



Rape and HIV Post-Exposure Prophylaxis: Addressing the Dual Epidemics in South Africa

Julia C Kim,^a Lorna J Martin,^b Lynette Denny^c

- a Senior Researcher, Rural AIDS and Development Action Research Programme (RADAR), School of Public Health, University of the Witwatersrand, South Africa; Clinical Research Fellow, Health Policy Unit, London School of Hygiene and Tropical Medicine, UK. E-mail: jkim@soft.co.za
- b Specialist Forensic Pathologist, Division of Forensic Medicine and Toxicology, University of Cape Town, South Africa.
- c Associate Professor and Senior Specialist, Gynaecology Oncology Unit, Department of Obstetrics and Gynaecology, Faculty of Health Sciences, University of Cape Town, South Africa

Abstract: *In South Africa, a country notable for both a rapidly escalating AIDS epidemic and high levels of sexual violence, the issue of HIV post-exposure prophylaxis (PEP) following rape has recently come to the fore, and a policy supporting provision of PEP has been approved by the national government. This paper compares the conditions for providing PEP in Europe and North America with the conditions faced by two initiatives in South Africa, one serving a primarily rural base, and one urban. It is based on a review of the literature on sexual violence in South Africa and use of PEP following occupational and non-occupational exposure. It incorporates perspectives from in-depth interviews in 2000 with 18 key informants, including survivors of sexual violence, gender and HIV activists, domestic violence NGOs, rape crisis centres, physicians, lawyers, researchers and HIV/AIDS advisors in the Department of Health. The paper argues that given the scientific evidence for PEP, and the nature of the dual epidemics of HIV and sexual violence in South Africa, the public health and social justice rationale for implementing PEP equals and indeed exceeds that put forward in industrialised countries. However, delays in accessing PEP caused by the public justice system and lack of training for service providers constitute significant obstacles to effective implementation. In this respect, provision of PEP presents an opportunity to reform and strengthen existing services for post-rape care and to link attention to the epidemic of sexual violence to HIV/AIDS prevention. © 2003 Reproductive Health Matters. All rights reserved.*

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SOUTH Africa is in the midst of one of the fastest growing HIV epidemics in the world. In the year 2000, an estimated 40% of deaths in adults aged 15–49 were attributable to AIDS, making it the single highest cause of death in South Africa. In the year 2002, there were more people living with HIV in South Africa than in any other country in the world.^{1–3}

Simultaneously, South Africa has been the site of growing alarm at the high levels of rape reported from various sources, and the issues of sexual violence and violence against women in general have gained considerable political importance and visibility.⁴ In South Africa, as elsewhere, accurate statistics capturing the true magnitude of sexual violence are difficult to obtain. Statistics released by the South African

Police Service note that in 2001, 52,860 rapes and attempted rapes were reported to the police.⁵ Although such records are likely to significantly underestimate the true incidence of rape, they remain the most readily available source of information and provide some basis for comparison between countries. In most presentations of international police statistics, South Africa appears at or near the top of the list for rape statistics.⁶

What is HIV post-exposure prophylaxis?

Recent years have witnessed a growing recognition of the links between violence against women and HIV/AIDS.^{7–9} One immediate expression of this link relates to the transmission of HIV following rape. Internationally, there has been growing interest regarding the provision of antiretroviral therapy (ART) to reduce the risk of HIV transmission following sexual assault. This interest has evolved in light of scientific evidence that such drugs can be both safe and effective when used following occupational exposure, such as a needle-stick injury.^{10,11} There are presently no conclusive data on the effectiveness of ART in preventing HIV transmission after sexual exposure. However, animal studies have suggested a “window of opportunity” may exist in which ART could suppress viral replication and prevent HIV infection following the initial exposure.^{12,13} Moreover, strong scientific evidence supporting the use of ART in the prevention of mother-to-child transmission in both developed and developing country settings has added further argument to the biological plausibility of such therapy in other exposure settings.^{14,15}

