Violence against young women and HIV/AIDS: Access to post-exposure prophylaxis after rape in South Africa

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INTRODUCTION

Post-exposure prophylaxis after rape to reduce the risk of HIV infection has been identified as a key health intervention to alleviate the impact of violence and HIV on women. In April 2002, after intense lobbying and advocacy by various role players, the South African government committed itself to providing post-exposure prophylaxis for rape survivors.[2] Future challenges include ensuring widespread implementation of the policy and creating knowledge of and easy access to these services. A key challenge is the need to spread awareness amongst younger women of their right to make reproductive and sexual health choices and, to create an enabling environment within which they can exercise their choices.

The South African Constitution entitles everyone to the right to access health care services subject to available resources and progressive realization. Various organisations in South Africa have campaigned to define the right and broaden the parameters of what government would be willing to provide. The Constitutional Court case of the Treatment Action Campaign (TAC) extended the interpretation of the right to health care to include mother-to-child HIV transmission prevention programmes.[3] Similarly the eventual decision to provide post-exposure prophylaxis (PEP) for rape survivors to reduce the risk of HIV transmission as a result of rape, broadened the scope of services provided at public health care level.[4] Existing government guidelines provide for the prevention and treatment of opportunistic infections in people living with HIV/AIDS, but do not extend to antiretrovirals to manage HIV itself. The campaign for the recognition of the health care rights of people living with HIV/AIDS has been long and tenuous. In addition to the campaigns for antiretroviral treatment, there is a need to focus on implementation to ensure that hard-won rights are realised, as evidenced by the lack of opportunistic infection drugs and the limited roll-out of sites for voluntary counseling and testing, post-exposure prophylaxis for rape survivors and mother-to-child transmission prevention. Many of these campaigns are paralleled on international level. There is a real need to

cooperate and network between countries and to share scientific, legal and lobbying experiences, towards the achievement of the right to affordable and accessible health care for all.[5]

This paper touches on some of the aspects affecting the accessibility of post-exposure prophylaxis for young women. Whilst the paper looks specifically at the provision of post-exposure prophylaxis (PEP) to reduce the risk of HIV, women would similarly need prophylaxis to prevent the risk of pregnancy and sexually transmitted infections (STIs), measures which are currently slightly more accessible to women who have been sexually assaulted. Similarly the paper focuses on PEP after rape and the scope of the paper does not allow a more detailed look at the need for PEP after many other forms of sexual coercion, a common occurrence for women. Lastly, the paper focuses on PEP and to a more limited extent on other health services that should be available to women who have been raped and does not attempt to address the many criminal justice issues faced by rape survivors.

PROBLEM STATEMENT

Rape is common in South Africa, as are many other forms of sexual coercion. Power relations are unfavourably balanced against young women who make up a large portion of the people who are subjected to these forms of violence. Violence against women has serious consequences for women's health including the risk of HIV infection. Women's vulnerability to violence and HIV is compounded by poverty and their subordinate status generally and within relationships. Addressing this requires both a short-term approach to reduce the spread of HIV and its impact on women and a longer-term approach that challenges and transforms gender inequalities and power relations. Current responses to HIV and violence against women runs parallel and are not complementary, with the specific needs of young women often neglected by both.

Access to health care services for rape survivors is restricted in many respects. In its *Report on Violence Against Women* the Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women (2002), based on submissions from various organizations, noted that women in historically white and urban centers have easier access to health services, whilst rural women experience particular problems around transport to clinics, hospitals and police stations. The report also noted a number of inadequacies with regard to the collection and beneficial use of forensic evidence collected in rape cases. Long waiting periods is another common problem. The Committee noted the frequent absence of post-sexual exposure prophylaxis for pregnancy

and sexually transmitted infections as well as the non-availability of post-exposure prophylaxis to reduce the risk of HIV infection. Rape survivors are seldom explained what health risks they face and the treatment available for it. The lack of counseling for rape survivors remains a concern.[6]

Various studies have revealed the extent of rape in South Africa. Whilst exact statistics vary between studies, it is generally accepted that more than half of rapes occur over weekends and after dark and many survivors know their attackers. Weapons are often used in attacks to threaten women (Denny, 2001).[7] Rape or coercive sex is the norm for many young women.

