RAPE AND POST-EXPOSURE PROPHYLAXIS IN SOUTH AFRICA

A review

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Note

This review is a companion document to a series of reviews of gender-based violence and HIV/AIDS in South Africa. Resources include a bibliography that is available as a searchable database on the CADRE website (www.cadre.org.za). Related project documents are also available on the website.

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INTRODUCTION

Statistics on the number of cases of rape in South Africa vary. In 2000, 52 550 cases of rape and attempted rape were reported, of which 21 438 involved minors under the age of 18 years (Crime Information Analysis Centre). South African Police Services (SAPS) statistics show that there were 37 711 rapes reported between January and September 2001. An exact figure for the incidence of rape in South Africa is difficult to obtain due to under-reporting. According to Rape Crisis, over the last three years, only 50% of their clients reported the rape to the police. Additionally, only a minute proportion of reported sexual offences go to court (Kim 2002). Multiple rapes make up a significant percentage of rape cases. Of rape cases dealt with at Groote Schuur Hospital, 25% are estimated to involve gang-rapes (Interview: Denny 2003).

These findings highlight the need for the provision of Post-Exposure Prophylaxis (PEP) in emergency and primary health care settings, to remediate multiple trauma as part of a rights-based approach to gender-based violence.

Apart from inducing severe trauma and injury, rape entails the risk of sexually transmitted infection (STI), HIV infection and pregnancy. This report focuses on various aspects relating to the provision of PEP for rape survivors in South Africa. It identifies obstacles to and implications of the provision of HIV-prophylaxis after sexual exposure, both at the level of individual health facilities and at national level.

At present, knowledge about the availability and method of PEP treatment is not widespread. Information is required on the right to and methods of the treatment within a programme of post-rape care. Such information is required not only for people directly affected by gender-based violence, but also for people to whom they turn for their health, psychological and social support needs. This report aims to provide information on the PEP treatment, on the organisational experiences of PEP providers, and on the development of information, education and communication (IEC) materials.

POST-EXPOSURE PROPHYLAXIS (PEP)

What is PEP?

Post-exposure prophylaxis relates to the reduction of HIV infection risk after potential exposure to HIV through exposure to HIV-infected blood or sexual contact with an HIV positive person, by means of anti-retroviral (ARV) drugs. The drug regimen for PEP consists of a combination of ARV medications that are taken over a period of four weeks.

Provision of drug therapy is only one aspect of post-exposure care in the case of rape. In addition, trauma and HIV counselling should be provided, as well as referral to support services and ongoing clinical monitoring.

PEP – A brief history

PEP after sexual exposure to HIV was developed from research on and experiences with administering PEP to persons who had been exposed to HIV in occupational settings – for example, exposure of health-care workers to HIV mainly through

needle-stick injuries. In these cases, a combination of anti-retroviral drugs was administered within a few hours of exposure, continuing for a period of four weeks. A review of occupational exposure of health-care workers showed that prophylactic treatment of needle-stick injury exposure to HIV with anti-retroviral drugs reduced the risk of HIV infection by 81% (CDC 1995; see also Cardo et al. 1997).

More recently, researchers have reviewed the administration of PEP following non-occupational exposure to HIV – for example, in cases of rape. Studies in South Africa, California, France and Canada have confirmed the efficacy of the PEP treatment (Smith 2000; Roland 2002). For example, in a study of PEP, Roland (2002) found no infections in 401 potentially exposed individuals at six months after exposure; and four infections at 12 months due to on-going exposure. In another sample, two infections were found by the twelfth week after the exposure; one was assumed to be the result of ongoing exposure, and another one was assumed to be the result of late initiation of PEP (at 72.5 hours after the exposure) and some missed doses in the first few days of taking one nucleoside.

In a South African study covering the time period between June 1998 and April 2002, 510 patients were given PEP within 72 hours of exposure. Of the 471 who returned for follow-up after six weeks, the only patient who seroconverted had been given PEP after 96 hours (Wulfsohn 2002).

Policies for PEP after sexual exposure exist internationally in the US, France, Italy, Spain, Australia (Kim 2002) and South Africa. PEP was pioneered in South Africa by non-governmental organisations (NGOs), private insurance companies, private hospitals, and some hospitals in the Western Cape before PEP policy and protocols were announced by the National Department of Health. In formulating PEP policy, health authorities relied on research findings on and experiences with PEP on the part of NGOs and private clinics.

Indications for PEP

In the US, the Center for Disease Control (CDC) guidelines suggest that PEP be administered only in cases in which *all* of the following criteria are met:

a person has had a *known high-risk* exposure to HIV, and

the person was exposed to another person, who is *known* to have HIV (especially if they have a high viral load), or the other person is *known* to be at very high risk for HIV, and

the exposure is an isolated incident and future exposures are very unlikely, and

the person is compliant with taking his/her medications, and

anti-retroviral medications are not contra-indicated in his/her case, and

treatment begins within several hours after the high-risk exposure, or if necessary, up to 24-36 hours after the high-risk exposure, and is sustained for approximately four weeks.

This list of indications makes it clear that in the countries of the global north, PEP was initially not recommended for treating people who have had exposures to a person whose HIV status is unknown, or whose risk factors are unknown (Sowadsky 1998:1-2). More recently, the limiting of indicators has been relaxed. Health services in many of the industrialised countries are making PEP available

through the public health sector for both occupational and sexual exposures, and for both consensual and non-consensual sexual exposures to HIV (see Kim 2002:17).

In South Africa, being judicious in weighing up risks of HIV transmission and risks of toxicity and resistance would mean taking into account specific scenarios. Rape is often violent, with increased risk of physical trauma and increased risk of HIV exposure. In consensual sex, the risk of transmission is estimated to be 0.8-3.2% for unprotected receptive anal intercourse, and 0.05-0.15% for receptive vaginal intercourse (Rey et al. 2000:698). In the case of genital or rectal trauma and bleeding, there is likely to be exposure to high HIV viremia. Genital and rectal trauma – incurred in a relatively high percentage of rape trauma treated in South Africa – are usually associated with violence and multiple exposures. In a case series of rape documented at the Hillbrow medico-legal clinic (covering north and central Johannesburg) in 1992, Martin found that there was more than one perpetrator in one-third of cases (in Kim 2002: 5; see also Swart 1999 in Kim 2002: 5). In South Africa, where ARV treatment is not generally available through the public health sector, the likelihood is that there was no prior ARV treatment of the source. All of these factors make for a dramatic increase in the percentage of transmission risk in cases of rape (Kim 2002).

With regard to traumatic exposure and PEP, Smith (2000) notes: 'Guidelines in the past may have exaggerated the risks of zidovudine (AZT) and minimised the potential benefits of PEP to survivors, and not put into perspective the elevation of risk associated with force, bleeding and high prevalence of STDs'. Similarly, Kim (2002:12) sums up the implications of the risk stratification debate for South Africa, by suggesting that '… a probability of source infection is at least comparable to, and likely higher than that seen in developed countries where PEP is currently offered'.