In this context, the US Centers for Disease Control and Prevention (CDC) have stated that: “because the therapy remains unproven and can pose risks, physicians should consider its use only in individual circumstances when the probability of HIV infection is high, the therapy can be initiated promptly, and adherence to the regimen is likely. It should not be used routinely and should never be considered a form of primary prevention.”¹⁶ Yet in spite of a lack of definitive recommendations, several centres in a variety of countries have begun to offer HIV post-exposure prophylaxis (PEP) following sexual exposure, and to develop their own guide-

lines and protocols.* Common regimens use a combination of two or three antiretroviral medications, taken several times a day, over a period of four weeks. Drugs include nucleoside analogue reverse transcriptase inhibitors such as zidovudine (AZT) and lamivudine (3TC) as well as protease inhibitors.

While PEP intervention and research initiatives have been established in the more industrialised settings of Europe and North America, some 95% of people infected with HIV and 95% of the lives claimed by AIDS are found in developing countries,²¹ reflecting the global imbalance between resources and need which has characterised the epidemic. Given the disproportionate burden of infection and the high levels of sexual violence reported in many high prevalence countries,^{22,23} there is an urgent need to understand the implications and potential impacts of PEP in the context of developing countries.

This paper reviews current evidence and experience of HIV post-exposure prophylaxis in the context of South Africa. It is based on a review of published and grey literature focusing on sexual violence in South Africa, as well as the use of PEP following both occupational and non-occupational exposure. In addition, it incorporates perspectives drawn from in-depth interviews undertaken in 2000 with 18 key informants in South Africa, who were selected purposively to include survivors of sexual violence, gender and HIV activists, domestic violence NGOs, rape crisis centres, physicians, lawyers, researchers and HIV/AIDS advisors within the National Department of Health.

Rape in South Africa: important considerations for PEP

In attempting to understand the potential benefits of PEP, it is important to gain a deeper understanding of the context of sexual violence

*In the USA, there are published guidelines on the use of PEP following sexual assault although these are not officially sanctioned.¹⁷ The states of Massachusetts, New York and California have official policies or guidelines in place for the use of PEP following sexual assault. In Europe, France, Italy, Spain and Switzerland have official policies recommending the use of non-occupational PEP, as does New South Wales in Australia.^{18–20}

in South Africa. Existing data suggest that it is young women who are most commonly raped. South African police statistics for 1996-99 indicate that for the crime of rape and attempted rape, 40% of survivors were under the age of 18,²⁴ and that rape was the most prevalent reported crime against children.²⁵ These findings are significant because they indicate that young women, the demographic group already at highest risk of HIV in South Africa,²⁶ simultaneously represent a group at high risk of rape, and are therefore likely to come into contact with those services where PEP may be available.

Who are the perpetrators? Cases of rape perpetrated by a stranger vary in different settings, ranging from 42.5% in a recent population-based study⁴ to 80% in a case series from Hillbrow medico-legal clinic.²⁷ These figures may well reflect a reporting bias in that the experiences most likely to be disclosed to researchers, or to present at police stations, health care facilities and rape crisis centres are those involving an unknown perpetrator. The implication for the provision of PEP is that the HIV status of the perpetrator may be unknown or unobtainable.

Furthermore, gang rapes feature prominently in South Africa. In one Johannesburg case series, Martin found that in one-third of rape cases there was more than one perpetrator,²⁷ and Swart found the same in 27% of cases.²⁸ Among rape care providers, the alarming and increasing frequency of rape by groups of men not affiliated with gangs, as well as the ritualised abduction, gang rape and murder of young women as part of gang initiation, are a very real concern.²⁹ The substantial implications of such traumatic rape, potentially involving multiple HIV-infected perpetrators, must be taken into account in assessing the potential role of PEP in South Africa.

However, rape perpetrated by a stranger reflects only a small proportion of women's experiences of coerced sex.⁴ In fact, the most common forms of sexual coercion are those most vulnerable to under-reporting.³⁰ These may occur within marriages, dating relationships, families or where sex is agreed to after blackmail, threats or other forms of coercion. Such acts have been recognised in the draft Sexual Offences Bill, which has been updated to incorporate "coercive circumstances" (rather than simply lack of consent), and in which marriage or any other rela-

tionship cannot be a defence against a charge of rape.³¹ To what extent such cases may come forward for PEP is unknown; however, given popular notions of rape, and the profile of those currently accessing post-rape services, this proportion is likely to be low.

