, sometimes inclusive of vital signs assessment. However, should the patient present with traumatic physical injuries the emergency care provider will treat the patient within their scope of practice.

As health care practitioners, taking heed of rape in all its epidemiology and social complexity is necessary to develop a positive stance and willingness to engage on a multi-level platform ranging from engagement with SAPS to the specialized care. Equally vital is the forming of linkages for community of practice amongst the key role players in the rape victim's road to recovery. This encompasses consultation with the specified units and clinicians, appropriate and timely referrals, evidence preservation and forensic clinical medical treatment and management. Emergency care provision, in the rape victim context, is a minimum standard. When this holistic and multidisciplinary approach is not taken, the public interest is not protected. Health care

practitioners become de facto custodians of the victim's health rights. Failure to protect the same has the potential to render emergency practitioners partial to the perpetrator and positions them against victims. This seems bizarre and counter-productive, but it is not uncommon for vulnerable groups worldwide to be neglected or victimized further by those institutions and individuals charged with their very protection and risk factor reduction ^[69]. The impact of poor responses – defined by not meeting the victim's needs - causes further harm such as secondary victimization instead of safety and the appropriate bundle of care to aid the victim in surviving rape trauma.

Victims of rape should be triaged as priority cases. Victims/survivors disclosing a recent sexual assault should be referred to the nearest appropriate facility for evaluation of life-threatening injuries and booked for a medical forensic exam immediately ^[70]. The health care provider should also be knowledgeable about the role that SAPS play in the treatment and prosecution of cases. When a chain of evidence is not initiated and/or maintained, the health care provider weakens the case for the state to prosecute the perpetrator ^[71]. When this process is not followed, exposing the gaps in the health system, the victims lose their window for specified life changing treatments and are at a higher risk at experiencing secondary victimization which could result in the victim choosing not to seek medical care and legal remedies, pregnancy and sexually transmitted infections – all of which may forego psychological and emotional closure. The notion of 'it's not my problem and/or I have not received sufficient training' cannot serve as an acceptable demeanor and be the norm amongst pre-hospital care providers.

The victim/survivor requires health care providers to have at least, as a minimum- basic training when it comes to the treatment and management towards victims of rape. Correct referral and a non-judgmental attitude when encountering victims/survivors of rape can be the link in preventing secondary victimization, resulting in a positive impact on the victim's road to recovery.

“Over the last decade, there have been major advances in the field, but services are extremely uneven and alongside areas of excellent care, there remain areas with substantial gaps in services, including inadequate facilities, health care providers with little special training and thus the continuing concern that the process of seeking health care and justice exposes patients to further trauma, with lost opportunities for preventing mid to long term physical and psychological harm” ^[68].

Pre-hospital emergency medical services (EMSs) have to rethink and re-conceptualize their role in the pre-hospital environment. In addition to placing the emphasis on the very static role of

'urgent transport' from the scene to a place of definitive treatment – which is by no means to be undermined - one must acknowledge that the specific needs and treatment to the rape victim may be irrespective of the chief complaint (particularly when victims may attempt to conceal the preceding assault). As the first point of contact to medical care; pre-hospital practitioners must acknowledge their role as a 'health resource' and act as a pivotal link for 'prevention and early detection' [2] in survivors that may not necessarily disclose their status of being raped. Some victims may heavily rely on the assumption that the health care practitioner they encounter have the required training and experience to take heed of the 'unspoken'. This is not a fallacious notion or belief to have as a patient seeking treatment, as it is a constitutional right to be treated by a competent health care provider. Should this not be the case? Should the health care provider be working in the pre-hospital environment where most patients encountered are vulnerable and need protection and preservation of their dignity by ensuring they receive the correct health care? [49].

As a health care professional regulated by the HPCSA, the ECP is required to provide the most appropriate care to all patients encountered in an emergency situation [6], ensuring that patient safety is always maintained as a priority [13]. Rape/sexually assaulted victims may at times present with physical injuries that may be life-threatening and superimpose other health concerns at the time of initial treatment. The healthcare practitioner is obligated to 'professionally and constitutionally' care for the rape victim [2]. So why is this not the reality? By way of explanation, "failure to provide appropriate care constitutes a secondary crime against sexually assaulted/rape victims as it violates the Constitution" [2].

It is repugnant to have EMS personnel view their role in the pre-hospital environment as a transportation service and not see themselves as key role players in the treatment toward victims of rape. This view was expressed explicitly and indirectly in the data. Health care practitioners are lawfully bound to treat victims of rape/sexual assault to the best of their ability and the patient has the right to receive appropriate medical care that is not harmful or detrimental to the victim.

PARTICIPANT 1: Basically, the treatment that we're currently doing is basically just transportation of, if we get on the scene SAPS will phone us and then we will transport patients. The idea behind the whole thing is not to really get involved. Yes, you can give the care and attention and make the comfortable as possible but don't interfere, don't ask questions or really get involved.

5.2 False dichotomies exist between male versus female (engendered) Emergency care responses to victims of rape

Thoughts and perceptions around what rape is defined as, who rape affects and how we treat rape is a function of what we have been exposed to as human beings - be it education or personal experiences and upbringing. Rape is commonly assumed to be a problem of women and the media plays to and promotes that misconception and myth. "Sexual assault is a highly gendered crime, and men are seen as unusual victims" ^[72]. Rape, as a form of sexual violence is a socially constructed phenomenon, enabled by hegemonic masculinity and misogyny. Health providers cannot be ambivalent about it ^[73].