Women attending tertiary institutions are at risk of rape in many situations: on the residences, at student gatherings, on campus, especially when working late or over weekends, in their communities, within relationships and on their way to and from campus. The physical structure of tertiary institutions, large buildings, inadequate lighting, dark corners, empty spaces and distance from communities, already poses a risk to young women, who would inevitably find themselves alone on campus at various stages during their studies. Women who live on residences face similar problems, compounded by their continued exposure to strangers or aggressive men, especially since tertiary institutions often house a couple of thousand students at a time. The risk of being raped extends to relationships where sexual coercion is often accepted as an inevitability by many women, especially those dependant on the financial resources of men on campus for food and other basic necessities, a dire need of many young women who manage to reach universities and other tertiary institutions. Women's marginalisation on campuses, especially if they come from other areas in the country, increases their vulnerability. The risk of rape faced by young students extends far beyond the borders of the campus, into the communities from which they come and virtually every other space they might occupy.

At the same time, young women are most at risk of HIV infection. The South African Antenatal Clinic Survey estimates the total prevalence rate of HIV at 24,8 percent (Department of Health, 2002). HIV is unevenly distributed between age groups and provinces[8]. It is estimated that 15,4 percent of women under 20 years, 28,4 percent of women between 20 and 24 years and 31,4 per cent of women between 25 and 29 years are living with HIV/AIDS.

It is essential that women who are HIV positive, receive adequate treatment and support to enable them to live healthy and productive lives. It is also essential that any threat to women's

health be addressed in a coherent and urgent manner, as envisaged by many human rights instruments. Preventing the risk of HIV infection after rape is one such health measure which women should be made aware of and should have access to. Whilst post-exposure prophylaxis after rape is theoretically available to women in South Africa, young women's physical access to this possibility remains severely constrained. In this regard it can be argued that tertiary institutions, as public institutions, have a specific responsibility where students are raped to ensure speedy access to health services including PEP to prevent HIV infection. The availability of such services are however negligible at tertiary institution level and a quick survey of technikons and universities revealed inadequate health services for women who have experienced violence, with many institutions lacking specific rape and HIV/AIDS policies.

The University of the Western Cape's HIV/AIDS policy explicitly provides for PEP after rape in situations where students are unable to access it at public health facilities.[9] In any event the University is committed to providing at least a starter pack for immediate use as well as other emergency services. The University's policy could serve as a useful guide on the extent to which Universities can and should take responsibility for health service provision, especially in emergency situations. It also acknowledges that the absence of such services for rape survivors could contribute to their further marginalisation on campus and decrease their ability to participate and perform on campus and in society. Similarly lack of access to services for students living with HIV could potentially hamper their inclusion in academic life on campus and place them at a distinct disadvantage compared to other students.

Women who have been raped often experience a wide range of difficulties when trying to access health services and support. This negatively impacts on their awareness of other health risks associated with rape, including HIV, and their ability to choose to take measures to reduce these risks. Problems cluster around issues such as knowledge, availability, accessibility, acceptability and affordability of services.

ACCESSING RIGHTS: SOME KEY CONCERNS AND DEMANDS

The *South African Constitution* 108 of 1996 makes explicit provision for the right to health care and privacy, as well as the right to freedom from violence and control over your body. Section 7(2)[10] of the Constitution places a responsibility on government to ensure protection and

realization of these rights. Two important points can be made with regard to young women's right to post-exposure prophylaxis to reduce the risk of HIV infection:

- **Although PEP is available to women on a policy level, this means nothing in the absence of measures to ensure its availability and accessibility to young women;**

- **Young women cannot exercise the choice to use PEP if they are not informed of this option and of their right to access it.**

Current policies on PEP after rape

McKerrow (2002, p18) explains that the rationale for PEP lies in four elements:

- The way in which HIV develops, which provides a 2-5 day window of opportunity to prevent HIV infection.
- The efficacy of PEP as tested in animals, based on the time between the exposure and the taking of PEP, the length of therapy and the choice of therapy (Stein, 2000).
- Evidence of efficacy of PEP in humans after occupational exposure and when used to prevent MTCT.
- The risks including side-effects measured against the benefits of possibly preventing HIV infection.

