

# Fear of the perpetrator: a major reason why sexual assault victims delayed presenting at hospital

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## Abstract

**OBJECTIVE** To identify the reasons for presentation of sexual assault more than 72 h after the incidents at Newcastle Hospital, South Africa.

**METHODS** A retrospective analysis of 534 medical records of victims seen between 2005 and 2009 at the hospital's sexual assault service centre.

**RESULTS** Overall, 219 (41%) of the victims presented at the hospital more than 72 h after the alleged sexual assault, mainly for fear of the perpetrator (37.4%). Females constituted 87%, and rape with vaginal penetration was the most common form of sexual assault reported (74%). Tests of significance showed a positive association between fear of the perpetrator and delayed presentation at hospital. Age under 9 years and being scared of what relatives would say about alleged sexual assault were also associated with delayed presentation.

**CONCLUSIONS** Attention needs to be focused on educating society on the importance of reporting sexual assault incidents promptly in order for victims to benefit from appropriate medical treatment.

**keywords** sexual assault, delayed presentation, fear of perpetrator, post-exposure prophylaxis

## Introduction

Sexual violence occurs globally and has been reported across various cultures and among all demographic and socio-economic groups. Although both sexes are affected, women are usually the victims and men the perpetrators; in some parts of the world, almost one in every five women has suffered at least one incident of sexual violence (WHO 2003). A WHO study (2005) estimated the extent of physical and sexual intimate partner violence against women in nine countries and revealed different prevalences of sexual violence: 6.2% in Japan, 6.3% in Serbia and Montenegro, 10.1% in Brazil, 30.7% in Tanzania, 46.7% in Peru, 49.7% in Bangladesh and 58.6% in Ethiopia. In South Africa, a national prevalence of 7%, with a range of 2% to 12% among provinces, has been documented (National Department of Health 1999); 17% of young South African women have experienced at least one incident of rape (Peltzer & Pengpid 2008). The South African estimates have been described as gross underestimation due to underreporting of sexual violence in the country (Kim 2000; Jewkes & Abrahams 2002). Sexual violence cuts across all age groups in South Africa (Vetten *et al.* 2008), and rape with forced vaginal penetration is the most common form of sexual violence

reported to the police with more than 50 000 cases annually (South African Police Service 2007), occurring at the rate of 1300 per 100 000 women per year (Jewkes & Abrahams 2002).

Disclosure of sexual assault is reporting the incident to family members, friends, criminal justice personnel or health professionals. Although there is no standard definition of the length of time that constitutes delayed disclosure in sexual assault, some authors attempted a 3-level categorisations as follows: (i) short-delay disclosers disclosed within hours of abuse; (ii) moderate-delay disclosers disclosed within days, weeks or months of abuse and (iii) long-delay disclosers waited one or more years to disclose or never did (Foyne *et al.* 2009). The interval between incidents of sexual violence and presentation is crucial for adequate medical assistance. If the victim presents no earlier than 72 h after the assault, post-exposure prophylaxis (PEP) against HIV infection, the presumptive treatment for sexually transmitted infections (STIs) and contraceptive against unwanted pregnancy are less effective (WHO 2003; Merchant *et al.* 2004; KZNDOH 2009). This is why victims who delayed presentation of sexual violence incidents do not usually benefit from these prophylaxes (Collings 2005; Bello & Pather 2008; Collings *et al.* 2008).