Caring for rape survivors: how well is the system coping?

The provision of PEP cannot be implemented in isolation, but must be considered as part of a systematic approach to caring for rape survivors. It is therefore important to take stock of the current state of such services in South Africa.

In the 1998 South African Demographic and Health Survey, only 15% of women who noted having ever been physically forced to have sex against their will said they had reported the incident to the police.³² The many barriers to reporting have been well summarised elsewhere,⁴ and include problems of physical access to police,³³ fear of not being believed,³⁴ fear of retaliation by the perpetrator and fear of the legal processes, including rudeness and poor treatment by the police.³⁵ In addition, many women do not go to the police because they anticipate that ultimately it will not lead to the perpetrator being punished. The evidence suggests that their concern is justified. Few rape cases go to court (ranging between 5% and 50% in Soweto police stations)³⁵ and of those that do, only 7-13% result in conviction and custodial sentences. By contrast, more than two-thirds of prosecutions for aggravated assault are successful.^{36,37}

Moreover, meeting the immediate sexual and reproductive health care needs of rape survivors (including STD care and pregnancy prevention, treatment of injuries, and counselling) is an important priority. Even in the absence of PEP, the need for timely access to emergency contraception (and failing that, early abortion) highlights the importance of early and integrated service delivery. In addition, medical evidence is of critical importance in the investigation and prosecution of rapists.

In the past, government district surgeons were responsible for examining and gathering medical evidence in cases of suspected rape. However, this system was fraught with difficulties, and has been severely criticised for providing a sub-standard service. District surgeons' attitudes

have been described as problematic, and in general, examinations have been cursory and collection of evidence poor.³⁸ Recognising these problems, and in light of the Primary Health Care approach, the district surgeon system has been abolished, leaving responsibility for management of rape survivors with the attending medical officer within each health care facility. However, with the phasing out of district surgeons no transfer of services was implemented to ensure that expertise remained within the health service.³⁹ To date, no national standardised training has been offered to doctors or nurses in the health system, leaving, in most cases, junior doctors to perform sophisticated clinical forensic examinations and manage rape survivors without adequate supervision or support. The training of forensic nurses has been proposed as a means to meet this gap, but to date few such nurses have been trained.

Counselling and ongoing psychosocial support have also been regarded as important components in helping survivors to heal. Such services are often provided through non-governmental organisations (NGOs) with expertise relating to gender-based violence. However, such NGOs tend to be concentrated in urban centres, and are limited in number relative to demand.³⁴ In addition to providing counselling and support following rape, these NGOs are increasingly playing an important advocacy role, often providing expert testimony and making links between medical, police and judicial services.⁴⁰

PEP in South Africa: from grassroots response to national policy

The first pioneering initiatives for PEP provision began around 1998, prior to the adoption of national policy or guidelines. Several service providers, including an NGO and a handful of public hospitals, private hospitals and insurance companies, in Nelspruit, Johannesburg and Cape Town, feeling compelled to do whatever possible to reduce the risk of HIV transmission following rape, began to introduce PEP as part of post-rape care (Personal communication, Barbara Kenyon, Lynette Denny, Lorna Martin, Adrienne Wolfsohn).

However, in the absence of a clear national directive regarding PEP, such initiatives remained vulnerable to prevailing political ten-

sions and controversy, and government support for fledgling PEP efforts varied widely across different provinces. In 1999, after a series of highly publicised court cases in which health professionals and their institutions were reprimanded for administering PEP, the South African Medical Association (SAMA) released a statement supporting PEP for rape survivors. SAMA undertook to publicise guidelines on support to rape survivors in liaison with the Minister of Health, local and international NGOs and the pharmaceutical industry.