Contra-indications of PEP

Relative contra-indications to the use of AZT and 3TC include:

- severe renal impairment;
- severe liver impairment.

Administration of PEP

Research findings vary on the time period after the exposure within which treatment is optimally effective. It is known that exposure to HIV does not necessarily result in infection. Where infection does occur as a result of exposure, there is an infection of the dendritic cells at the site of inoculation. During the first 24-48 hours, these infected cells will migrate to the regional lymph nodes. Systemic infection starts when the infected dendritic cells settle in the lymph nodes. To prevent infection, ARV treatment has to be initiated before the infected cells settle in the lymph nodes (Casabona 2002:5). However, there is no clear consensus on the time limit for administering PEP. Animal studies indicate that PEP given at 24 hours after exposure and continued for 28 days, is more effective than administering PEP at 72 hours. However, the interval after which there is no benefit to humans is unknown (CDC 1998). While Sowadsky suggests provision of PEP 24-36 hours after the exposure, other international guidelines suggest 24-48 hours (Rey et al. 2000:697). The New York State Department of Health AIDS Institute Guidelines stipulate that PEP should be initiated as soon

as possible after exposure, ideally within one hour and generally not more than 36 hours post exposure (Stevens 2001:1). South African policy stipulates PEP be administered within 72 hours after the exposure.

Minimum delay between exposure and initiation of treatment is especially important in the case of children.

Conditions of treatment effectiveness [1]

In order to render the PEP treatment effective and to prevent seroconversion after a rape incident, the survivor should be counselled to:

- start PEP treatment as soon as possible, but maximally within 72 hours after the rape incident;
- take every dose of the medication as prescribed for 28 days;
- be tested for other STIs;
- be tested for pregnancy;
- practice safe sex for at least six months after the rape incident;
- return to the health facility for follow-up tests and counselling at six weeks, three months, six months, and one year after the rape incident.

PEP drugs

PEP consists of one, or of a combination of two or three anti-retroviral medications, taken several times a day, over four weeks. It has not been proven whether dual or single therapy is more effective (Roland 2002).

The drugs administered for PEP include nucleoside reverse transcriptase inhibitors (NRTIs) and protease inhibitors. Use of AZT exclusively has shown an 81% reduction of transmission risk in occupational exposure (Kim 2002). In some cases where there is a risk of drug resistance, a cocktail consisting of these two classes of drugs may be used together, as they become effective at different times during the cycle of viral replication. In other cases, multiple NRTIs may be taken simultaneously, although it was believed that these cocktails could have toxic effects. More recent studies have shown, however, that the drugs, when effectively administered, are relatively well tolerated, and do not produce lab toxicity (Roland 2002).

In South Africa, the standard PEP combination as recommended by the Department of Health consists of AZT (200mg 8-hourly for 28 days) and 3TC (150mg 12-hourly for 28 days) in combination. Starter packs supplied through state health facilities usually contain AZT (300mg bi-daily). Alternatively, Combivir may be used, which is a pill consisting of both AZT and 3TC. Combivir is prescribed as a one twice-daily dosage for 28 days. Combivir (prescribed bi-daily), while being more expensive, has the advantage of being more easily administered, with the likelihood of a greater degree of adherence to the drug regimen. Children under 12 years of age receive a combination of AZT and 3TC.

Side effects

The CDC notes that in general, PEP drugs, given over a short period of time, appear to be well-tolerated by adults and children; and that adverse side effects

are rare. The potential effects of toxicity, while apparently minimal, should be considered when prescribing ARV medication. The dosage should not exceed that required to eliminate the infection. Drug tolerance is important for drug compliance and treatment effectiveness.

As in most other anti-retroviral drugs, negative side effects of drugs prescribed for PEP – often compounded when more than one drug is prescribed – include:

- nausea
- diarrhoea
- vomiting
- fatigue
- flu-like symptoms
- headaches
- muscle pains
- kidney stones
- hepatitis
- suppressed blood cell production.

These side effects are temporary, and can be relieved with conventional medications against pain and fever (for example, paracetamol).

Taking contraceptives and antibiotics in conjunction with the drugs prescribed for PEP may compound the side effects of PEP. The effect of PEP on pregnant women and the foetuses is not clear, and provision of PEP for pregnant women should be determined by the degree of risk of the exposures. A group of clinicians who presented a paper on 'Occupational post-exposure prophylaxis (PEP) in pregnant health care workers' to the 13th International AIDS Conference in Durban in July 2000 noted that the benefits of preventing vertical transmission and the risks of foetal toxicity are critical considerations (Dong et al. 2000). Other guidelines for PEP refute the teratogenicity of AZT and 3TC in the first trimester of pregnancy (AIDS Consortium). It remains, however, that the safety of the drugs to the foetus in the first trimester of pregnancy cannot be guaranteed.

FACTORS IN TREATMENT EFFECTIVENESS

Counselling and information

Provision of counselling, support, information and monitoring with PEP is imperative. Drug compliance and follow-up counselling and testing are closely related to the effectiveness of the treatment. The rape survivor should be notified to return for follow-up visits to the health facility after six weeks, three months, six months and one year. Holistic and comprehensive post-rape care requires the integration of various kinds and levels of counselling for various post-rape stages: trauma counselling, pre- and post-test HIV counselling, drug adherence counselling, risk reduction counselling, and stress management counselling.

Venter points out that taking anti-retroviral drugs after a rape incident gives the survivor a sense of control over her own health in a situation often marked by a sense of powerlessness (in Beresford 2001). Denny has noted, on the other hand, that some women find it difficult to complete the course of medication, as taking the drug brings back memories of the rape experience.

Drug compliance

Internationally, poor drug compliance has been noted for PEP and other ARV treatments.[2] Wulfsohn (2002) has demonstrated that out of 510 rape survivors who were given PEP between June 1998 and April 2002, 65% returned for follow-up tests six weeks after sexual assault incidents. In other clinical settings, where co-ordinated medical treatment, counselling, and monitoring are not prioritised, compliance rates tend to be poor.

There are several reasons for poor compliance. Rape survivors are severely traumatised after the rape incident, and will, under those conditions, not be able to assimilate information on treatment and drug regimens, side effects, the importance of compliance, the necessity of follow-up visits, and of safe sex practices until one year after the rape incident. Denial, a well-documented response to trauma, might interfere with regular taking of the drug(s). Poor compliance rates could also be the result of a misunderstanding about test results on the part of the survivor (see Smith below). A negative test result immediately after the rape incident does not give accurate information of one's current HIV status.

A study by Wulfsohn, findings of which were corroborated by Venter (in *Health Link*, 20.2.03), noted that if the perpetrator is someone known to the rape survivor, s/he was less likely to follow through with treatment.