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Whilst it is generally acknowledged that South African women experience a high level of sexual violence, the extent of this crime is grossly underestimated partly due to non-disclosure (WHO 2002), which in turn is often attributed to the fear of not being protected adequately after reporting incidents of sexual violence as the victims fear possible reprisal from their attackers (Baumer *et al.* 2003). Barriers to reporting incidents of sexual assault include poor access to the police by the victims, fear of retaliation from the perpetrator, fear of not being believed, fear of ruined reputation if the incident is known, fear that confidentiality will not be respected by health workers, poor treatment by personnel in the criminal justice system and anticipation that the reporting will not result in conviction of the perpetrators (Kim 2000; Christofides *et al.* 2003). The uncaring and unsympathetic attitude of the health personnel, lack of privacy at the service centres and fragmented service delivery resulting in victims having to revisit the centre several times are part of the reasons that might inform the decision of victims to visit health institutions for medical treatment (Kim *et al.* 2009). Some victims may not wish to acknowledge the unwanted sexual encounter as sexual assault and therefore prefer to keep it to themselves (Moscarello 1990). Against this background, this study aimed at identifying factors associated with delayed presentation of sexual assault victims at the sexual assault service centre in Newcastle, South Africa.

## Methods

This was a descriptive study based on a retrospective analysis of hospital records of sexual assault cases that presented between January 2005 and December 2009 at the sexual assault service centre of the Newcastle Provincial Hospital, Newcastle, South Africa. Delay disclosure of sexual assault in this study is described as any incident reported more than 72 h after the incident occurred. The inclusion criteria for sample selection were all ages, sex and those with available records. All available 534 records of victims were retained as study sample. The cases to be reviewed were identified from the hospital registers where names of victims that reported sexual assault incidents were recorded. Detailed information contained in the medical records of each victim was retrieved with the aid of a data abstraction tool designed for this study; this served as a checklist for the required information to be retrieved from victims' medical records. The variables recorded were victim's demographics, type of injuries sustained by the victims, perpetrator characteristics, previous history of the sexual violence, the time the assault was committed and the time it was reported

at the hospital, and the reason given for the delay in reporting at the hospital. Strict confidentiality and anonymity were observed. Each victim was assigned a serial number for the data collection sheet which had no link with the victim's name or hospital number. Extracted data were captured into an Excel spreadsheet by double entry method, cleaned and subsequently analysed with Epi-info 3.4.3. Frequency tables, proportions and summary statistics were used to describe the data. Tests of significance were performed using the chi-squared test to explore factors associated with delayed disclosure of sexual assault. Results are presented as odds ratios (OR), with 95% confidence intervals (CI) and  $P$ -value  $<0.05$ . Ethical clearance was obtained from the Senate Research Committee of University of the Western Cape, and permission to conduct the study was granted by the management of Newcastle Hospital.

## Results

There were 534 cases of alleged sexual assault incidents that were reported at the hospital between January 2005 and December 2009. The age of the victims ranged from 2 to 81 years (median 15 years). 87.3% (466) were females, about 60% were under 18. 41% came to the hospital after more than 72 h to seek medical assistance, 21.5% had previously experienced sexual assault, 67.6% of the victims knew the perpetrators, and 19.7% were HIV positive at the time of presentation.

Rape with vaginal penetration accounted for most reported sexual assaults (74%), followed by genital fondling at 9.2% and the least was attempted anal intercourse (0.9%). The various reasons given by the 219 victims who presented more than 72 h after being sexually assaulted are given in Table 1. Fear of reprisal attack from the perpetrator was stated as a reason by 37.4%. 22.4% of these late-presenting victims were under 9 years old, which meant that they could not have come to hospital unless an adult suspected sexual violation of the child. About 10% did not provide any reason, 6.4% delayed disclosure due to fear that their relatives would not believe that they were sexually assaulted.

Among those who presented at the hospital after 72+ hours (Table 2), females accounted for the majority (78.5%); those aged 6–17 years delayed presentation longest (64.4%). Among those who came to the hospital within 72 h, forced anal intercourse and attempted anal rape occurred to male victims as shown in Table 2.