Although only anecdotal evidence of the efficacy of PEP for rape survivors exists in South Africa, it is generally accepted that it could be used provided it is not used in cases of low risk or more than 72 hours after exposure.

McKerrow (2002) notes that for PEP to succeed, broad awareness and openness around issues of rape, HIV and PEP is essential. One need early disclosure of sexual abuse, early presentation at health services and a commitment to PEP within health services.

The existing National Health Guidelines on dealing with rape survivors requires the Department of Health to provide physical and psychological care for rape survivors and to collect medico-legal evidence that would be sufficient to prosecute a perpetrator. Rape survivors who present at a health facility should be treated with dignity and their statements should be assumed true. Accredited health care providers should introduce themselves to the rape survivor, take a

detailed medical history and history of the incident and explain the nature of the exam to obtain forensic evidence – consent must first be obtained. After examination emergency medical treatment should be provided and prophylaxis for STIs and pregnancy. Rape survivors should be given a letter to attend a family planning clinic after her next menstruation, information on follow up services, and referral to appropriate counseling services. Rape survivors should also be counseled on the possibility of HIV infection and the need for voluntary counseling and testing. They should be offered medical certificates for school/work and informed of complaint mechanisms. A health care worker must call the police if a woman wants to lay charges.

The guideline does not include prophylaxis to prevent HIV and for many years the Department of Health refused access to post-exposure prophylaxis for rape survivors. In her address to the National Assembly on 16 November 1999, the National Minister of health, Dr ME Tshabalala-Msimang, stated that the government does not supply AZT (zidovudine) (generally used with other drugs) to pregnant women, and people who may have been infected through needle stick injuries or through rape because of the absence of research on the possible harmful side-effects of AZT, affordability and the fact that AZT was not registered for use in the case of rape survivors (Parliament, 2002). In terms of the Department of Health's rape protocol and a separate protocol on administering of PEP after rape that was released in May 2002, PEP is now legally accessible for women who have been raped. In practice, access is unfortunately not guaranteed.

In November 2000, the Western Cape Department of Health published its policy and standard guidelines on the management of rape survivors with the aim that by June 2001 at least 2 districts per region would provide a comprehensive service through use of local resources to rape survivors in terms of the guidelines. "Central to the policy on medical, psychological and forensic management is the recognition that the management of rape survivors requires special training and expertise, as well as an integrated management approach. This guiding principle will impact on the consequences of a survivor's future mental and physical well being and in the arrest and ultimate conviction of the perpetrator of such violence" (Western Cape Department of Health, 2000). The Policy was developed on request of health workers and NGOs by the Provincial Reference Group established in 1999 and consisting of primary health care workers, gynaecologists, forensic pathologists, psychologists, health managers, NGOs and legal advisors. Drafts of the policy and guidelines were distributed to regions, NGOs and other role players for

input and comment. The implementation of the guideline was piloted at the Thuthuzela (24 hour) rape center at GF Jooste Hospital, in Cape Town.[11]

Making informed choices

Section 12(2)(b) of the *Constitution* entitles everyone to bodily and psychological integrity, which includes the right to security in and control over their body. This and other rights in the *Constitution* means little to a woman who has been raped if she is unaware of her rights or lacks sufficient information to be able to act thereon. The right encompasses two requirements: adequate information to exercise a choice in health care and the ability to freely give or withhold consent for treatment (Cook, 1994, p25).

The various health risks faced by a rape survivor requires adequate information to enable her to make choices on the appropriate treatment to deal with such risks. Such information should ideally be provided in general public health messages and in all educational institutions to ensure that everyone is aware of the range of services available at a time of crisis. Specific information tailored to the particular situation of the rape survivor is necessary when she accesses health services. This should include adequate information about the risk of HIV infection and the benefits and disadvantages of PEP.