PARTICIPANT 4: ...it's not just women who get raped, it's men as well and it's something that is kind of overlooked a bit...which is bizarre. I mean, rape is rape...I mean, you think of sexual assault you immediately think of a female patient. You don't think of a male patient.

Various factors play a role in the underreported male cases of rape; these factors share similarities with cases of raped woman, such as the hesitancy to report their case to police for fear of embarrassment. Men fear losing their masculinity and sexuality when they see themselves as victims of rape, and this results in men rape victims suffering from Rape Trauma Syndrome (RTS)- much like woman, they cannot fathom the fact that they couldn't prevent the rape from happening ^[74]. Another key factor to acknowledge is the fallacy that only homosexual men are raped and that one heterosexual man could and would never rape another heterosexual man ^[74]. Debunking these false beliefs is that rape is not an act of extreme violence ^[75].

There seems to be avoidance when it comes to differentiating and distinguishing the needs of the rape victim- albeit male or female. Participant 2 speaks about their views when it comes to the management of male versus female rape victims, and is evident that there lacks education in what the male and female rape victims may experience, what bundle of care they require and how they would present post sexual assault.

PARTICIPANT 2: ...I'm a male, the females don't really want to be assessed by a male. ...I don't want to intrude or ...don't want to intimidate the patient too much. From what I've experienced being a male, coming into a patient that has just been raped by a male, it is a bit more upsetting to the patient... I think it would be advantageous to have a female assessor, a female that has been raped, just to avoid that anxiety and the stress that could possibly happen.

Both male and female rape victims experience the same physical and psychological responses to sexual violence which includes emotions such as fear, depression, suicidal ideation and anger^[74]. They don't necessarily have a preference to which gender treats and care for them in their time of need, but rather have desire for someone to not judge them and to care for them in a way that aids in their recovery and healing process and not cause further harm and victimization. Falsely engendered responses promote the stereotyping of what care victims need and by whom.

5.3 Disparate emergency care provider exposure to rape relative to rape incidence

South Africa has one of the highest incidences of rape in the world^[30], suggesting a woman is raped every 35 seconds^[76]. The reality of such alarming statistics is one where the status quo of HPCSA policy deficiencies in the treatment of rape survivors, is one that cannot continue unchallenged. It is inevitable that practitioners will come into contact with victims of rape which will require appropriate treatment and referral. The current haphazard approach of treating/not treating victims of rape cannot be accepted by the health care governing bodies and should be addressed as an immediate primary health care priority.

A forensic medicine dearth exists in clinical training and education toward victims of rape within the pre-hospital emergency care platform. The aforementioned is a consequence of staff apathy, resistance toward the responsibility of treating and managing victims of rape and the truancy of a sexual assault/rape policy by HPCSA. The pre-hospital care environment lacks community of practice, no-one wants to engage with this area of treatment and try to solve this gap in knowledge which is a peculiarity of no desire to gain experience^[77].

Sharing knowledge, identifying which treatment bundles is appropriate in which context and referral linkages amongst all health care practitioners involved in the treatment of victims of rape is vital in ensuring a community of practice is grown and nurtured. The initial data analysis projected amongst all the participants (Emergency medicine consultants, Clinical forensic medical practitioners and emergency care providers) that very little to no referral takes place amongst the three entities, and those that sometimes happen, happen incidentally or by instruction with no consultation and feedback. There is also no frame of reference or guide for

the treatment required pre-hospitally as how to go about evidence preservation in relation to the role of SAPS as part of the management toward victims of rape.

“Central to the policy on medical, psychological and forensic management is the recognition that the management of rape survivors (women, men and children) requires special training and expertise, as well as an integrated management approach” ^[78]. This is pivotal as it directly impacts the survivor’s future mental and physical wellbeing, with the possibility of eventually convicting the perpetrator of this heinous crime ^[78]. The public health sector should be cognizant of rape as an act of violence and should prioritize allocation of resources and services available to such survivors ^[78].

5.4 Lack of Referral and facility policy in conjunction with a lack of policy for treatment of victims of rape in the pre-hospital setting

Currently there is no policy for the management of rape victims for emergency medical care practitioners. Despite the absence at a national level, when considering what is happening at an international level, benchmarking is unlikely when the extent of rape prevention and treatment policies are unknown. “Moreover, evidence on what works in the area of prevention and sexual violence is limited, particularly in developing countries” ^[1].

Introducing a strengthened referral system between the health sector, the criminal justice sector and designated sexual assault/rape units is the ultimate goal to ensure rape victims/survivors do not become lost in a fragmented system. “This is in keeping with the minimum standards for service delivery in victim empowerment: It should be ensured that victims have received effective developmental assessment, referral and support services, enabling the victim/witness to effectively participate in court proceedings” ^[79]. All health care workers are responsible for referrals and therefore require every health professional to have basic medico-legal training as a minimum to ensure patients receive care in every aspect of rape management (medical and non-medical). To ensure appropriate referrals are given to meet the patient’s needs and circumstances in consideration of available resources, practitioners should be familiar with the range of facilities and resources available within their local surroundings for victims of rape. “It is the role of the health care worker to help patients identify and choose the most suitable option(s) for their particular requirements” ^[74].