Compliance patterns may also vary according to whether PEP is administered following occupational or sexual exposure; consensual or non-consensual sex; same-sex or heterosexual activity. Some of these compliance patterns may be conditioned by self-perceived risk of HIV infection:

> *Given adequate counselling and support, a woman who seeks treatment after being gang-raped in South Africa may be much more inclined to complete treatment than a health-care worker who has sustained a minor needle-stick injury while performing routine clinical trials in a low prevalence country. Thus, it would seem likely that a client's self-perceived risk of HIV infection due to her/his exposure may play a key role in influencing treatment completion rates (Kim 2002:14).*

To improve compliance rates, monitoring, and ensuring ongoing counselling, organisations have developed a policy to provide starter-packs of PEP drugs to all rape survivors. Survivors are then advised to return to the health facility after three days or after seven days for counselling, testing, and further advice and information on the drug regimen, and for the remaining course of treatment. Those survivors who cannot return for a follow-up visit after three or seven days for logistical or financial reasons, receive a 28-day supply of the PEP medications.

More generally, compliance rates can be improved by providing around-the-clock, accessible and friendly health-care services undertaking holistic post-rape care, including follow-up (through home visits and calls), monitoring, and referral to organisations offering counselling, care, and support.

Counselling and testing

Health workers should provide for follow-up visits for information, counselling, testing and monitoring. HIV antibody testing should be done until at least half

a year after the completion of PEP. Safe sex practices should be adopted until at least six months after the completion of PEP.

The information provided should not only relate to the PEP treatment, but also to testing, as negative test results may be misunderstood by the rape survivor. It must be explained that the HIV test taken immediately after rape is to test the survivor's HIV status *before* the rape, and that a negative HIV test taken on the day or night of the rape does *not* indicate that the survivor is no longer at risk of HIV infection. The importance of repeated testing at six weeks, three months, six months, and one year after the rape incident must be stressed, as any potential HIV infection resulting from the rape will only show up in HIV tests at those time lapses after the rape incident.

However, counselling efforts should not be disproportionately centered around persons who present with an HIV-negative test result at any stage of the follow-up procedures. Rape survivors who test HIV-positive, should also be given follow-up visits for counselling, referral, and treatment for HIV-related conditions or for ARV treatment.

While it is important to provide integrated counselling that covers the entire spectrum of post-rape care (trauma counselling, VCT, drug regimen counselling, stress management counselling, referral, etc), the specific nature of PEP counselling should not be lost sight of. In some hospitals, VCT counsellors are delegated to provide PEP counselling as well, and the counselling training covers both. However, the problems experienced with drug regimen compliance, with the associated risks of seroconversion and drug resistance, merit specific attention in counselling training and in counselling offered to rape survivors.

STI and other treatment after a rape incident

The rape survivor should also receive testing and treatment for other STIs. ARV drugs will not prevent or cure other STIs. In South African hospitals that provide PEP, treatment is usually given as part of a rape kit that includes a morning after pill (for example, Ovral 28) to prevent pregnancy, antibiotics and a fungicide to prevent STIs. Some drugs compound the side effects of the PEP and the rape survivor should be informed of this.

PEP: THE SOUTH AFRICAN EXPERIENCE

Political context

The provision of PEP has been debated by national and provincial politicians, medical doctors, researchers, activists, and NGOs lobbying for ARV treatment and supporting people living with HIV. In April 2002, Cabinet announced the roll-out of PEP treatment for survivors of sexual assault in South African hospitals and clinics. A series of implementing facilities were established and the general roll-out was announced to take place by December 2002. A protocol dealing with rape and a separate protocol on the administering of PEP were released in May 2002. More comprehensive National Guidelines for the Management of Survivors of Sexual Assault are being developed. A first draft was circulated for discussion in May 2003.

Provincial responses

There are variations in implementation patterns between the provinces, and even within provinces. This is partly due to the fact that in the absence (until relatively recently) of a national implementation plan, provinces have responded individually to the roll-out of PEP.

The Western Cape led the PEP initiative long before the National Department of Health's decision. The process involved wide consultation, with active contributions from health-care workers and medical practitioners, NGOs, rights activists and legal experts, to the formulation of policy and protocol. Policy and guidelines on the management of rape survivors were published in 2000. At the beginning of 2002, there were 52 implementing facilities for PEP. Having led the initiative, implementation in the Western Cape was yet hampered by various problems. The director of the Western Cape HIV/AIDS and STI Programme noted the lack of psychosocial support for counsellors, non-compliance, and service-related problems, including a lack of manpower and communication between government departments.

The office of the MEC for Health in Gauteng announced the implementation plan in April 2002. By October 2002, 16 of 26 sites had implemented the PEP programme.

In the Free State, protocol was handed down from the beginning of July 2002. There are 28 institutions on record that are administering PEP including four Victim Empowerment Centres, which are one-stop centres for people who have suffered abuse. They offer medical examinations and counselling. A representative of the HIV/AIDS and STI programme noted the lack of clarity on the administrative process of PEP provision, the lack of monitoring of implementation, and budgetary problems. He expressed concern that PEP policy may not be fully understood by practitioners because it was adopted and implemented without adequate preparation. The department undertook a formal evaluation and cost analysis of the roll-out in this province.

KwaZulu-Natal announced the provision of free anti-retroviral drugs for PEP purposes at all hospitals, crisis centres and community health centres at the end of September 2002.

Across the provinces, implementation has remained uneven, partly due to funding, staffing, training, research, monitoring and other infrastructural constraints, and partly due to lack of clearly formulated and disseminated policy directives.

PEP POLICY IN SOUTH AFRICA

PEP and the law

The AIDS Law Project suggests that all women and men aged 14 years and older who come to a health facility after having experienced a rape incident should be counselled on the HIV transmission risks. They should also be offered treatment if they come to the health facility within 72 hours after the rape incident. It is up to the survivor if s/he wishes to undergo HIV testing immediately. The survivor should be made aware of the potential side effects of anti-retroviral drugs given for PEP.

According to the present Department of Health Policy Guideline for Management of Transmission of HIV and Sexually Transmitted Infections (STIs) in Sexual Assault, the provision of PEP beyond the initial starter pack is based on the results of an HIV test. If a rape survivor tests negative for HIV, he or she will be given PEP. If the person tests positive, PEP is not provided. Some health facilities will not provide PEP if the rape survivor declines to undergo an HIV test. This is problematic, as it does not take into account the difficulties that rape survivors may experience in giving their informed consent to HIV testing following rape. The new draft National Guidelines for the Management of Survivors of Sexual Assault have noted these difficulties, and are proposing revisions to the present protocol.

Some health facilities, notably in the Free State and North West Province, make the provision of PEP conditional upon reporting of the rape to the police, and upon the results of an HIV test. In most other health facilities, reporting the rape incident to the police is not a requirement and the new draft National Guidelines for the Management of Survivors of Sexual Assault do not stipulate this as a condition.

In the case of children of up to the age of 16, reporting sexual assault to the police is required by law.

It is important to inform the survivor of all the steps of the procedures. Consent has to be obtained from the survivor over 14 years of age for medical examinations, for HIV testing and counselling, for releasing the report and evidence collected by the police, for releasing information to referral agencies, and for any medical treatments including PEP.

Pregnant women who seek treatment after a rape incident, should be informed that the safety of the foetus cannot be guaranteed in the first trimester of pregnancy if PEP is administered. They should also be informed of the possibility of HIV transmission to their unborn babies should they seroconvert.