As revealed in the risk factor analysis in Table 3, victims who feared reprisal attacks from the perpetrator were five times more likely to delay presentation than

A. O. Adefolalu **Why sexual assault victims delay presenting at hospital****Table 1** Reasons given by victims who came to hospital after 72 h

Reasons for delay presentation at the hospital ( <i>n</i> = 219)	Freq	%
Fear of perpetrator	82	37.4
Victim was a minor (<9 years)	49	22.4
Dejection and shameful	20	9.1
Scared of not being believed by relatives	14	6.4
Victim held captive by perpetrator	12	5.5
Victim was intoxicated	8	3.7
Victim mentally retarded	7	3.2
Sick or injured	3	1.4
Lack of faith in criminal justice system	2	0.9
Distance from sexual assault service centre	1	0.5
None	21	9.6

those who were not (OR 5.11; 95% CI 3.25–8.04; *P*-value = 0.000). Victims who were minors (<9 years) at the time of the assault were also likely to delay presentation (OR 3.66; 95% CI 2.15–6.22; *P*-value = 0.000). Victims who were held captive by the perpetrators were three times more likely to delay presentation than those who were not (OR 2.99; 95% CI 1.10–8.08; *P*-value = 0.02), and those who were scared that their family members would not believe them (OR 21.4; 95% CI 2.79–164.3; *P*-value = 0.000) were also likely to delay presentation at hospital; as were those who knew the perpetrators and those who suffered alleged anal rape.

**Discussion**

The fact that the majority of the victims in this study were people within the age range 0–24 years is consistent with literature (Collings 2005; Bello & Pather 2008), indicating that young people are the most vulnerable and at highest risk of being victims of sexual assault in the society. Higher incidence of sexual assault among these young people is often attributed to their physical and mental immaturity and their lack of ability to physically defend themselves against the perpetrators (Collings 2005; Bello & Pather 2008). Children who are too young to understand what constitutes sexual assault do not usually report to anyone after being sexually assaulted (Paine & Hansen 2002). These children were primed by the perpetrators into secrecy (Paine & Hansen 2002); a phenomenon that is explained by the child sexual abuse accommodation syndrome theory, which postulates that sexually abused children develop coping mechanisms to deal with sexual assault (Summit 1983). Consistent with the results of previous studies (Mein *et al.* 2003; WHO 2003), the present study findings indicate that women are more affected than men in terms of sexual violence. One

**Table 2** Gender analysis of victims' characteristics *vs.* time of presentation

	Within 72 h ( <i>n</i> = 315)		After 72 h ( <i>n</i> = 219)	
	Female Freq (%)	Male Freq (%)	Female Freq (%)	Male Freq (%)
Age				
0–5	29 (9.9)	1 (4.8)	14 (8.1)	4 (8.5)
10–Jun	20 (6.8)	4 (19)	41 (23.8)	17 (36.2)
17–Nov	94 (32.0)	10 (47.6)	65 (37.8)	18 (38.3)
18–24	64 (21.7)	6 (28.6)	26 (15.1)	6 (12.7)
25–34	33 (11.2)	0	19 (11)	2 (4.6)
35–44	29 (9.9)	0	1 (0.6)	0
45–54	13 (4.4)	0	3 (1.7)	0
>55	12 (4.1)	0	3 (1.7)	0
Marital status				
Single	245 (83.3)	21 (100)	164 (95.3)	47 (100)
Married	32 (10.9)	0	6 (3.5)	0
Widowed	9 (3.1)	0	1 (0.6)	0
Divorced	8 (2.7)	0	1 (0.6)	0
Victim in intimate relationship				
Yes	185 (62.9)	2 (9.5)	66 (38.4)	6 (12.8)
No	109 (37.1)	19 (90.5)	106 (61.6)	41 (87.2)
Form of sexual assault				
Rape with vaginal penetration	252 (85.7)	0	142 (82.5)	0
Forced anal intercourse	0	8 (38.1)	1 (0.6)	18 (38.3)
Attempted vaginal rape	29 (9.9)	0	11 (6.4)	0
Attempted anal intercourse	0	3 (14.3)	2 (1.2)	0
Genital fondling	12 (4.1)	5 (23.8)	14 (8.1)	18 (38.3)
Forced oral sex	1 (0.3)	5 (23.8)	2 (1.2)	11 (23.4)
Injury sustained by victim				
Yes	180 (61.2)	10 (47.6)	54 (31.4)	8 (7)
No	114 (38.8)	11 (52.4)	118 (68.6)	39 (83)
Previous history of sexual violence				
Yes	87 (29.6)	0	26 (15.1)	2 (4.3)
No	207 (70.4)	21 (100)	146 (84.9)	45 (95.7)
Existing medical condition				
Yes	80 (27.2)	0	22 (12.8)	4 (8.5)
No	214 (72.8)	21 (100)	150 (87.2)	43 (91.5)
HIV status				
HIV positive	60 (20.4)	6 (28.6)	34 (19.8)	5 (10.6)
HIV negative	234 (79.6)	15 (71.4)	133 (77.3)	42 (89.4)
Unknown status	0	0	5 (2.9)	0
Perpetrator known to victim				
Yes	166 (56.5)	17 (81)	131 (76.1)	47 (100)
No	117 (39.8)	2 (9.5)	35 (20.3)	0