ECP's work in an unpredictable environment, with limited point of care diagnostic tools that requires them to think on their feet and rely on their environment for contextual clues. This said, when presented with a rape victim, that has no life-threatening injuries one is required to make sense of convoluted situations. Where possible the ECP is to try to prevent long term medical and social ramifications of rape by providing informed and competent services that is only possible with training and education in this field. The management of rape victims requires health professionals to work within a multidisciplinary platform to ensure that treatment and referrals are appropriate for the rape victim at that point in time^[68].

5.5 Succinct medical record keeping is required to ensure EMS personnel are safeguarded against legal and ethical implications

Principles of medical ethics such as 'beneficence' and 'non-maleficence' are of nuanced significance to emergency medicine practice. Health workers are duty-bound to ensure their professional skills are used in an ethical manner at all times and to make sure they treat within the acceptability of the community and laws of the country. When providing services to victims of sexual violence, principles of justice, fairness and autonomy is of outmost importance^[80].

ECP's should be cognizant of the following traits and characteristics when delivering a service to victims of rape, as it directly impacts the practicality in which the service is provided^[74]. These traits and characteristics are namely:

- Awareness of the needs and wishes of the patient;
- Displaying sensitivity and compassion;
- Maintaining objectivity^[74]

ECPs should be trained to document injuries and patient presentation proficiently, along with treatment rendered as per the individual's needs. Orbinsky et al. 2007 states that the responsibility of medical practitioners as being able to 'document and bear witness to violations of human rights, and to intervene to alleviate suffering if possible'^[81]. The aforementioned is critical, as the role of the health care worker is not to be a bystander but an advocate for the patient during their time with the victim and beyond.

Evidence collection may not be the ECPs primary focus; however, education and training on how to best preserve evidence on the body and on scene when treating these patients are fundamental to forensic emergency practice. This will allow for a higher caliber in which patients are presented at the designated rape centre or ED and in turn will assist with future criminal proceedings against the perpetrator of the sexual assault/rape^[68].

5.6 EMS education is obligatory from pre-hospital to in hospital care of rape survivors to improve the health system response.

The emergency care provider participants expressed that not nearly enough of them knew what a Thuthuzela Care Centre was and those that had encounters with them; felt that they lacked education around what the TCC actually does for victims of rape, what services they offer and they felt that there was a lack of communication and referral between the different health entities. From an organizational point of view, emergency care providers felt that the communications centre lacked specified dispatch policy with regards to sexual assault and did not seem to acknowledge that these victims should be classified as a priority irrespective of the extent of physical trauma. This was supported by acknowledging that this area of health care was lacking and that it displayed a fragmented system with the (self-reported) root cause stemming from a lack of education and awareness.

According to Vetten et al. “The devastating consequences of rape have galvanized policy-makers to provide services intended to ameliorate rape’s after-effects, as well as promote women’s access to justice”. Nonetheless it is one thing to acknowledge the ramifications of rape, but to implement interventions seems to be a mammoth task on its own. Policy makers admit that it may be one thing to identify what the lacking policies might be but is a wholly new task to test what ‘makes policy effective in practice’^[56].

The world Health Organization 2003 stated that “Given appropriate knowledge and training any health worker in a health or medical facility should be able to provide first level health care to victims of sexual violence. Expertise in the field will develop with further training, professional support and given adequate resources. Ideally, all health workers (i.e. nurses, physicians, social workers, mental health professionals) who come into contact with victims of sexual violence should receive appropriate training^[74].

It is safe to assume that the level of training and education required by pre-hospital emergency care workers is that of a basic nature, as they are required to stabilize the patient if necessary

pending any physical injuries – being mindful of evidence preservation, identify the sexual assault and make proper referrals. If this is the international norm or standard, the question remains - why is there still no rape response policy for emergency medical care personnel? It has been shown that when immediate services are appropriate for the victim's individual needs, and are rendered in a non-judgmental manner, the victim does not suffer from secondary trauma. He/ she are more likely to continue post-rape/sexual assault treatment and makes use of the mental health services to help mitigate the long term impact of rape. Awareness of secondary trauma and victimization that may be experienced by the victim as a result of negative behavior by providers at all levels, should be a point of focus for all sectors/services that may interact with victims/survivors of rape^[82].

5.8 Emergency Department current responses to rape cases and referral processes

The emergency care consultants that participated in this study felt strongly that rape victims should not be seen in the ED. They also added that for as long as they can remember, no victim's rape had had been seen in the ED. They were all in agreement and referred to a policy they have within their hospitals, which states that only victims of rape that had sustained life-threatening physical injuries would be seen in the ED, and in the event that this takes place, a clinical forensic medical practitioner would be called to the ED to assess the rape victim and perform a rape kit in a room where privacy could be maintained. The absence of emergency medicine specialisation in some rural areas would require competent emergency and forensic care by the ED and pre-hospital practitioners.