Finally, in April 2002, in a move that took many by surprise, the Cabinet announced, with immediate effect, its support for the provision of PEP for survivors of sexual assault in South African hospitals and clinics. Following protocols established in developed countries, a two-drug regimen using AZT and 3TC was adopted. In addition, plans for roll-out following the establishment of a series of pilot sites were declared. Although these announcements signified an important step forward and were greeted with widespread approval, these interventions cannot function or exist in isolation.

A tale of two cities: case studies

The following two PEP initiatives both attempt to provide care through the public services, which would be the entry point for the majority of South Africans. However, they also illustrate the stark contrasts which exist within the country, in terms of political support, and rural versus urban population bases, infrastructure and health systems development. Both programmes aim to integrate PEP within standard clinical and forensic treatment for post-rape care.^{41,42}

Case A: Nelspruit (GRIP Rape Intervention Programme)

GRIP is a non-profit community-based organisation working with rape survivors in the Greater Nelspruit municipal area, Mpumalanga Province.* The initiative was begun in March 2000 by a group of six concerned women from different local churches and has established rape care centres based in two public hospitals

*For more information on GRIP, see <www.grip.org.za>.

servicing the area. In addition, they have established a private waiting room for rape survivors at the local Magistrates Court, a rape care centre at the local police station and two counselling centres.

Since 2000, GRIP has been working to enable the two hospital-based centres to provide PEP to rape survivors. Because PEP is not covered by most medical aid schemes (and most of their largely indigent clients are not covered by medical aid), obtaining the funds to sustain this service has proved an ongoing struggle. Currently, a one-week starter kit (containing a seven-day supply of AZT and 3TC) is offered free of charge to all rape survivors who present within 72 hours of the assault. Because the hospitals have a limited capacity to provide voluntary HIV counselling and testing (VCT), blood that is routinely collected for syphilis is subsequently screened for HIV using an ELISA test. Clients are then contacted by phone or in person to return for a follow-up visit within one week. If the HIV test is negative (confirming that the patient may be at risk of seroconversion due to the rape), the remaining medication to complete a 28-day regimen is given. If the test is positive (confirming that the patient was already HIV-positive at the time of the rape) the antiretrovirals are stopped. In either case GRIP refers the client to a nearby clinic for further counselling and support, and for those who are positive, follow-up HIV care.

Finding the funds to cover PEP beyond the starter kit has been a time-consuming aspect of GRIP's work, involving appeals to local businessmen to "adopt" a rape survivor and sponsor their medication. Monitoring side effects and encouraging treatment compliance has also raised dilemmas. Because long distances and lack of communication or transport have limited return visits to the hospital, GRIP has started to use trained volunteers to follow up patients in the community. However, covering the costs of training and supervision, public transport and a volunteer stipend to maintain this critical link are an additional financial strain for the organisation. Other difficulties have included a time delay before rape survivors reach one of the hospitals, on average a delay of 12 hours at police stations. GRIP has been working with local police and child protection units to raise awareness about the importance of reducing this delay.

GRIP is a truly grassroots initiative, arising from a community-driven response. Thus, many of the technical and logistical aspects of the work have had to be developed through experience, without the formal support of the health services. Moreover, GRIP's catchment area encompasses a largely rural population base, with associated infrastructure and resource constraints. A final challenge has been the resistance which the organisation has encountered from Provincial health authorities. Due to political controversy, GRIP has been at the centre of a series of eviction attempts and court cases which have diverted energy and funding from core activities. Although a detailed analysis of this situation is beyond the scope of this paper, it highlights the importance of a supportive policy environment and political will in implementing new and potentially controversial initiatives.

Case B: Cape Town (Groote Schuur Hospital and GF Jooste Hospital)

Groote Schuur Hospital (GSH), a government hospital and the largest tertiary care centre in the Western Cape, has been offering PEP to rape survivors since 1998. GF Jooste Hospital (GFJ) established a one-stop rape crisis centre in 2000 in conjunction with a Department of Justice initiative, and has also implemented PEP as part of its services. At GFJ, contact with a prosecutor from the sexual offences court is established from the outset. In contrast to GRIP, the location of these two hospitals in the Cape Town metropolitan area has enabled them to take advantage of better developed resources and infrastructure. Moreover, these initiatives have developed within a broader province-wide policy and strategy to improve care and services for rape survivors, including a standardised protocol for post-rape care.⁴² PEP is fully covered by provincial funds at both sites, except for those who are covered by medical aid or who can afford to pay for the medication.