(continued)

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	Within 72 h (n = 315)		After 72 h (n = 219)	
	Female Freq (%)	Male Freq (%)	Female Freq (%)	Male Freq (%)
Unknown	11 (3.7)	2 (9.5)	6 (3.5)	0
Number of perpetrators				
One	265 (90.1)	18 (85.7)	153 (89.0)	45 (95.7)
Multiple	13 (4.4)	1 (4.8)	9 (5.2)	2 (4.3)
Unknown	16 (5.5)	2 (9.5)	10 (5.8)	0
Weapon used by perpetrator				
Yes	134 (45.6)	5 (23.8)	42 (24.4)	3 (6.4)
No	148 (50.3)	15 (71.4)	120 (69.8)	44 (93.6)
Uncertain	12 (4.1)	1 (4.8)	10 (5.8)	0

of five of the victims in the present study had been sexually assaulted in the past, which supports the assertion that there is likelihood of reoccurrence of sexual assault in women who were once victims of sexual assault (Coid *et al.* 2003; Dunkle *et al.* 2003). The implication of this is the long-term effect of such recurrent incidents on the victims: some victims resort to perpetrating sexual violence on others themselves or become victim of sexual-related crimes in their later life (Malamuth *et al.* 1985).

The most common form of sexual assault reported was rape with vaginal penetration, which is similar to findings from other studies (Collings *et al.* 2008; Chesshyre & Molyneux 2009), and is corroborated by a report by Statistics South Africa (StatSA 2000) that rape with forced vaginal penetration is the most common form of sexual assault in South Africa with more than 50 000 cases reported to the police every year. Attempted vaginal rape accounted for only 7.5% in the present study. This form of sexual assault is underreported in South Africa because the victims do not report such incidents as it usually occurs within intimate partner relationship, and the victims feel there is no case against the perpetrators and therefore do not report the incidents (Buga *et al.* 1996; Henttonen *et al.* 2008). In the present study, 67.6% of the victims knew the perpetrators, highlighting the fact that sexual assault is usually committed by people known to the victims (Schafran 1996). Research indicates that in about 40–65% of sexual assault incidents the victims know the perpetrators (Merchant *et al.* 2004; Chesshyre & Molyneux 2009). This percentage is even higher among young victims, where about 84% of rapes are carried out by people known to the young victims (Vetten *et al.* 2008). The