The participants expressed strong sentiments that responding to rape victims is not a specialist intervention of an ED doctor. This was alarming in that not all participants had received training around the management of a sexual assault case. The participants that had done the training felt that their job was to care for the trauma and medical emergencies and not rape victims. In contradiction to the above, taking into consideration what a rape victim experiences and the care they require in specified time frames, that ED Doctors, when faced with victims of rape, begin treatments such as PEP and EC and maintaining a chain of evidence.

Given the low EMS exposure to rape cases, it is surprising that a participating Emergency Consultant stated that rape victims are not ordinarily seen in the ED. Only exceptional cases where the victim has life threatening injuries, and even in this scenario, the chief complaint of rape is not the priority or point of care, but saving the patient's life is. Some consultants have done the specified training around forensic medical care examinations and the use of a rape kit, this by no means is the norm nor is it a professional requirement, unless you chose this field of specialty on your own volition. Apart from the consultants, the casualty staffs have rarely received any sort of specialist training around the management of victims of rape ^[84-85].

EMERGENCY CONSULTANT 1: They're [rape victims are] not [seen in the ED], is the answer...We have a Rape Centre, so they don't ever get seen in the Emergency Department. It's not appropriate...it's never happened in my unit...So in the event that a patient is too unstable or they're on a ventilator or there's a reason why we can't move them, then we have an agreement that that rape kit examination will be done in the EC...So that's the one policy that we do have here...There's no-one here that's qualified to manage them and I say that- I've done the course. I am technically qualified but I've never done a rape kit in my career and I plan for that to not change...

EMERGENCY CONSULTANT 1: ...I don't want to be involved with it. If I wanted to do rape examinations, I would take job in a Thuthuzela and I don't want to do that. I want to be as far away from it as possible and I think that that's quite a pervasive feeling because people are threatened by it. It's horrible. It's not a nice type of work to be doing... there's no doubt that information needs to be shared and that knowledge needs to be gained and that the language needs to be learnt. So that when they take the patient to the appropriate venue, they can say this is Mrs So and So, this has happened, this is why she's here and then there shouldn't be a problem.

"Unless special measures are taken, the location of services in casualty seriously compromises the quality of care provided to victims of sexual assault, with casualty staff likely to see their services to rape survivors as an add-on (if not burden) and their work in casualty as their first priority" ^[84-85].

Summary

In developing national strategies or policies it is of vital importance to address sexual assault/rape management toward men, women, adults and children, 'global advocacy for the inclusion of rape prevention in national policies is needed'^[1].

When reflecting against the analysis and findings of this report, we can deduct that rape management has been sub-optimal borderline absent in the pre-hospital setting by emergency medical care practitioners. This was influenced by a lack of policy, deficient education and training resulting in inadequate resource usage and referral to the designated facilities that does exist (underutilized by EMS).

The consequences are poor quality performance, fragmented treatment when initiated and zero multi-sector involvement/engagement. Lack of training and resources directly impacts documentation of the forensic examination, resulting in poor quality hand over of evidence (where applicable). Secondary traumatization of survivors is a result of a fragmented system and untrained personnel^[78]. Evidence-based prevention is necessary in developing national policies. Particularly the needs of survivors should take priority within the policy. It is hoped that the findings of this study will support national engagement in efforts to include rape prevention, along with comprehensive quality care to rape survivors, in national sexual assault policies and strategies for HPCSA. Further, the risk of vicarious traumatization of the practitioners deserves policy attention as well. The adage of "salus patientis praeferendus" (preferred patient safety) is self-limiting if the care-givers are neglected or placed at risk of vicarious traumatization. The study is found to satisfy the major elements of trustworthiness as a measure of study quality.

CHAPTER 6: CONCLUSION & RECOMMENDATIONS

The aim and objectives of this study was to qualitatively explore the management of rape in the EMS setting in the absence of direct clinical guidelines/policy. It also considered what the current practice consisted of and if it had the potential for greater benefit to the population of rape victims. Clinical decisions and discretion in sexual assault and domestic violence intervention is possibly influenced by existing individual knowledge and beliefs and organizational culture toward victims of sexual assault and domestic violence. Due to the shortcomings faced by the emergency care providers in this current state, this study aimed to formulate policy recommendations for a re-contextualised and professional emergency care response to survivors of rape.

Participants were forthcoming with their experiences working in the pre-hospital environment and highlighted key areas for consideration with regards to current practice and management of victims of rape. Key areas of particular importance were discussed in chapter five and recommendations are intended to address the existing fragmented system highlighted by interviewing key role players in the treatment of victims of rape. The recommendations are structured around principles namely a community of practice amongst key role players and accountability of emergency care providers.

Emergency care providers – Emergency Medical Care Personnel:

6.1. Place rape and sexual assault on the EMS agenda

It is imperative that the current curriculum is reviewed and sexual assault/rape as a critical addition to pre-hospital education and scope of practice is included. Rape should be recognized as an emergency care burden that provides an emergency care case definition that empowers emergency care providers to be responsive to rape. Scope of practice is yet to be determined for emergency care providers, and that would require further research as an implementation science imperative. However, this study has determined that a mandatory introduction and practitioner awareness in the pre-hospital setting is urgently required. Priorities include: identification of sexual assault (male, female and child victims), medico-legal awareness around the rights of the victim as well as the rights of the emergency care provider ^[74], evidence preservation, what the do's and don'ts are for management and treatment of victims of rape ^[83]

along with which facilities victims of rape should be transported to depending on patient presentation and needs at the time of encounter.