Those who present within 72 hours of exposure are counselled and offered a starter pack of AZT. Because of the concern that rape survivors may not be emotionally or psychologically prepared to undergo HIV VCT at initial presentation, VCT is deferred until a follow-up visit three to seven days later. At that time, counselling and testing are offered and those who test

HIV-negative are then offered the remaining medication to complete a 28-day course. Should the patient be unwilling or unable to return for VCT, the full drug regimen is dispensed on the first visit.

Preliminary data collected from GSH and GFJ since 1998 suggest that of the approximately 998 rape survivors who have presented, roughly 66% have received PEP.⁴³ Follow-up visits for monitoring of seroconversion, follow-up lab tests and counselling are scheduled for one week, six weeks and three months. Monitoring mechanisms are only now being established, so analysis of this data is not yet available.

Rape and PEP in South Africa: key implementation issues

In July 1997, the US Centers for Disease Control and Prevention (CDC) sponsored an External Consultants Meeting on Antiretroviral Therapy for Potential Non-Occupational Exposures to HIV. In its report, the CDC noted that the decision to provide PEP following possible non-occupational HIV exposure must balance the benefits and risks. Five key factors that influence the potential efficacy of PEP following sexual exposure were identified.⁴⁴

• The probability that the source contact is HIV-infected

A review in the USA concluded that the possibility of obtaining the HIV status of an alleged assailant after sexual assault is highly unlikely and is fraught with logistical, legal and ethical dilemmas.⁴⁵ Hence, current PEP protocols in industrialised countries use risk stratification, one component of which involves estimating the assailant's risk of being HIV-positive.^{46,47} However, given the generalised, high prevalence, heterosexual HIV epidemic in South Africa, the probability of a source contact being infected is significantly higher, and such risk stratification has not been used.

• The likelihood of transmission

Studies among HIV sero-discordant couples have estimated the risk of HIV transmission from a single act of unprotected receptive vaginal or anal intercourse to be similar in magnitude to the risk associated with percutaneous occupational exposure, for which PEP is now the standard of

care in South Africa.^{48,49} The risk of HIV transmission is known to increase with exposure of non-intact mucosa, and for this reason, rape may be associated with higher risks of transmission. Among sexual assault victims, there are often documented genital injuries,⁵⁰⁻⁵² and a high rate of STIs.⁵³ These factors are especially relevant in South Africa, where untreated STIs among sexually active adults are prevalent, and where violent sexual assault of women and young girls may result in high levels of genital injury. A preliminary analysis of the first 460 women seen and treated for rape during an 18-month period at GSH and GFJ found that vulvar or vaginal injuries were noted in 65% of cases, and anal penetration was a common occurrence (8%).⁴³ In addition, the viral load of the assailant may also be a factor influencing likelihood of HIV transmission.⁵⁴ Finally, although the additional risk associated with gang rape has not been empirically documented, it is likely that both the probability of multiple source contacts being HIV-infected and of transmission due to multiple traumatic exposures will result in an overall higher risk of transmission than that associated with consensual sex.

• The interval between exposure and initiation of therapy

Guidelines relating to PEP in both occupational and non-occupational settings universally recommend that PEP be implemented as soon as possible after exposure, preferably within a few hours. Animal studies suggest that PEP is not effective when started after 24-36 hours, but the interval after which protection is lost in humans is unknown.^{55,56} Most PEP protocols for non-occupational exposure have incorporated presentation before a 24- or 72-hour time limit as an inclusion criterion.

Obstacles and delays relating to police services, the criminal justice system and accessing forensic medical care for survivors of rape all impact upon the time interval between exposure and the initiation of PEP, and have been encountered by service providers in both case studies described earlier. Yet these early experiences are already generating important lessons. In both sites, there has been a move towards the centralisation of services around a health facility capable of providing forensic examination, standardised post-rape care, counselling, (and in some cases, access to police and criminal justice

services) as well as PEP. This model has been described as a “one-stop rape crisis centre”; similar models have evolved in other countries.⁵⁷ As the link to health facilities, GRIP has been developing rape care centres in government buildings based in or near police stations, and this may be a more appropriate strategy for rural areas. There has been a shift in public awareness, encouraging initial presentation at a health facility rather than a police station, in order to bypass potential delays.