**Table 3** Unadjusted ORs of the association between reasons for the delay and delayed presentation

Characteristics	N	OR	95% CI	P-value
Fear of perpetrator				
No	137	Referent	Referent	
Yes	82	5.11	3.25–8.04	0.001
Feeling dejected and ashamed				
No	199	Referent	Referent	
Yes	20	1.48	0.78–2.83	0.24
Victim mentally retarded				
No	212	Referent	Referent	
Yes	7	2.57	0.74–8.88	0.11
Victim was minor (<9 years)				
No	170	Referent	Referent	
Yes	49	3.66	2.15–6.22	0.001
Victim was intoxicated				
No	211	Referent	Referent	
Yes	8	0.59	0.25–1.37	0.22
Victim was held captive by perpetrator				
No	207	Referent	Referent	
Yes	12	2.99	1.10–8.08	0.02
Scared of not being believed by relatives				
No	205	Referent	Referent	
Yes	14	21.44	2.79–164.3	0.001
Relationship between victim and perpetrator				
Unsure/unknown to victim	173	Referent	Referent	
Known to victim	361	3.13	2.08–4.70	<0.001
Assaulted with weapons				
No	327	Referent	Referent	
Yes	184	0.33	0.22–0.49	<0.001
Genital or physical injury sustained				
No	282	Referent	Referent	
Yes	252	0.26	0.18–0.38	<0.001
Attempted vaginal rape				
No	494	Referent	Referent	
Yes	40	0.52	0.25–1.07	0.07
Forced anal intercourse				
No	507	Referent	Referent	
Yes	27	3.65	1.57–8.96	0.001

fact that these perpetrators are known to these victims is more psychologically damaging than being assaulted by a stranger. Such incidents tend to destroy the ability to trust people (Schafran 1993).

More than 40% of the victims came to hospital after 72+ hours of being sexually assaulted for a number of reasons. Other studies have found similar results in terms of delayed presentation, which prevented the victims from benefiting from post-exposure prophylaxis treatment given to victims of sexual assault (Collings 2005; Bello & Pather 2008; Collings *et al.* 2008). Delayed disclosure or non-disclosure of sexual violence can have major impact on the victim; a primary concern in South African with high

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prevalence of HIV is the risk of contracting HIV by the victim that suffered penetrative anal or vaginal rape as a result of tearing, which further increase the chances of HIV infection. Access to the sexual assault service centre appeared not to be a major problem for the victims in this study as only 4.1% of the victims said they could not come to the hospital immediately because of the distance from their home. Factors such as availability of PEP, accessibility and sympathetic health providers at sexual assault service centres often influence utilisation of sexual assault services (Christofides *et al.* 2006).

21.5% of the victims claimed that they feared the perpetrators were going to harm them if they disclosed the incidents. Fear of the perpetrator is a known predictor of delayed presentation of victims seeking medical assistance, which causes the victim not to disclose incident of sexual violence (Baumer *et al.* 2003). When, in addition, the perpetrator is known to the victim, chances of reporting the incident are very small. For example, some women in South Africa assume that rape by intimate partners is not a serious event that should be reported to the police or to any other authorities (Buga *et al.* 1996; Wood *et al.* 1998). Victims often delay disclosure because they assumed nothing would be done if they reported to the law enforcement agents (Kim 2000; WHO 2003), but the assertion that some victims do not report rape in South Africa because they lack faith in the criminal justice system (Kim 2000) seems not to be reflected among the victims in the present study as very few (0.4%) gave this reason for their delayed presentation at the hospital. Available data in South Africa support the fact that reporting a perpetrator to the police will often not lead to the perpetrator being prosecuted or punished. This is evidenced in the low conviction rate of sexual offenders and the slow pace of prosecution (Walker & Louw 2005; Jewkes *et al.* 2009). Police records show that of the 45% reported cases of sexual violence taken to courts in 2000, only 16.5% of prosecutions resulted in a guilty verdict. This translates to a 1 in 13 chance of getting a conviction from reported cases of sexual assault (Christofides *et al.* 2003). Some victims in this study failed to report because of the fear of what their relatives would say. It is common for some victims' relatives not to believe that they were sexually assaulted, and where they do believe the victims, they often blame them for the assault (Moscarello 1990). Some communities even shield perpetrators of sexual assault from prosecution because of their beliefs about sexual offences as something abominable that should not be made public (Jewkes *et al.* 2005). This belief, together with societal norms supportive of male superiority and sexual entitlement, weak laws and policies related to sexual violence and gender equality are societal factors that

perpetuate sexual violence within the community (WHO 2002).