The government's obligation to protect and promote the right to security and control over one's body, implies that information is not an end in itself. A person who has been raped should be given adequate information to enable her to make decisions. It is not enough that she knows that PEP exists, she must be aware of the facilities which offer this and be able to access it if she so chooses. Promoting informed consent goes hand in hand with ensuring implementation of PEP.

Health services should also be acceptable, if it is to enable women to exercise their choices. The *Beijing Platform of Action* (United Nations, 1995, par 22) states "parties should also report on measures taken to ensure access to quality health services, for example, by making them acceptable to women. Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[12]

Tertiary institutions have a particular role to play in providing access to information to all its students and staff. It also has a unique opportunity to instill a framework of rights in their students that they would take with them back to their communities. Some institutions like the Peninsula Technikon, goes a step further and has trained several of its students as peer educators on HIV/AIDS in communities. There are ample opportunities to spread awareness on HIV/AIDS and violence against women and to promote a human rights culture. Taking positive action and seizing these opportunities are essential if we want to challenge the HIV/AIDS epidemic and curtail the pervasiveness of violence against women.

Ensuring implementation of PEP

In a recent Constitutional Court case on the right to housing[13], the Court stated that government policies should take into consideration various factors when implementing a socio-economic right, ensuring earlier access to those most in need and, where not otherwise possible, gradually improving access until the entire population have equal access to such a right. The Constitutional Court case assessing the government's obligation to institute a programme for pregnant women with HIV to reduce their infants' risk of possible infection[14], elaborated on this issue, requiring that the plan to implement a policy should have clear time-frames to ensure eventual access to everyone. In that case the Court ruled that, while a comprehensive mother-to-child transmission prevention programme should progressively be implemented, the government should also immediately ensure that pregnant women who need it, can access Nevirapine at state facilities, which requires a concomitant rapid expansion of the availability of voluntary counseling and HIV testing.

To date no comprehensive plan for the implementation of PEP exists. Guidelines exist on how PEP should be administered, but many other factors still influence whether a woman in fact has access to PEP after rape. Few women are aware of the need to present at a health facility within 72 hours after the rape to access PEP. After the incident, the immediate health concerns are around specific injuries and, where a woman reported the rape, attending a medico-legal examination. Whilst access to PEP for pregnancy and STIs, as well counseling, are important, where women are not specifically offered this service, they might not be aware of their right thereto, the usefulness thereof and its availability. The same applies to PEP to prevent HIV. This means that many of the health risks faced by women are not adequately addressed, especially in the case of young women.

The Constitutional Court case of *Grootboom*, required that government ensure that specific measures are in place to assist access for the most vulnerable groups. In *Grootboom* the Court held that -

> To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right (par 44).

This is an important guideline for any government when planning implementation of a policy to provide PEP after rape. Young women, as a particular vulnerable grouping, have particular needs with regard to accessing health services that should be friendly and sensitive towards them and ease their physical and psychological pain. The policy to provide PEP, in the absence of any attempt to broaden its scope to young women, especially those whose access to health services are limited as a result of cost, transport or a multitude of other barriers, will be purely of 'symbolic' value, as is the case with so many health services provided to women, especially in response to gender-based violence cases.

The *Grootboom* case continued that a programme for the realisation of socio-economic rights

> Must be balanced and flexible and make appropriate provision for attention to . . . crises and to short, medium and long term needs. A programme that excludes a significant segment of society cannot be said to be reasonable (par 43).

In the *Treatment Action Campaign* (TAC) case, the Constitutional Court insisted that "there is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences" (par 70).