Legislation on the compulsory HIV testing of sexual offenders is currently being considered in parliament. Presently, there is no legislation which permits HIV testing without a person's informed consent.

Adolescents of 14 years and older do not need their parents' or guardians' permission to have an HIV test, and to take ARV drugs. For children younger than 14, one of the parents or the guardian or the hospital superintendent would need to give consent. These issues should also be explained to the child in a language that he or she is able to understand. In emergency situations where children under 14 have been raped and need urgent assistance, doctors should be guided by the best interests of their patients and their duty to give emergency medical treatment (Department of Health 2002).

Medical evidence is crucial for the investigation of rape cases and for the prosecution of the perpetrators. It is important that forensic evidence is collected and handled in a way that complies with legal and court criteria and procedures. Rates of conviction for rape are extremely low in South Africa.

PEP policy

In South Africa, PEP policies and protocols have been, until recently, largely determined by the provinces. In the Western Cape, research into issues of policy and protocol has yielded a response that is unique when compared to that of other provinces. The Western Cape developed, tested and adopted a standardised protocol for the medical and forensic examination of rape survivors in 2000. A Provincial Task Team on Sexual Violence was constituted, and a comprehensive provincial policy was developed for treating rape survivors. All health professionals in the Western Cape have received training on the implementation of the policy. A training manual was developed. Comprehensive post-rape care is integrated into the work of the Directorate for Women's Maternal and Child Health Care. There is ongoing monitoring to ensure that the PEP medication (AZT and 3TC) are available. In developing and implementing this policy, protocol, and training, the Western Cape provincial health structures have received no support from the National Department of Health. Western Cape medical practitioners and crisis counsellors who have been active in developing and implementing PEP policy and protocol, are now collaborating with their counterparts in Limpopo and Eastern Cape provinces to implement the policies there.

Health activists based at hospitals and clinics in the Western Cape have been among the pioneers of research on PEP and its administration in the form of a starter pack, follow-up visits for counselling, HIV-testing, and provision of the remaining course of PEP treatment. Denny recommends administering the first dose of ARV to the rape survivor on arrival at the health facility, regardless of the HIV status of the rape survivor. One dose, or even a three-day starter pack, it is believed, will not cause drug resistance in those survivors whose status on testing turns out to be HIV-positive. The system of a three-day starter pack and return for further counselling, diagnosis and treatment has been implemented by other organisations and health facilities – for example, in Mpumalanga, by GRIP at Rob Ferreira Hospital in Nelspruit, and by ACTS Clinic in White River.

Protocol issued by provincial health authorities in Gauteng and Limpopo requires that rape survivors be supplied with treatment for one week in the first instance. The remaining treatment is supplied either in weekly instalments (Gauteng), or in one supply given at the first return-visit after seven days (Limpopo). This is based on the view that a severely traumatised rape survivor would not be receptive to information and counselling in the first 24-48 hours after the rape incident; and that ways should be found to ensure follow-up, counselling and monitoring to improve the generally poor compliance rates.

National Department of Health guidelines were initially not clear on this issue. While national protocol had stipulated an HIV test as a prerequisite for the provision of PEP treatment, it recommended the system of a starter pack of treatment to be handed out to rape survivors even before administering an HIV test, or before having received the results of the HIV test (Department of Health 2002). It became accepted practice to administer an HIV test with pre- and post-test counselling at the first return visit, with the completion of the starter pack three or five or seven days after the rape incident. A new set of National Guidelines was drafted in 2003. The Guidelines are sensitive to the impact of trauma, and the corresponding hesitation to undergo an HIV test soon after sexual assault.

What was also initially not clear was the question as to whether reporting a rape incident to the South African Police Services was a requirement for the provision of PEP. Some health care providers, notably in the Free State and North West Province, have made this a condition for the provision of PEP. The new draft National Guidelines, however, do not stipulate this as a requirement. In all health facilities providing PEP that have been surveyed for this report, the decision of the survivor as to whether or not to report the rape to the police, is respected. In any case, survivors should be informed of procedures of laying a charge, and, if they decide to press charges, they should be assisted with the procedures. In the case of children up to the age of 16, reporting sexual assault to the police is required by law. Health practitioners and facilities providing services to children and elderly people who have been raped, should report these cases to the director general in the Department of Social Development.

Counselling, treatment for injuries, prophylactic treatment of STIs, and the provision of a starter pack of PEP are seen as priorities. The organisations providing services for rape survivors are mindful of the trauma experienced by the survivor, of her fear of secondary victimisation, and of other barriers to reporting, which are substantial. Kim summarises the research on the barriers to reporting, noting that

> *… many women will only try to report to the police incidents which fall within popular notions of 'rape' as fear of not being believed is a substantial barrier to reporting to the police. These fears are confirmed by police assertions that many women … lie about rape. There are a range of other barriers to reporting to the police including problems of physical access to police, fear of retaliation by the perpetrator and fear of the legal process including experiencing rudeness and poor treatment by the police. … deeply ingrained racial and sexist stereotypes compound these obstacles, particularly for black women.*
>
> *Many women do not go to the police because they anticipate that ultimately their action will not lead to the perpetrator being punished. Few rape cases go to court (ranging between 5% and 50% in Soweto police stations) and those which do, only 7-13% result in conviction and custodial sentences. Corruption in the form of perpetrators paying to 'lose' dockets is widely acknowledged as a problem in the system. Other corrupt practices included police, prosecutors and other court officials being paid to destroy the case, taking the suspect to the complainant to tell them to accept money and drop the case, asking for payment to complete the investigation and having sex with the rape survivor to 'check if she was raped' (Kim 2000: 6-7).*

Another weak link in the chain of reporting and convicting a perpetrator of rape is the district surgeon system. Conditions of poor pay, lack of incentives to attend to rape survivors outside office hours and to provide medical care, inadequate training in assisting rape survivors, combine to create a sub-standard service. Many rape survivors experience the forensic medical examination after rape as traumatic. Little information about procedures and medication is given, the examination in many cases is cursory, and the collection of evidence often does not meet the legal requirements (Jewkes and Abrahams in Kim 2000:7).

This is one of the factors that has motivated the drive to establish 'one-stop' rape crisis centres that can meet all the needs of rape survivors – counselling, medico-legal examination, testing, and treatment – under one roof, rather than in separate procedures with long waiting times and limited accessibility.

ORGANISATIONAL PERSPECTIVES ON AND EXPERIENCES WITH PEP

Although a roll-out of PEP is in the process of implementation, the availability of the treatment is patchy. The treatment is most readily available in government health institutions (usually hospitals) in the Western Cape, Gauteng, and KwaZulu-Natal, but even there the supply is uneven.

Various South African organisations who provide post-rape care including PEP, were interviewed to gain grassroots perspectives on and experiences with administering PEP.