6.2. Promote a community of practice for rape/sexual assault health care responses

Community of practice, it would appear, is crucial to the care of rape victims. Communities of practice are defined as “people who engage in a process of collective learning in a shared domain of human endeavor”^[77]. It is of vital importance that such communities amongst key role players are nurtured, enabling a passion for the topic of rape and sexual assault, along with an environment that fosters learning and development. A step in the right direction and a good start would be for key role players to have frequent and regular meetings which would be inclusive of the emergency department of hospitals in the area, the Thuthuzela Care Centre/ or rape crisis centre, emergency medical services as well as the Family Violence Child Protection and Sexual Offences unit from the SAPS. This is required to ensure fragmentation and inefficiencies in the system are avoided at all costs, ensuring the victim receives the best care possible. This would allow all parties involved with the victim at one point or another to understand their role in the treatment of victims of rape as well as open the platform for consultation and referral when the need arises. Non-governmental organisations and faith based-organisations may have particular benefit in advocacy and health promotion activities. The recommendation for community of practice was supported unanimously by all three stakeholder groups that participated in this study.

Clinical forensic medical practitioners

6.3. Crux of treatment and management of rape victims

Consensus amongst clinical forensic medical practitioners working in both the rape crisis centre and Thuthuzela Care Centre’s were around the lack of specified resources that could increase level of care of the rape victim and enable the state to prosecute the perpetrator(s). These missing resources include a digital camera used to capture graphic and indisputable details of the victim’s physical presentation where the need arises as well as urine analysis for victims that could have potentially been drugged prior to being raped. This leaves the clinical forensic medical practitioner with no alternative for evidence collection save visual description.

Consideration should be taken to make available resources that are still not at the disposal of the clinical forensic medical practitioners, such as laboratory facilities to analysis urine samples as well as a digital camera and required software to maintain a chain of evidence. It was unanimous amongst the participants that integral stakeholders in this multidisciplinary approach should be focused on patient-centered care; however to achieve this, stakeholders would require education and awareness around sexual assault/rape victims. In order to prevent secondary victimization which further negatively impacts the victim, it is vital to understand what is expected of the health care provider, which roles they play in the management and treatment of the victim as well as understand what services are offered by the rape crisis centre in comparison to the Thuthuzela care centre.

There is a lack of clinical forensic medical practitioners that are devoted to this field of study. This may be due to the lack of professional opportunity. Participant's felt that a diploma for further forensic study (and not a postgraduate degree) resulted in a field of specialization with little financial gain contributed to the lack of uptake to the field. The participants felt that working shifts in the rape crisis or Thuthuzela care centre would positively impact the emergency care providers, as this would allow them to work with patients from the beginning to end of treatment, giving them insight and experience on what the victims require. This would ensure that when treating victims of rape as first responders, they are confident in their skills and have built great working relationships with these facilities.

To aid in the treatment of victims of rape, the participants felt that consideration of a medical record form could assist the emergency care provider in such a way that it provides a uniform guide on how to treat and record important information when rendering care to victims of rape. With the current patient report form not being designed for sexual assault record keeping as well as the J88 form best suited for the forensic exam performed by a Doctor, a simplified yet accountable medical record form would be ideal and best suited for emergency care providers. However, prior to commencement of such an important medical record that is essentially evidence, crucial training is required.

Universities ought to relook at what is being offered to medical doctors looking to specialize in the field of forensic medicine, to consider upgrading the current post-graduate diploma to a degree. The Department of Health should view forensic medicine as crucial to the public health interest and render working conditions and remuneration for forensic medicine more attractive.

The HPCSA, as the regulator, should incorporate the following recommendations into its regulations:

- I. Insofar as the PBEC relates to victims of rape, there is a need to develop a position statement that posits itself in relation to rape and emergency care responses;
- II. The resultant position statement may infer tacit or radical changes to the scope of practice that links to the critical outcomes of rape management such as: chain of evidence, empathetic responses, responsible referrals, prevent secondary victimization;
- III. The follow-up obligation will be to engage in curricula reform that may include experiential learning at forensic emergency care sites. This has the value of adjusting knowledge, attitudes, beliefs and emergency care practice. Further the community of practice ideal eluded to earlier may be promoted.

Emergency Medicine Consultants

6.4. Address deficiencies within the Emergency Department

All emergency medicine consultants should receive some basic training around the management of sexual assault cases. In addition to the training, all specialists should treat victims of rape when encountered in the ED and consult with the referring/receiving doctors and/facility. Community of practice is required to ensure all role players understand their key roles and ensure a closed loop communication amongst stakeholders within a positive feedback cycle.

Recommendations for future studies:

To improve the probative value¹² of a medical record form specifically designed for sexual assault/rape documentation by an emergency care provider, future studies could design more relevant medical records for emergency care providers. Its implementation and associated training is required prior to its commencement. Considering that emergency care providers are limited in their treatment, the care provided along with appropriate referral is crucial in the continued care of the patient, accountability, and surveillance.