As a result, GRIP has noted a decrease in the time interval between first contact at a police station and presentation at the hospital from three days to 12 hours (Personal communication, Barbara Kenyon, August, 2000). A review of 460 women seen at GSH and GFJ showed that 74% had presented within 24 hours of the rape.⁴³ These are early and limited findings and should therefore be interpreted with caution. However, they do provide some insight into the challenges and feasibility of initiating therapy within a 72-hour time period, and highlight the need for further operational research.

• The efficacy of the drug(s) used to prevent infection

A review of the potential efficacy of the drugs currently being offered or considered for PEP following sexual exposure is beyond the scope of this paper. However, an obvious consideration concerns the affordability and accessibility of the drug regimen used, and a relatively inexpensive single-drug regimen (such as AZT) would likely be most practical in the South African setting. An oft-cited case-control study of a regimen that utilised only AZT found an 81% risk reduction for HIV transmission among health care workers following occupational exposure.¹¹ Moreover, PEP protocols which have evolved in settings such as Vancouver, San Francisco and New York have incorporated two- and sometimes three-drug regimens due mainly to a theoretical potential for drug resistance.⁵⁸ Yet to date, there is no empirical evidence to demonstrate any additional protective benefits of dual- or triple- therapy over monotherapy following sexual exposure in these settings. Moreover, even if such benefits were to be shown, the relevance and applicability of multi-drug regimens need to be assessed against the probability of HIV-positive rapists having had

prior exposure to ART. Because the vast majority of those who are HIV-positive are unaware of their status in South Africa, and because ART is not presently a routine component of HIV care, this likelihood is very low.

• Drug adherence

Lack of adherence to the full ART regimen has been documented among health care workers taking PEP following occupational exposure in France, the UK, USA and Canada.^{11,47} Similar findings have been noted with PEP provision following sexual assault in industrialised countries.⁵⁹ The issue of non-compliance with therapy (whether due to drug side effects or other factors) would be a matter of concern in South Africa due to the theoretical risk of reduced efficacy, as well as the risk of generating drug resistance.⁶⁰ Certainly, logistical barriers to adherence were evident in the experience of GRIP where, prior to establishing a system of follow-up, opportunities to monitor and encourage compliance were severely limited. The capacity to provide adequate counselling and motivation to support treatment completion, as well as the mechanisms to monitor and follow-up side effects and adherence were identified as significant challenges in both case studies, and raise important operational research questions for PEP in South Africa (see Figure 1).

However, it is unclear to what extent treatment adherence profiles may be generalisable between occupational and non-occupational exposures, between consensual and non-consensual sexual exposures, and between countries with vastly different HIV prevalence rates.* 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

*Consensual and non-consensual here does not refer to the associated genital trauma (though these might well vary) but rather to the fact that in industrialised countries, PEP is made available to those (primarily gay men) who come forward after a consensual sexual exposure with a known partner who is HIV-positive or thought to be high risk. (This is similar to the use of emergency contraception, though much counselling is done to avoid repeat use.) Hence, perceptions of risk and agency, and consequently rates of compliance, may not be generalisable to South Africa, where it is likely most of those seeking PEP will present after a rape.