Some provinces, Gauteng and Western Cape, have announced programmes to progressively realise the rights of rape survivors to PEP to prevent HIV, yet no national strategy for implementation exists. An implementation plan for the Western Cape for instance encompasses specific sites for immediate implementation and a clear time-frame indicating at what stage all facilities should provide PEP. Additional issues to be covered at the implementation stage would be the training of health care workers on the rape and PEP protocols, and the equipment of facilities with adequate resources, human, financial, and other wise, to enable them to perform this additional service with ease. The specific antiretrovirals used to prevent HIV after rape, should be easily available in facilities, requiring comprehensive plans around drug procuring and distribution, as well as the addition of these drugs to the essential drugs list. Unfortunately so

many medicines on the essential drugs list are unavailable to patients, especially medicines used to treat opportunistic infections. This is partly due to the wide disparities in the health care system between areas and facilities, with some hospitals easily affording such medicines whilst others struggle for running water and electricity. The spirited comments of the Constitutional Court in the *Treatment Action Campaign* case is of note in this regard -

> The magnitude of the HIV/AIDS challenge facing the country calls for a concerted, co-ordinated and co-operative national effort in which government in each of its three spheres and the panoply of resources and skills of civil society are marshalled, inspired and led. This can be achieved only if there is proper communication, especially by government. In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately (par 123).

I submit that the section 27(1)(a) entitling everyone to access to health care services, including reproductive health care, read with section 27(2) which states that "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights," entitles a person who have been raped to the provision of PEP. The South African Law Commission, in its recommendation on PEP, went one step further and argued that PEP should be provided free of charge since the State failed in its obligation to prevent violence. To the extent that women can access PEP at public facilities, they do not have to pay for it. What is needed is a comprehensive plan to ensure implementation of the policy on PEP after rape. The extension of PEP to other forms of sexual violence should also be considered.

The obligations impose by article 12 of *the International Covenant on Economic, Social and Cultural Rights* (United Nations, 1966) indicates a similar duty on States to take progressive measures to realize the right to health.[15] General Comment 14 of the Committee on Economic, Social and Cultural Rights states that core obligations on States would at least include a) to ensure access of health facilities especially for vulnerable groups; d) essential drugs; e) equitable distribution of health facilities and services; f) adopt and implement a national public health strategy and plan of action, giving particular attention to all vulnerable and marginalized groups (par 43). Article 16 of the *African Charter on Human and Peoples' Rights* (Organisation of African Unity, 1981) also indicates a duty to protect health.[16]

Article 12(1) of the *Convention on the Elimination of All Forms of Discrimination against Women* (United Nations, 1979) states that: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality between men and women, access to health care services, including those related to family planning." General Recommendation No. 24 (United Nations, 1999) specifically elaborates on the content of Article 12 of CEDAW: "The duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realise their right to health care" (par 17). States are also required to eliminate any barriers women face in gaining access to health care services and take measures to ensure their timely and affordable access to such services (par 21).

In the absence of PEP that is easily accessible within 72 hours after rape, the role of educational institutions and workplaces in providing PEP to their staff or students should be seriously considered by such institutions. The University of the Western Cape's HIV/AIDS policy provides for the provision of PEP where their students were unable to access it at public health facilities. Whilst the University is based in a province which does have a plan for implementation of PEP, it acknowledges that it is not always easy for a woman to access such services timeously within communities. The limited window of opportunity within which PEP can be administered, requires a pragmatic approach which focuses on the urgent need of a anyone who has been raped, to be able to exercise the choice to use a drug which could prevent a life threatening disease. Tertiary institutions have a range of loopholes that they can use to escape liability for any infringement of the right to freedom from violence which happened on campus. Nevertheless, the potential impact of not providing PEP is great, and any refusal to provide such service could amount to indirect discrimination, especially where other health services are provided to students. Section 8(2) of the *Constitution* states that "a provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right." The Constitution prohibits direct or indirect unfair discrimination against anyone on any of the prohibited or analogous grounds.[17] An analogous ground could be health. The absence of adequate health services for people living with HIV/AIDS or at risk of HIV infection, could contribute to their marginalisation on campus and would hamper their ability to participate in the academic sphere on an equal footing with their peers. Even where there is no direct positive duty on universities to provide such services, the acknowledgement of the marginalisation that such

students face and the duty to promote equal access to services, would necessitate not only an HIV/AIDS policy and rape protocol for each institution, but also a sincere attempt to provide health services to students, especially where such services are absent in their own communities or where they live away from home.