Evaluation studies of rape case responses and recommendations should be considered for possible quality improvement in rape response implementation within the pre-hospital environment. This could potentially give insight to what directly implies to the current need and demands of the environment as well as align to the capabilities of the current working emergency care providers. The findings should then be considered for possible curriculum reform and training. If the training and expectation is to address rape, then due diligence must be paid to the risk of vicarious trauma to the caregiver. Risk factors, self-awareness, routine debriefing and CPD activities could be protective mechanisms against vicarious traumatisation.

Research is required into rape surveillance and estimation as this is crucial to estimating the magnitude of the burden and the impact of interventions. Consideration must be had for emergency care providers as central to the treatment of rape victims and referral on a multidisciplinary level in the interest of beneficence. Furthermore, it is fundamentally important to consider inclusion of emergency medical care providers into the national directives, policy and legislation as a health care partner.

¹² Probative value relates to evidence which is sufficiently useful to prove something in a trial.

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Appendix A: One on one interview discussion guide

As a paramedic working in an environment where policy and guidelines are used to guide our treatment, it was hard for me to treat victims of rape, knowing I did not have the experience or know how in this so called “grey area”. This was problematic for me, taking into consideration that we are currently the rape capital in the world. This is when my interest for rape awareness and guided practice began.

The purpose of this study is to qualitatively document what implications do current emergency care responses to cases of rape have for the development of standardised evidence-informed guidelines for pre-hospital emergency care practice in South Africa?

EMS Personnel

1. What treatment are you currently rendering to rape victims?

2. What was their response and how did that influence your continuity of care?

3. How do you think your role within your organization is impacted upon/influenced by your response to victims of rape?

4. Within your organization, have you been trained on the management of rape victims in the pre-hospital setting?

5. Do you feel you should be able to do more/less? Why?

6. To improve outcomes, please advise on what changes in the EMS education are required/needed to promote ‘continuity of care’ and ‘community of practice’ from pre-

hospital to in hospital care of rape survivors.

Thuthuzela Personnel

“Post incident care of rape victims are complex or complicated”.

1. What are your thoughts around a multi-disciplinary approach with regards to the management and post care of victims of rape/survivors?

1.1 Who, in your opinion should be the parties involved and are you aware of what their roles should be, could you please elaborate?

2. When one encounters a rape victim, there is a dual responsibility that needs to take place: one is the medical aspect (i.e. provision of medical care) and the other is the legal implications for both practitioner (iro forensic roles) and victim (as integral to the crime/scene).

2.1 What are the legal implications for you as the medical practitioner treating rape survivors?

2.2 What is the tension between the rights of you as the caregiver and the rights and requirements of the survivor being treated?

Follow up question: How neutral is the engagement?

2.3 What are your thoughts and opinions around emergency care personal (paramedics) treating/responding to rape victims? In your opinion should this be added to their curricula and should their scope allow for the treatment of/response to this cohort of patients? E.g. administration of PEP?

2.4 To improve the health care response, please advise on what changes in the EMS education are required/needed to promote ‘continuity of care’ and ‘community of practice’ from pre-hospital to in hospital care of rape survivors.

2.5 Never mind the political correct responses, what is your personal opinion given your experience, on EMS personnel doing any more/ any less? Why?

Follow up: Anene Booyesen, what reflections can you offer for integrated health sector responses to such cases.

Emergency Registrars/Consultants/Medical Officer

1. How are victims of rape treated and managed in the ED? If you refer these patients to the rape crisis centre/thuthuzela, what treatment is given in the interim? As we are aware that for certain treatments to be eligible, time has to be considered?

2. What are your thoughts and opinions around emergency care personal (paramedics) treating/responding to these rape victims? In your opinion should this be added to their curricula and should their scope allow for the treatment of/response to these patients? E.g. administration of PEP?

3. What training have you received?

4. The training referred to in question 3, was this received in your undergraduate or post graduate degree?

5. What do you feel should be taught to you? And at what level do you think this should be taught?

6. Where did you receive your training? At what institution?

7. Did you get any in service training?

Appendix B: Permission to conduct research within EMS

Director of Provincial Government Western Cape – EMS

Dear Dr De Vries

I am currently completing my Masters in Emergency Medicine and need to conduct primary research that will allow me to do this. The topic I have chosen explores how pre-hospital practitioners in the Cape Town Metropole working for provincial EMS treat and manage victims of rape? The goal of my research is to inform protocols and build links between EMS, rape crisis centres and the emergency department staff that deal with the victims of rape in Cape Town. This would ensure that the rape victims receive all necessary treatment available, allowing them to make the transition from victim to survivor with limited risk of secondary victimisation.

The order in which the data will be collected is firstly the individual interviews with representatives of the Thuthuzela Care Centres in Cape Town and with the emergency medical care personnel who have dealt with the victims of rape in the past. Thereafter the focus group interviews with the emergency physicians (consultants) will be held according to the participants' availability. For the focus group interviews the researcher will use the data collected from the individual interviews to develop themes or guideline questions, therefore the individual interviews will be analysed and interpreted prior to conducting the focus groups.

In aims of developing stronger bonds between organizations, stakeholders and training institutions and to improve student preparedness through informed policy and protocol, I earnestly seek your permission to conduct research involving 3-6 of your employees in their time off, at their place of work or at a mutually acceptable venue. It will only take an afternoon from the participants in the time that's suits them best, the period in which we are looking at are in the months of June-July 2014.