GRIP (THE GREATER NELSPRUIT RAPE INTERVENTION PROJECT), NELSPRUIT, MPUMALANGA

GRIP is a non-profit community-based organisation, established in March 2000, that provides services to rape survivors in the Greater Nelspruit area covering 2.5 million residents living in largely rural conditions. GRIP provides 24-hour post-rape care, including PEP, emergency contraception, STI prophylaxis, ongoing counselling to rape survivors, education on rape and HIV prevention to a range of institutions including schools, and collaboration with the South African Police Services, and with prosecutors. GRIP is in the process of establishing rape care centres at the local police stations. The organisation has, in addition, helped to establish two counselling centres staffed by Lifeline counsellors, and has collaborated with other organisations and concerned individuals in providing the services in hospitals and clinics further afield (for example, ACTS Clinic in White River).

Before the drugs for PEP became available through the hospitals (though not all hospitals in the area), GRIP raised funds for drugs to provide rape survivors who could not afford them. The starter pack (four days) drugs was purchased for the hospitals at R200 each. The cost of the treatment for the remaining 25 days amounted to approximately R850 – a cost prohibitive to rape survivors not covered by a medical aid scheme.

Since December 2002, the drugs for PEP have been provided through the public health system at Rob Ferreira and Themba Hospitals. At Rob Ferreira Hospital, the drugs are supplied to rape survivors in a care room. Rape survivors are examined by a doctor, and receive counselling, treatment for STIs, and a care pack of toiletries, clothes and teddy bears. No PEP for children is supplied by the hospital, so GRIP provides this medication as well. In cases where rape survivors are not brought to the hospital by police officers, police investigators are called to the care room to take a statement. At Themba Hospital, GRIP provides drugs for adults and children at night and over weekends, as it is not available at these times in the casualty department. At KwaNyamazane, rape survivors are referred to a private doctor for forensic examinations. The doctor does not make the drugs accessible to rape survivors, preferring to refer to Rob Ferreira Hospital for treatment. This contributes to delays in treatment.

GRIP has not had support from the provincial Department of Health, and has been taken to court for allegedly failing to obtain correct permission to staff a care room at Rob Ferreira Hospital. GRIP is also still attempting to get permission

from the SAPS and Department of Public Works to run the care room from KwaNyamazane Police Station after being expelled.

Nowadays GRIP supplies an initial seven-day PEP starter pack to rape survivors. The starter pack is given to all rape survivors who present themselves at the hospitals within 72 hours after the rape incident. An HIV test is performed, with results being usually available to GRIP within 24 hours. If the survivor tests negative, she is contacted by phone or in person to return to the hospital to pick up the medication for the remaining 25 days. GRIP also supplies anti-emetics to lessen nausea and to increase compliance. GRIP pays for the HIV tests at both hospitals and at the ACTS Clinic. GRIP counsels the rape survivor on the treatment regimen, and asks her to sign a consent form. Follow-up visits are scheduled for counselling after one, three, and six months. Rape survivors are contacted either telephonically, or visited by a fieldworker to fetch them for the appointments. HIV-positive rape survivors are given immune-boosters, counselling, and referral to organisations providing support. Drug adherence presents a big problem, due to fear of stigmatisation and violence, and due to the side effects of PEP medications.

There are as yet no conclusive studies on the lower age limit for post-exposure prophylaxis drugs for children. Child rape survivors receive PEP treatment on the basis of a consideration of the 'best interests' of the child. In most cases, PEP medications have to be administered to children in syrup form. As paediatric PEP syrups are not provided by any of the health facilities in the area, GRIP purchases this medication for child rape survivors. Children who are looking after themselves need special information, counselling, and support in taking the appropriate doses at the right times.

GRIP operates with three counsellors, ten fieldworkers (with more being trained presently), and over 40 'defusers'. In cases of specialised counselling needs, the organisation refers rape survivors to a psychologist or Lifeline for longer-term counselling. GRIP provides a comprehensive post-rape care service with extensive and on-going information and counselling, for which the existing funding and staffing situation is inadequate.

GRIP also runs pre-court training in two areas and two staff members provide court assistance at the regional court. Cases are monitored and progress mapped for survivors. Survivors who are particularly vulnerable receive food parcels and clothing.

According to GRIP, information on PEP is scarce, and some people do not know about the treatment. Apart from the ALP/CSVR pamphlets providing information on post-rape counselling and legal-medical services, there are no information, education and communication (IEC) materials that assist counsellors and health workers to inform rape survivors about the treatment. Thus GRIP has produced an eight-page booklet in English and siSwati, detailing all STI medication and side effects, information on HIV testing and contact details of service providers. GRIP has also produced IEC materials on the court process, to assist rape survivors in understanding the justice process.

ACTS CLINIC, WHITE RIVER, MPUMALANGA

The ACTS Clinic in White River is an NGO providing a continuum of care and support to people living with HIV/AIDS, including Voluntary Counselling and Testing (VCT), nevirapine for pregnant women, ongoing support and palliative

care. Since June 2002, the organisation has included PEP in its health-care delivery system. In close co-operation with GRIP, 'defusers' have been trained to do pre- and post-test counselling, and administer HIV tests. Police officers bring the rape survivor to the clinic and collect the crime kit containing forensic evidence collected by the doctor. Every rape survivor receives emergency contraception, prophylactic STI treatment, and a care pack of toiletries, clothes and teddy bears that are supplied by GRIP. If the rape survivor tests HIV-negative, she receives a three-day starter pack. A schedule is set for follow-up counselling and medication collection for completion of the PEP course. Follow-up visits for counselling and for repeated testing are scheduled for one week, six weeks, three months and six months.

Previously the ACTS Clinic prescribed dual therapy for PEP. However, experience of poor compliance rates motivated the decision to switch to the prescription of Combivir (bi-daily), which is more easily administered.

Health workers attending to rape survivors at the ACTS Clinic have not seen any seroconversions. On the whole, compliance rates in terms of follow-up visits are poor. Very few rape survivors have returned for follow-up counselling and monitoring beyond six weeks. Thus 25 fieldworkers follow up on rape survivors at their homes and conduct further HIV tests.

ACTS provides services free of charge to rape survivors. PEP medication supplied by GRIP and the ACTS Clinic is funded by a national banking group. HIV-positive rape survivors – constituting on average 25% of rape survivors seeking treatment and support – receive counselling, immune-boosters, and treatment according to the stage and severity of their symptoms.

The ACTS Clinic has noted an increase in rape survivors – especially young teenagers and children seeking treatment and support. It is assumed that previously, fear of secondary victimisation, poor services, and long waiting periods were disincentives to reporting rape. However, since the establishment of more comprehensive and rights-based services, and greater general awareness, the rates of reported rapes have increased considerably. Most rape survivors come to the ACTS Clinic within 72 hours following the rape incident. Police are also aware of the time limit.

Other health facilities in the Masoyi area that provide post-rape care are overburdened, with insufficient medical staff, and few counsellors trained in PEP protocols. Counselling is an important component of service provision, and needs to be sustained over time. Fieldworkers follow up survivors in their homes, and provide advice on drug regimens. The doctor on duty at the ACTS Clinic does the medico-legal examination, gives evidence in court, and conducts DNA testing on alleged rapists (who are increasingly being brought to the clinics by police investigators). However, the rates of conviction for rape are still very low. This is attributed partly to the fact that forensic evidence does not always reach the courts. Liaison with the SAPS, and training in the collection and handling of forensic evidence were identified as issues requiring urgent attention.