### Conclusion

Sexual violence incidents have always been poorly reported by victims in South Africa. Despite the health system's efforts to establish sexual assault services in the country and to create ongoing advocacy to educate people on the need to urgently report incidents of sexual assault, many victims still delay reporting or do not report sexual violence incidents at all. Females and young people continue to be the groups that are mainly affected, and rape with vaginal penetration appears to be the most common form of sexual assault reported. Most of these victims delayed presentation at the hospital for fear of reprisal attacks by the perpetrators. Consequently, to improve the health system response to sexual violence and to strengthen sexual assault services in the country, the factors responsible for delayed disclosure among victims need to be ascertained continually. Potential victims must be educated on the importance of reporting sexual violence promptly, and awareness of signs of sexual abuse in children must be raised among parents and guardians. Finally, further research into service-related factors that could influence the decision of victims to seek medical care after sexual assault is needed.

### References

- Baumer EP, Felson RB & Messner SF (2003) Changes in police notification for rape, 1973–2000. *Criminology* **41**, 841–872.
- Bello M & Pather M (2008) Profile of rape victims attending the Karl Bremer Hospital rape centre, Tygerberg, Cape Town. *South African Family Practice* **50**, 46.
- Buga GAB, Amoko DHA & Ncayiyana D (1996) Sexual behaviour, contraceptive practices and reproductive health among school adolescents in rural Transkei. *South African Medical Journal* **86**, 523–527.
- Cheshyre E & Molyneux E (2009) Presentation of child sexual abuse cases to Queen Elizabeth central hospital following the establishment of an HIV post-exposure prophylaxis programme. *Malawi Medical Journal* **21**, 54–58.
- Christofides N, Webster N, Jewkes R *et al.* (2003) *SAGBVHI Report: The State of Sexual Assault Services in South Africa*. Medical Research Council of South Africa, Cape Town.
- Christofides N, Muirhead D, Jewkes R, Penn-Kekana L & Conco D (2006) Women's experiences of and preferences for services after rape in South Africa: interview study. *British Medical Journal* **332**, 209–212.
- Coid J, Petruckevitch A, Chung W *et al.* (2003) Sexual violence against adult women primary care attendees in East London. *British Journal of General Practice* **53**, 858–862.