I look forward to your positive response.

Kind Regards

Raina Gihwala

r.gihwala@gmail.com / GihwalaR@cput.ac.za

(Cell) 071 678 3162; (Work) 021 953 5604

Appendix B: Permission to conduct research within Rape Centre's situated in Cape Town

Clinical Forensic Medical Practitioner's

Dear Dr Andrews, Dr Chuunga & Dr Tiemensma

I am currently completing my Masters in Emergency Medicine and need to submit research that will allow me to do this. The topic I have chosen explores how pre-hospital practitioners in the Cape Town Metropole working for provincial EMS treat and manage victims of rape? The goal of my research is to inform protocols and build links between EMS, rape crisis centres and the emergency department staff that deal with the victims of rape in Cape Town. This would ensure that the rape victims receive all necessary treatment available, allowing them to make the transition from victim to survivor with limited risk of secondary victimisation.

The order in which the data will be collected is firstly the individual interviews with representatives of the Thuthuzela Care Centres in Cape Town and with the emergency medical care personnel who have dealt with the victims of rape in the past. Thereafter the focus group interviews with the emergency physicians (consultants) will be held according to the participants' availability. For the focus group interviews the researcher will use the data collected from the individual interviews to develop themes or guideline questions, therefore the individual interviews will be analysed and interpreted prior to conducting the focus groups.

In aims of developing stronger bonds between organizations, stakeholders and training institutions and to improve student preparedness through informed policy and protocol, I earnestly seek your permission to conduct research involving 3-6 of your employees in their time off, at their place of work or at a mutually acceptable venue. It will only take an afternoon from the participants in the time that's suits them best, the period in which we are looking at are in the months of June-July 2014.

I look forward to your positive response.

Kind Regards

Raina Gihwala

r.gihwala@gmail.com / GihwalaR@cput.ac.za

(Cell) 071 678 3162; (Work) 021 953 5604

Appendix C: Consent Form

Re: Out-of-hospital assessment and management of rape survivors by pre-hospital emergency care providers in the Western Cape.

With the attached participant information sheet, I hereby understand all risks and benefits of the study undertaken by R. Gihwala and am willing to participate.

Name:

Surname:

Date:

Signature:

Appendix D: Participant information sheet

Dear Participants,

I am a Masters (MSc Med) student at the University of Cape Town, researching how pre-hospital practitioners in the Cape Town Metropole working for provincial EMS treat and manage victims of rape.

Study Title: Out-of-hospital assessment and management of rape survivors by pre-hospital emergency care providers in the Western Cape.

What is the purpose if this study?

The aim of the study is to determine how emergency medical service personnel are currently treating victims of rape in the pre-hospital setting in contrast to the emergency personnel in hospital and rape crises centres. I plan to review what criteria is used currently with what should be done as per the rape crisis centres making recommendations for protocol to be set in place for EMS personnel treating these victims.

What do I expect from you if you agree to participate?

If you agree to participate in my study, I would ask you to avail time for me to conduct an individual interview in the time that would best suit you. There will be a psychologist on standby for you to use should the need arise. This would pertain to members of EMS and rape crisis centre. For the emergency physicians I would ask you to avail yourselves in a timeslot that you all could be present for, in order for me conduct the focus group, there will be a psychologist on standby should the need arise at any point before, during or after the focus group has been conducted. (The latter stands for the participants of the individual interviews as well)

Will my confidentiality be guaranteed?

Confidentiality and anonymity will be maintained as you will not be asked any personal information; however it cannot assure confidentiality and anonymity in the context of the focus group discussions and the very small population of forensic practitioners working in the field of rape crisis intervention.

The aim is to share your experiences with a view to improve future medical care for these patients. Your name or medical practice numbers will not be divulged at any point in the study. How will the students/participants be chosen?

In order to participate you have to meet the following criteria:

1. Be a registered Emergency Care Practitioner (ECP) with 1 or more years of experience.
2. Currently employed at the Rape Crisis centres participating in this research project.
3. Currently working as a consultant at the secondary hospitals participating in this research project.
4. Give informed consent to participate (agreeing to participate)

When and where will it take place?

The study will take place at (to be discussed during the month of May 2014) Further instructions and details will be given to participants who agree to participate.

What are the benefits and risks in my participation as a student?

The risks in participating in the study include:

1. Reliving experiences that could bring up unwanted emotions.
(There will be a psychologist on call for you to use should the need arise.)

The benefits of participating in the study include:

2. No direct benefit to you as the participant however you will contribute to making recommendations for protocol to be put in place for EMS personnel, by means of experiences shared (pro's and con's).
3. The findings of this research will be made available to all participants should you be interested in the conclusion of the study and the recommendations that will be made

Your participation will be appreciated, however, it is completely voluntary and you may withdraw from the study at any time. Your identity will be kept confidential.

I request your participation in this study.