THUTHUZELA RAPE CRISIS MANAGEMENT CENTRE, GROOTE SCHUUR HOSPITAL, CAPE TOWN, WESTERN CAPE

Groote Schuur Hospital, a state hospital in Cape Town's metropolitan area, is the largest tertiary care centre in the Western Cape. It has been offering PEP free of charge to rape survivors who cannot afford it since 1998. Doctors at the hospital

have pioneered the protocol for PEP treatment of rape survivors and this has become standardised throughout the province. Health authorities in the province have supported such initiatives, as they form part of a province-wide strategy for improving multi-sectoral care and services for rape survivors. The directorate dealing with maternal, women's and child health has taken the provision of comprehensive post-rape care under its umbrella. The hospital's Crisis Centre, Thuthuzela, is open 24 hours a day, with a doctor always in attendance. Medical examination, collection of forensic evidence and treatment is conducted, and there is thus no need for the services of a district surgeon. Facilities include a shower, to enable the rape survivor to wash after the examination. Clean clothes and a comfort pack are also provided.

Thuthuzela operates as a one-stop facility. If the rape survivor comes to the Crisis Centre directly, a police officer is contacted to take a statement from the rape survivor. The Hospital has been offering counselling and a starter pack of AZT (300g bi-daily) to rape survivors who present themselves up to 72 hours after the rape incident. Subsequently, the protocol was changed to the combination regimen: AZT 300mg bi-daily and 3TC 150mg bi-daily (which is considered a more effective treatment). Considering that rape survivors may not be in a state to undergo HIV counselling and testing when they initially come to a health facility, these services are deferred until a follow-up visit three or seven days later. Test results are available within 24 hours. Those who test negative receive the treatment for the remaining days until completion of the course. Everyone who undergoes an HIV test receives post-test counselling. Partners of rape survivors tend not to come along for counselling.

An average of about ten rape survivors are seen per month at the Crisis Centre. According to Denny, of 100 rape survivors who presented themselves at Groote Schuur Hospital in 2000, 68% had received PEP. Formal monitoring and evaluation mechanisms are in the process of being developed by the hospital. Problems are experienced with the supply of crime kits, which are not always available at Thuthuzela Rape Crisis Management Centre. This does not, however, hamper the collection of forensic evidence. While the drugs are generally in sufficient supply, there are times when they are not available. There is a dearth of counsellors, but doctors are trained to do counselling. There is no support system for counsellors.

THUTHUZELA CARE CENTRE, GF JOOSTE HOSPITAL, CAPE TOWN, WESTERN CAPE

GF Jooste Hospital is a public hospital situated in the Cape Town metropolitan area. It established a one-stop rape crisis centre, named Thuthuzela Care Centre, as part of the Casualty Department in June 2000, and provides rape survivors with comprehensive post-rape care services. It provides PEP under the same protocol and policy, following guidelines similar to those of Groote Schuur Hospital.

Ambulance services are provided to take the rape survivor home after service provision. The Care Centre staff liaise with police services and with prosecutors. A police investigator is sent to the Care Centre if the rape survivor elects to report the case.

ALBERTINA SISULU RAPE CRISIS CENTRE, SUNNINGHILL HOSPITAL, SANDTON, GAUTENG

Sunninghill Hospital is a private hospital and is situated in the northern suburbs of Johannesburg and serves a diverse population. When it initiated the provision of PEP within the framework of comprehensive post-rape care in 1998, it provided the service free of charge to indigent patients. At present, it provides the medications (not covered by Netcare) to rape survivors at cost, if they present themselves within 72 hours of the rape incident.

Rape survivors who come to the Crisis Centre are offered a three-day starter pack comprising AZT (200 TID) and 3TC (Lamivudine) 150mg bi-daily. In cases of severe exposure (determined on the basis of the criteria of multiple exposures, severe trauma, and current menstruation), Nelfinavir is added to the combination. VCT is offered at the first visit. The ELISA test is used, and results are usually available after three hours. Those who test HIV-negative receive the remaining 25-day course of PEP. Those who test HIV positive discontinue PEP, and are offered follow-up visits for care and support and referral to organisations supporting people living with HIV/AIDS. For those who receive PEP, follow-up visits are scheduled at two weeks, six weeks, three months, six months, and one year for repeat HIV testing, monitoring of drug tolerance, and lab indices.

The centre's model of comprehensive post-rape care is followed by other Netcare facilities in Gauteng, for example, Milpark Hospitial, Garden City Clinic, Rand Clinic and Union Hospital. Sunninghill Hospital was one of the first health facilities to put into place mechanisms to facilitate monitoring, data collection and research. The research data have been influential in the design of protocol and further research.

The Rape Crisis Centre has liaised with the SAPS to ensure that rape survivors are referred to the nearest clinic for PEP first, and to encourage police officers to collect reports from the clinic, so as to spare the rape survivor another trip to the police station.

SINAKEKELWE CRISIS CENTRE, NATALSPRUIT HOSPITAL, KATLEHONG, GAUTENG

Sinakekelwe Crisis Centre is a facility in which the Gauteng provincial Department of Health started providing PEP in July 2002. The treatment protocol was set out by the department, but no training was provided and the centre organised the training of hospital staff.

The Crisis Centre is open 24 hours a day, seven days a week. There are several prerequisites for the provision of PEP drugs: The PEP protocol requires that rape survivors present themselves within 72 hours after the rape incident, that they consent to a rapid HIV test, and that they test HIV negative. Reporting the case to the police is not a prerequisite, as it is recognised that time delays experienced in the process might jeopardise the effectiveness of PEP treatment.

Rape survivors receive medical treatment for their injuries, counselling, a medico-legal examination, STI prophylaxis, and PEP treatment. Physical injuries are attended to first. Once injuries have been treated and the pain has been alleviated, counselling is initiated. The doctor on duty performs the examination, whilst nursing staff administer the HIV test. A rapid HIV test is used and results are available within 20 minutes. Rape survivors who test HIV-negative are given a

PEP starter pack, and advised to return for counselling and for another seven-day regimen after one, two, three and four weeks. Persons who for economic or logistical reasons cannot return for follow-up visits, receive the total 28-day supply. Crisis Centre staff make every effort to visit them at home, and to encourage them to go to the nearest clinic if they experience difficulties with taking the drugs.

If survivors decide to report the case to the police, they are referred to the police station after the medical examination and treatment. In the case of children, members of the Child Protection Unit are called to the Crisis Centre to investigate, and to decide on ways of ensuring the children's safety.

On a busy day, staff at the Crisis Centre attend to six to seven rape survivors. About half of the cases seen are children between 18 months and 14 years of age. Mostly affected are girls in the age groups of six to eight years, and teenagers between 14 and 18 years. Among children, approximately 95% test HIV-negative. Among girls and women older than 14, approximately 60% test HIV-positive.