Figure 1. Key research questions for PEP

- What are the rates of demand for PEP, and the rates of acceptance? What systems need to be in place to make PEP accessible and acceptable to rape survivors in various settings?
- What minimum monitoring systems need to be in place for adequate follow-up of potential side effects and drug toxicity?
- What are treatment adherence rates for various delivery models, and do they differ from those in other settings where PEP is offered (e.g. low HIV prevalence countries or following occupational exposures)?
- What factors influence treatment adherence, and how can adherence best be supported?
- Which drug regimens are most appropriate for South Africa? Are there short-course regimens which might enhance adherence rates while maintaining effectiveness? Is there a role for risk stratification, or should all rape survivors in South Africa be considered high risk?
- What percentage of those who present for post-rape care are already HIV-positive? How are they able to cope with learning their HIV status, and how best can they be supported?
- To what extent does PEP become a form of primary prevention? What kind of counselling and support is needed to enable survivors to reduce their risk of HIV infection within ongoing sexual relationships?
- What kind of training is needed to implement PEP? How can roles be shared among different service providers? What impact does PEP have on other services and sectors relating to post-rape care?

sustained a minor needle-stick injury while performing routine clinical duties in a low prevalence country. Thus, it would seem likely that a person's self-perceived risk of HIV infection due to exposure may play a key role in influencing treatment completion rates. There is some evidence that this may be the case. In one San Francisco feasibility study involving 401 participants (94% of whom presented after a sexual exposure, and 43% of whom knew their exposure source was HIV-infected), 78% completed four weeks of therapy, in spite of the commonly reported experience of side effects.⁶¹ Similarly, a study in Vancouver found that patients at highest risk

for HIV infection were more likely to accept prophylaxis and more likely to complete treatment than those at lower risk.⁴⁷

Rape and PEP in South Africa: a strong public health and social justice rationale

The emerging picture suggests that, given the existing scientific evidence for PEP and the nature of the dual epidemics of HIV and sexual violence in South Africa, the public health rationale for implementing PEP can be said to equal—and indeed exceed—that of the more industrialised countries from which it arose. Moreover, the fact that PEP initiatives have arisen in South Africa, often amidst difficult circumstances, and that grassroots lobbying and advocacy have elevated the issue to the level of national policy, suggests that beyond public health arguments, the provision of PEP raises deeper principles of social justice. Preventing HIV infection following rape is a matter of health and human rights.

Yet, in order for PEP to be an effective intervention in South Africa, the significant operational barriers that exist cannot be ignored. Now that a policy framework in support of PEP has been approved in South Africa, the challenge lies in translating policy into action. As the two case studies have illustrated, early PEP initiatives have gone a long way towards identifying gaps in knowledge and areas for further operational research (Figure 1) and highlighted key ethical considerations to be addressed (Figure 2). With appropriate support for implementation, monitoring and evaluation, these initiatives are ideally placed to begin generating models for the broader expansion of PEP within the country.

Conclusion: the need to strengthen and reform current services

The pressing need to strengthen and reform the current services available to rape survivors in South Africa was a concern voiced by most key informants interviewed in the course of this research. However, many also expressed the belief that, given the current crisis facing South Africa as regards both sexual violence and HIV/AIDS, such reform should be regarded as a concurrent goal, rather than a pre-condition, to providing PEP following rape.

Figure 2. Key ethical considerations for PEP in South Africa

- Forensic examination and legal reporting should not be pre-conditions for receiving PEP.
- Informed consent, including information on the lack of direct evidence of efficacy, should be a standard component of any PEP protocol
- Those who test HIV-positive at initial screening should be offered adequate support and access to the current standard of HIV treatment and care in South Africa.
- Equal access to PEP services is an important consideration, both in regards to the ability to pay for drugs and to broader resource and infrastructure constraints in rural settings.
- Provision of PEP following rape should encompass the broader dimensions of coerced and forced sex in South Africa, and not be restricted to cases of "stranger rape". At the same time, repeat or routine use of PEP should not become a form of primary prevention for HIV.

In this respect, efforts to provide PEP in South Africa may represent an opportunity to raise the level of skills and awareness among those sectors currently working with survivors of sexual violence – including the police, judiciary, and health services. As current initiatives have indicated, the very act of providing PEP highlights the links between violence against women and HIV in very concrete and visible ways. Dismissive attitudes towards what has often been regarded as a marginalised, feminist issue may be forced to shift as the obligation to provide swift and standardised services to rape survivors is operationally linked to the national priority of HIV

prevention. Access to ART has become a politically hot topic in South Africa, and there is no doubt that the recent acceptance of PEP has ridden on the tide of activism surrounding both prevention of mother-to-child transmission and wider access to treatment campaigns.