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- Collings SJ (2005) Provision of antiretroviral prophylaxis to child rape victims in South Africa: HIV status and delayed reporting. *Psychological Reports* **96**, 17–18.
- Collings SJ, Bugwandeen SR & Wiles WA (2008) HIV post-exposure prophylaxis for child rape survivors in KwaZulu-Natal, South Africa: who qualifies and who complies? *Child Abuse & Neglect* **32**, 477–483.
- Department of Health, KwaZulu-Natal Provincial Government (2009) *The management of survivors of sexual violence and abuse*. [Online], Available: <http://www.kznhealth.gov.za/protocol1.htm> (accessed on 19 March 2009).
- Dunkle K, Jewkes R, Brown H, McIntyre J, Gray G & Harlow S (2003) *Gender-based violence and HIV infection among pregnant women in Soweto*. A Technical Report to the Australian Agency for International Development. Johannesburg: AusAID.
- Foynes M, Freyd J & DePrince A (2009) Child abuse: betrayal and disclosure. *Child Abuse & Neglect* **33**, 209–217.
- Henttonen M, Watts C, Roberts B, Kaducu F & Borchert C (2008) Health Services for survivors of gender-based violence in northern Uganda: a qualitative study. *Reproductive Health Matters* **16**, 122–131.
- Jewkes R & Abrahams N (2002) The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science & Medicine* **55**, 1231–1244.
- Jewkes R, Penn-Kekana L & Rose-Junius H (2005) If they rape me, I can't blame them": reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science & Medicine* **61**, 1809–1820.
- Jewkes R, Christofides N, Vetten L, Jina R, Sigsworth R & Loots L (2009) Medico-legal findings, legal case progression, and outcomes in South African rape cases: retrospective review. *PLoS Medicine* **6**, e1000164.
- Kim JC (2000) *Rape and HIV post-exposure prophylaxis: The relevance and the reality in South Africa*. Paper presented at the WHO Meeting on violence Against Women and HIV/AIDS: Setting the Research Agenda: Geneva.
- Kim JC, Askew I, Muvhango L *et al.* (2009) Comprehensive care and HIV prophylaxis after sexual assault in rural South Africa: the Refentse intervention study. *British Medical Journal* **338**, b555.
- Malamuth NM, Linz D, Heavey CL, Barnes G & Acker M (1985) Using the Confluence model of sexual aggression to predict men's conflict with women: a 10 year follow up study. *Journal of Personality & Social Psychology* **69**, 353–369.
- Mein JK, Palmer CM, Shand MC *et al.* (2003) Management of acute adult sexual assault. *Medical Journal of Australia* **178**, 226–230.
- Merchant RC, Keshavarz R & Louw C (2004) HIV post-exposure prophylaxis provided at an urban Paediatrics emergency department to female adolescents after sexual assault. *Emergency Medicine Journal* **21**, 449–451.
- Moscarello R (1990) Psychological management of victims of sexual assault. *Canadian Journal of Psychiatry* **35**, 25–30.
- National Department of Health (1999) *South Africa Demographic and Health Survey 1998 Preliminary Report*. Pretoria.
- Paine M & Hansen D (2002) Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review* **22**, 271–295.
- Peltzer K & Pengpid S (2008) Sexual abuse, violence and HIV risk among adolescents in South Africa. *Gender and Behaviour* **6**, 1462–1478.
- Schafran LH (1993) Writing and reading about rape: a primer. *St John's Law Review* **66**, 979–1061.
- Schafran LH (1996) Topics for our times: rape is a major public health issue. *American Journal of Public Health* **86**, 15–16.
- South African Police Service (2007) *Rape in the RSA for the period 2005/2006* [Online], Available: [http://www.issafrica.org/cjm/stats0906/\\_pdf/category/rape.pdf](http://www.issafrica.org/cjm/stats0906/_pdf/category/rape.pdf)
- Statistics South Africa (2000) *Qualitative research findings on rape in South Africa*. [Online], Available: <http://www.statssa.gov.za/publications/Rape/Rape.pdf>. (accessed on 20 March 2009).
- Summit RC (1983) The child sexual abuse accommodation syndrome. *Child Abuse and Neglect* **7**, 177–193.
- Vetten L, Jewkes R, Sigsworth R, Christofides N, Loots L & Dunseith O (2008) *Tracking justice: The attrition of rape cases through the criminal justice system in Gauteng*. Johannesburg: Tshwaranang Legal Advocacy Centre, the South African Medical Research Council and the Centre for the Study of Violence and Reconciliation.
- Walker SP & Louw D (2005) The court for sexual offences: perceptions of the victims of sexual offences. *International Journal of Law and Psychiatry* **28**, 231–245.
- WHO (2002) *World report on violence and health, Chapter 6, Sexual Violence 2002*. [Online], Available: [http://www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap6.pdf](http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf) (accessed on 7 March 2009).
- WHO (2003) *Guidelines for medico-legal care for victims of sexual violence*. [Online], Available: <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>. (accessed on 2 March 2009).
- WHO (2005) *Multi-country study on women's health and domestic violence against women*. [Online], Available: [www.who.int/gender/violence/who\\_multicountry\\_study/en/](http://www.who.int/gender/violence/who_multicountry_study/en/). (accessed on 10 October 2009).
- Wood K, Maforah F & Jewkes R (1998) "He forced me to love him": putting violence on adolescent sexual health agendas. *Social Science & Medicine* **47**, 233–242.

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