There is a regular supply of drugs at the Crisis Centre. Ten courses of PEP are kept in stock at all times. During the day, the dispensary supplies the drugs. Over weekends, when the dispensary is closed, the Crisis Centre supplies them from the care room. The drugs are financed from the provincial Department of Health budget.

Some rape survivors complain about the side effects of the drugs. Approximately 60% of those who receive the treatment, complete the course. Return for follow-up visits after the completion of the course is erratic with approximately 40% returning for testing afterwards. Among those who have followed the treatment regimen, no seroconversions have been reported.

There is no clear communication with the provincial Department of Health regarding ongoing monitoring and data-collection. The Crisis Centre has developed a system of record-keeping. However, the need has been identified for operational research, and for improving the conditions and mechanisms for treatment effectiveness.

The national Department of Health supplies leaflets with basic information on VCT, PEP treatment, and rape. There is as yet no widespread information and knowledge about the availability of PEP, about the time limit within which the treatment can be effective, and about the benefits of counselling. It was noted that a survivor's expectation on arrival at the Crisis Centre was 'to be cleaned up', to receive testing for HIV and pregnancy, and to be treated with prophylactics for pregnancy and STIs.

TINTSWALO HOSPITAL, ACORNHOEK, LIMPOPO; ELIM HOSPITAL, LIMPOPO

Tintswalo Hospital organised an internal workshop in 2002, aimed at changing the Hospital 's policy on rape to include anti-retroviral treatment. This initiative was to a large extent driven by the Health Services Development Unit (HSDU), which is based at Tintswalo Hospital. The provincial Department of Health is supportive of this initiative, but has not itself become actively involved in it. In neighbouring Mapulaneng Hospital, it was noted that health workers are aware of PEP policy, but have not started implementing it. Rape survivors who come to Mapulaneng Hospital do not receive the PEP treatment.

In Elim Hospital, PEP treatment for rape survivors has been initiated recently. It had been provided for health workers with needle-stick injuries, but was not until recently accessible to rape survivors. Counsellors have been trained and other infrastructural requirements have been met, largely due to the initiative of the Care Group, an NGO operating from the hospital premises. PEP and VCT counselling and counselling training are conducted in tandem.

Since December 2002, Tintswalo Hospital operates a 24-hour facility for rape survivors, offering comprehensive post-rape care including PEP. Tintswalo is a state hospital and follows provincial PEP policy. Rape survivors are supplied with a starter pack – usually seven-days – and are then asked to return after several days for follow-up counselling. If they test HIV-negative they are provided with the remaining PEP course. Once the medico-legal examination is completed, a police investigator is contacted to collect the forensic evidence and to fetch the rape survivor if she has elected to report her case. While the police services are willing to co-operate at this level, they have been less interested in receiving training on rape trauma and survivor empowerment. While a negative HIV test is the prerequisite for the provision of PEP, reporting the incident to the police is not.

Bottlenecks were experienced in the supply of PEP drugs, but the hospital now has a regular drug supply. The standard drugs for PEP – AZT and 3TC – are used and risk stratification is not applied.

Information about treatment is integrated into the counselling process, as general awareness of PEP is low. The rape survivor routinely receives basic information on treatment in written form. A leaflet is available detailing PEP treatment and management of rape survivors.

While the hospital has many trained counsellors for VCT on stand-by 24 hours a day, there is only one nurse – a psychiatric nurse – who is trained in PEP protocol. The caseload for this counsellor is overwhelming, as it involves addressing information and counselling needs at various levels: initial crisis/ trauma counselling, and ongoing follow-up counselling.

DISCUSSION AND RECOMMENDATIONS

RESEARCH

Cabinet's April 2002 decision to provide PEP at all health facilities, has not been immediately matched by nationally co-ordinated protocol and policy. Individual provinces and organisations have taken the initiative to develop strategies for comprehensive, integrated protocol, services, and care. However, in May 2003, a comprehensive set of National Guidelines for the Management of Survivors of Sexual Assault were drafted. The implementation of the roll-out has been uneven, and compliance patterns vary accordingly. Part of the problem has been the dearth of counsellors and counselling training specifically geared towards conditions of multiple counselling needs, including rape trauma, HIV testing, drug adherence, and stress management. Counselling on all of these levels is crucial for PEP drug adherence and treatment effectiveness.

A progress report on the provision of PEP to rape survivors compiled by the office of the Gauteng MEC for health, includes the following statistics emerging from Gauteng's implementing facilities for end-June to end-September 2002:

- 1 620 clients were seen;
- 1 022 of these received VCT;
- 858 initiated ARV treatment;
- 112 completed the treatment.

Although the monitoring process was constrained by various factors including problems related to co-ordination, categorisation, and differing protocols, it appears that PEP compliance is poor.

In general, there are a lack of monitoring and evaluation systems for PEP service provision, and it is noted that research is urgently required. Analysis of treatment effectiveness is important for health systems development, and for the monitoring and prevention of drug resistance. Research is urgently required on the conditions of drug administration, counselling, the double trauma of rape/HIV infection, stigma, secondary victimisation, drug side effects and other factors affecting adherence to drug regimens. Operational research is also needed on optimal models for the delivery of PEP, particularly in rural areas.

COMPREHENSIVE POST-RAPE CARE: CONDITIONS AND ACCESS

The revision and co-ordination of various PEP treatment practices and protocols indicated in the new National Guidelines for the Management of Survivors of Sexual Assault drafted in May 2003, points to some new directions in the conditions and criteria for access to PEP. Some of the earlier qualifying pre-requisites (reporting of the rape incident to the police, HIV testing) seem to have given way to a more open approach to the provision of PEP in cases of exposure to HIV due to sexual coercion. 'Sexual coercion', however, does not cover the range of non-consensual or unintentional exposure and there is a case to be made for broadening the access to treatment for those cases.

In the case of sexual assault, more specifically, the multifaceted nature of rape trauma highlights the need for the combination and co-ordination of trauma counselling, VCT provision, treatment counselling and risk-reduction counselling.

The integration of these traditionally separated counselling approaches, often administered at different sites, is a motivation for one-stop rape crisis centres. One-stop centres reduce the risk of rape survivors getting 'lost in the system' between referrals, as well as unnecessary time delays and secondary victimisation. Such service provision requires inter-sectoral linkages between health, psychological, police and legal services as well as integration of training and communication systems.

One-stop crisis centres should be accessible 24 hours a day. This is particularly important in the light of the finding that most rape incidents occur over weekends and in the evenings (Swart et al. 1999). In a holistic post-rape care system, it is essential to reduce the delays in initiating PEP. Until recently, such delays were (and in many instances still are) due to access and cost factors related to reaching police stations, as well as delays averaging 12 hours at some police stations (see Kim 2000:10). The long distances from police stations to district surgeons, the poor availability of district surgeons, and delays in being examined by a district surgeon have also been noted (Jewkes & Abrahams in Kim 2000:7).

To facilitate access to transport, and to ensure a minimal delay between the rape incident and medical treatment, GRIP has been fundraising for dedicated rape ambulances, primarily for use in rural areas.