For any inquiries you are free to contact me:

Raina Gihwala: 071 678 3162 (r.gihwala@gmail.com)

Yours Sincerely

Researcher: Raina Gihwala

Emergency Care Practitioner: HPCSA No: ECP 0002410

Ethics approval No: HERC/REF: 320/2014

Supervisors: Professor L. Martin & N. Naidoo

Appendix E: Ethics letter of approval (UCT)



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492 • Facsimile [021] 406 6411
Email: Sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

06 June 2014

HREC/REF: 320/2014

Prof L Martin
Forensic Medicine & Toxicology
Room 1.01.9
Falmouth Building
FHS

Dear Prof Martin

Project Title: OUT-OF HOSPITAL ASSESSMENT AND MANAGEMENT OF RAPE SURVIVORS BY PRE-HOSPITAL EMERGENCY CARE PROVIDERS IN THE WESTERN CAPE (MSc Candidate - R Gihwala)

Thank you for your letter dated 03 June 2014, addressing the issues raised by the Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

Approval is granted for one year until the 30 June 2015.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

We acknowledge that the following student:- Raina Gihwala is also involved in this project.

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator.


Please quote the HREC REF in all your correspondence.

Yours sincerely

PP **Signed**
PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Hrec/ref:320/2014


Appendix F: Ethics Letter of approval (UCT) - Extended



UNIVERSITY OF CAPE TOWN
UNIVERSITEIT VAN KAPSTAD

18 MAR 2015

HEALTH SCIENCES FACULTY
Human Research Ethics Committee



FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

HEALTH SCIENCES FACULTY
Form FHS006 Protocol Amendment

HREC office use only (FWA00001637; IRB00001938)			
<input checked="" type="checkbox"/> Approved	<input checked="" type="checkbox"/> Type of review: Expedited	<input type="checkbox"/> Full committee	
This serves as notification that all changes and documentation described below are approved.			
Signature Chairperson of the HREC	Signed _____	Date	18/3/2015

Note: All major amendments should include a PI Synopsis justifying the changes for the amendment (please see notice dated 23 April 2013)

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	17 March 2015		
HREC REF Number	320/2014		
Protocol title	Out-of-hospital assessment and management of rape survivors by pre-hospital emergency care providers in the Western Cape.		
Protocol number (if applicable)			
Principal Investigator	Prof LJ Martin / Raina Tara Gihwala		
Department / Office Internal Mail Address	Lornai.martin@uct.ac.za gihwalar@cput.ac.za		
1.1 Is this a major or a minor amendment? (see FHS006hlp) Major (tick box) Minor (tick box)	<input type="checkbox"/> Major	<input checked="" type="checkbox"/> Minor	
1.2 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
1.3 If the amendment is a major amendment and receives US Federal Funding, does the amendment require full committee approval?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

2. List of Proposed Amendments with Revised Version Numbers and Dates

Please itemise on the page below, all amendments with revised version numbers and dates, which need approval.
This page will be detached, signed and returned to the PI as notification of approval. Please add extra pages if necessary.

Dear: Professor M. Blockman
Chairperson UCT Human Research Ethics Committee
Cc: Professor L. Martin
Navindhra Naidoo

Appendix G: Approved request to conduct research in EMS



DIRECTORATE: **EMERGENCY MEDICAL SERVICES**

ENQUIRIES: **Dr Shaheem de Vries**

📧 shaheem.devries@pgwc.gov.za

☎️: +27 21 932 1367

Attention: Raina Gihwala

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Ms Gihwala,

Your email on the above matter refers.

Thank you for the request to conduct research within the Western Cape Government Emergency Medical Services. I have been informed that your proposal has been evaluated by the Emergency Medicine Division Research Committee and has been recommended for approval by this office.

I am therefore pleased to inform you that such approval is hereby granted. In addition, I note your need to conduct a portion of your data collection within the provincial EMS and am pleased to grant such access as well.

I wish you well in your endeavor and trust that you will keep this office and its department informed of your findings when these become available.

Yours sincerely,

Signed

Dr Shaheem de Vries

Head: Emergency Medical Services

Western Cape Government Health

Date: 18th December 2014



WCG Health: EMS - Emergency Communications Centre

📍 Private Bag X24; Bellville 📞 (+27) 21 932 1367 📠 (+27) 21 931 8490

🌐 www.capegateway.gov.za

Appendix H: Ethics letter of approval (DOH)



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP079/2014
ENQUIRIES: Ms Charlene Roderick

**8 Prince Arthur Roads
Landsdown
7780**

For attention: **Raina Tara Gihwala**

Re: OUT-OF-HOSPITAL ASSESSMENT AND MANAGEMENT OF RAPE SURVIVORS BY PRE-HOSPITAL EMERGENCY CARE PROVIDERS IN WESTERN CAPE.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

GF Jooste	H Human	Contact No. 021 377 4306
Karl Bremmer	L Naude	Contact No. 021 918 1222
False Bay	W Waddington	Contact No. 021 782 1121
Mitchell's Plain	H Human	Contact No. 021 377 4306
New Somerset	D Stokes	Contact No. 021 370 5004

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. The reference number above should be quoted in all future correspondence.

Yours sincerely

Signed

DR J EVANS *JJ*

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: *6/10/2014*

CC P OLCKERS

K GRAMMER

DIRECTOR: KLIPFONTAIN/MITHELL'S PLAIN

DIRECTOR: SOUTHERN/WESTERN

The End