However, a technical response to the issue is not enough; a broader, structural response to the interface between gender-based violence and HIV/AIDS is needed. Recent initiatives such as the Global Fund to Fight AIDS, tuberculosis and Malaria, are making resources to address HIV/AIDS available on an unprecedented scale, and donor enthusiasm for introducing anti-retroviral drugs must be met with an equal commitment to strengthening the systems that enable such drugs to be accessible, and which give them broader meaning.⁶² The provision of PEP should be seen as one component of a comprehensive and deliberate strategy to address the gender dynamics currently driving the HIV epidemic in South Africa. In that respect, its broader importance lies in articulating how existing initiatives to address gender-based violence must be strengthened and embraced as critical components of a national HIV prevention strategy.

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Résumé

En Afrique du Sud, pays connaissant une rapide escalade de l'épidémie de SIDA et des niveaux élevés de violence sexuelle, la prophylaxie après exposition au VIH lors d'un viol a récemment fait l'objet d'un débat, et une politique soutenant l'accès à cette intervention a été approuvée par le Gouvernement national. L'article compare l'administration de la prophylaxie en Europe et en Amérique du Nord avec les conditions de deux initiatives en Afrique du Sud, l'une desservant une base essentiellement rurale et l'autre urbaine. Il examine la littérature sur la violence sexuelle dans le pays et l'utilisation de la prophylaxie après exposition professionnelle et non professionnelle au VIH. Il inclut les données d'entretiens menés en 2000 avec 18 informateurs clés – victimes de viols, militants de groupes de femmes et de lutte contre le VIH, ONG spécialisées dans la violence familiale, centres d'aide aux victimes de viols, médecins, juristes, chercheurs et conseillers sur le VIH/SIDA au Département de la santé. Compte tenu des données scientifiques en faveur de la prophylaxie et de la nature de l'épidémie double en Afrique du Sud (VIH et violence sexuelle), les arguments de santé publique et de justice sociale en faveur de la prophylaxie semblent égalier et même dépasser ceux qui sont avancés dans les pays industrialisés. Néanmoins, des retards dans l'accès à cette prophylaxie, dus au système de justice et au manque de formation des prestataires de services, s'opposent à une application efficace. Pourtant, l'administration de cette prophylaxie donne l'occasion de réformer et de renforcer les services existants pour les soins après viol et de lier l'attention sur l'épidémie de violence sexuelle à la prévention du VIH/SIDA.

Resumen

En Sudáfrica – un país conocido tanto por la rápida extensión de la epidemia de SIDA como por los altos niveles de violencia sexual – se ha destacado últimamente el tema del manejo del riesgo post-exposición (PEP por sus siglas en inglés) en casos de violación, y el gobierno nacional ha aprobado una política apoyando la provisión de este servicio. En este artículo se comparan las condiciones para la provisión de PEP en Europa y Norteamérica con las condiciones enfrentadas por dos iniciativas en Sudáfrica – una rural y otra urbana. Se basa en una examinación de la literatura acerca de la violencia sexual en Sudáfrica y el uso de PEP en casos de exposición ocupacional y no ocupacional. Incorpora perspectivas recogidas de entrevistas con 18 informantes claves, incluyendo a sobrevivientes de violencia sexual, activistas pro derechos de género y de las personas viviendo con VIH, ONG que tratan el tema de la violencia doméstica, centros de emergencia para víctimas de violación, doctores, abogados, investigadores y consejeros de VIH/SIDA del Departamento de Salud. Se plantea que dada la evidencia científica sobre PEP, y las características de la doble epidemia de VIH y violencia sexual en Sudáfrica, sobran razones de salud pública y justicia social para implementar PEP. Sin embargo, retrasos en el acceso a PEP causados por el sistema judicial público y la falta de capacitación de los proveedores constituyen obstáculos significativos para su implementación efectiva. La provisión de PEP presenta una oportunidad para reformar y fortalecer los servicios de atención post-violación existentes y para vincular la atención a la epidemia de violencia sexual a la prevención de VIH/SIDA.