ADHERENCE

Predictors of poor adherence to HIV medications include:

- poor clinician-patient relationship;
- lack of patient education, and uncertainty of patients regarding drug regimen;
- lack of reliable access to primary medical care or medication.

Predictors of good adherence to ARV medications include:

- availability of emotional and social support;
- the ability of patients to fit the medications into their daily routine;
- understanding that poor adherence can lead to seroconversion and drug resistance;
- the recognition that taking all medication doses is important;
- feeling comfortable in taking medications in front of people;
- keeping appointments for follow-up visits to the clinic (Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents 2002).

RELATIONS WITH THE GOVERNMENT

NGOs rendering assistance to rape survivors have played a pivotal role in providing integrated services, including advocacy, education, communications, and forging inter-sectoral collaboration linkages. While NGOs should not necessarily be expected to 'do the work for government', their expertise is invaluable and they should be consulted in formulating and implementing a national strategy

on violence against women, and in developing policy and protocol for the examination, treatment, and support of survivors of sexual assault.

COMMUNICATIONS

Comprehensive and ongoing information, counselling, support and monitoring are key to effective PEP treatment and it is necessary to provide appropriate communication support materials. This is considered to be particularly important in the case of trauma survivors. Literature on rape and HIV should be provided in all languages, taking into account varying literacy skills. To date, few generic national level materials have been developed. Some organisations have developed their own information leaflets (for example, GRIP, ACTS Clinic). The AIDS Law Project (ALP) and the Centre for the Study of Violence and Reconciliation (CSVR) held a workshop on treatment literacy and information needs of rape survivors in November 2001 and subsequently developed a booklet entitled *Preventing HIV after rape: Steps you can take to protect your health* which has been distributed in English and three other national languages. The booklet contains information on various aspects of PEP and provides contact information of organisations dealing with gender-based violence and HIV/AIDS. The booklets have been widely distributed by NGOs, doctors and in clinics, hospitals, schools and police stations.

To date, there remains a lack of materials for assisting health workers, counsellors, and survivors of rape with more detailed information on PEP. ALP and CSVR are, however, developing a manual for health practitioners, counsellors and other service providers that will address women's health issues in the context of gender-based violence. It will include detailed information on PEP and other post-rape care provisions, for example, counselling, conditions for PEP treatment effectiveness, etc.

Issues that should be addressed in communication materials include:

- right to adequate information to be able to exercise a choice;
- right to confidentiality and privacy, and other rights of the survivor;
- what (not) to do after a rape incident;
- health risks and psychological impact following rape (pregnancy, STI, trauma, stress);
- risk of HIV infection;
- the need for testing and treatment;
- the benefits of counselling;
- services available;
- medico-legal examination;
- facilities that offer PEP;
- PEP protocols and qualifying criteria;
- benefits of PEP;
- PEP regimen and importance of adhering to it;
- importance of return visits for follow-up;
- HIV test;

- pre- and post-test counselling;
- reporting the rape to the SAPS;
- treatment for children;
- resources and organisations for further and ongoing support needs.

Information materials for health workers should include:

- considerations of children's tolerance of ARV drugs ;
- contra-indications and side-effects;
- compounded side effects with the prescription of ARV drugs in conjunction with pregnancy-prevention drugs and antibiotics;
- PEP for pregnant women;
- strategies of communication for drug regimen counselling, and risk reduction counselling;
- legal aspects of PEP.

Materials for counsellors could include the following aspects:

- integration of trauma, medical, pre- and post-test, risk reduction, drug regimen, and stress management counselling;
- benefits of counselling;
- importance of visiting rape survivors in their homes if they cannot come to the Crisis Centre;
- experiential accounts of rape survivors, encouraging discussion and analysis;
- communication strategies and modes of address;
- facilitating support groups and themes for support groups;
- teaching people to mobilise support structures;
- integrating information and counselling.

Recommendations from a workshop on PEP

In May 2003, CADRE organised a workshop at the South African Gender-Based Violence and Health Conference in Johannesburg entitled: 'PEP- What are the communication needs?'. The objectives of this workshop were to bring together researchers, health workers and gender activists to review:

- communication needs around PEP in the context of gender-based violence;
- co-ordination and partnerships to prevent duplication of IEC materials;
- current activities, research and service gaps, and recommendations for the development of IEC materials on PEP.

There were 23 participants from various institutions: international and national NGOs, gender activists, provincial and national government representatives, legal rights officials and activists, and academics. The discussion focused on PEP information, education and communication materials that are already available

in various sectors, on gaps in these materials, and on recommendations for the development of new materials.

What communication materials are available?

It was noted that there are few materials available, and where these do exist, they are limited by language, and are generally only available in larger centres. Specific gaps in communication were noted.

Materials should include training guides, protocols, and information for PEP users/clients.

The needs of illiterate people are not catered for.

Materials are not generally available in multiple languages .

Guidelines are not generally available to doctors regarding the use of crime kits.

The government PEP policy may be insufficiently developed.

Private hospitals are not always included in communication activities.

There is insufficient information on prescribing PEP for children.

There is insufficient information available on follow-up frequencies or side-effects of drugs .

The materials produced by pharmaceutical companies use technical medical terms which are not understood by most people.

There is insufficient information on rights.

There has been little feedback on implementation of PEP.

Recommendations for communications materials included:

The production of communication materials should be co-ordinated to avoid duplication and to ensure consistency with PEP policies and practices.

Language should be clear and multilingual materials should be produced.

Materials should be relevant to their contexts of intended use.

Posters were identified as a useful format, and materials should include illustrations.

Existing community resources should be used for dissemination.

Use should be made of multimedia approaches and extend to the involvement of community leadership structures.

Materials should be co-ordinated within government structures – national, provincial and local – as well as co-ordination with NGOs.

Information on rape and PEP should be included in the school curriculum as part of lifeskills education. It should be included in updated lifeskillls programmes and materials.

ENDNOTES

1. The distinction between 'efficacy' and 'effectiveness' is instructive here: In intervention trials, the concepts of 'efficacy' and 'effectiveness' are used to convey the difference between those impacts which can be observed in the 'ideal' (often laboratory) setting, and those which may be seen in a 'real life' situation, where additional (and often unexpected) opportunities and constraints come into play. When applied to policy on PEP, 'it is not only the potential biomedical benefits of providing PEP that should be taken into account, but also the potential for associated broader impacts which such a policy might have on ongoing efforts to address both sexual violence and HIV/AIDS' (Kim 2000:14).
2. Compliance rates cannot be pre-judged by reference to socio-economic status, educational levels and degree of literacy, living conditions, etc. Counselling, accessible and affordable health-care delivery services, and social support are crucial to drug adherence. A report from a rural community setting in Uganda speaks of 91.5% of patients with 100% adherence after six months of therapy (Kohli 2003). Similarly, the Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents (2002) report on a programme that achieved a 70% adherence rate among the homeless [in the US], citing flexible clinic hours, accessible clinic staff, and incentives as reasons for this success.

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