In addition section 12(1)(c) of the Bill of Rights states that "everyone has the right to freedom and security of the person, which includes the right to be free from all forms of violence from either public or private sources." All educational institutions and workplaces should take positive measures to prevent violence against women on their premises. This can encompass a range of actions including improving security measures, placing additional lights on the premises, and warning students and staff of the risk of violence. A speedy response to assist a person who has been raped, would include informing such person of the need to access health services and to assist such student in accessing this service. In the University of the Western Cape example, many security and residence staff have been trained to deal with rape cases, to ensure support after hours. This is especially needed since many women live on the residences and will find it difficult to access police and health services on their own after hours.

WHAT HEALTH SERVICES SHOULD BE AVAILABLE TO WOMEN WHO HAVE BEEN RAPED?

Some existing facilities provide a role model of service provision for rape survivors. To ensure that young women are able to access health services including PEP, requires a detailed analysis of their needs and a thorough investigation of the key factors which hampers young women's access to such services. Services should recognize and address the following key factors: **Accessibility, Affordability, Availability**, and **Acceptability.**

Tanya Jacobs (2002) identifies some challenges and shortfalls within the public health system in addressing violence against women, including:

- Fragmentation of service provision.
- Lack of effective management of physical and emotional needs of the complainant.
- Lack of insight and subsequent frustrations of service providers, incorrect notions of blame and responsibility.
- Poor/inefficient referral systems between criminal justice system and health sectors.
- Difficulty in accessing services.

- Health care workers lack information and training.
- Poor intersectoral collaboration between the health sector and non-governmental organisations (NGOs), and community based organisations (CBOs).
- Problems with regard to resource allocation.
- Women's experiences and barriers to access health and other services need to be heard and inform change.
- Health care workers must be supported professionally and personally to maximize assistance to women.

The International Planned Parenthood Federation's *Sexual Rights Charter* suggests that the right of every person to sexual and reproductive health care should include:

- Access to the widest possible range of services
- Choice to decide whether to use services
- Safety concerning the methods and services made available
- Privacy when being offered information and services
- Confidentiality regarding personal information
- Dignity when using sexual and reproductive health care services
- Comfort concerning the quality of care of services offered
- Continuity guaranteeing future availability of services
- Opinions about the service offered

In this context, the following issues deserve consideration. This is not an exhaustive list and many other factors could be added:

Improved health care worker attitudes and service delivery:

Whilst resources might drive the implementation of many services, rape survivors have the right to expect kindness and sensitivity from health care workers. In this regard there is a need to sensitize health care workers on gender issues. This requires in-service training of clinical staff and front-line support staff. Health care worker recruitment should take these values into consideration, and health care workers should face disciplinary procedures where a patient's right to dignity has been infringed (Jewkes, 2001). Health care workers should especially be sensitized to the needs of young women who are often ignored or overlooked when presenting with complaints. The emotional difficulties faced by young women when accessing services

should be addressed and young women's right to health services should be respected. The type of service offered should be acceptable to young women and student friendly.

Given the disjointed nature of services and the disparities between services offered in different areas, quick and efficient referral systems are needed. Such services must be accessible, and where possible, the travel of trained medical or counseling staff to the facilities where rape survivors are situated, should be investigated. It seems outrageous that traumatized rape survivors should be sent from one facility to the next to ensure access to all the relevant services. Especially in the case of young women, there is a real possibility that they will give up seeking assistance where services are too difficult to access. This is especially the case since young women are often unaware of the health risks they face and the health services available to them.

Confidentiality is an essential part of service provision. Rape survivors, especially young women, might feel less inclined to access services where they perceive a possibility that their sexual experiences might be related to other people. If young women are to freely access services, they will need full assurance that confidentiality will be maintained. All services *must* be private and confidential, including information on whether a person went for HIV testing and what services she chose to access. The HIV status of a woman prior to rape or after rape should not be disclosed to police or judicial services without a woman's permission.

It has been suggested that rape survivors access accredited health care workers. Such health care workers could retain competence in conducting sexual assault examinations if they are required to perform a minimum of about 50 examinations per year in an attempt to maintain minimum standards (Christofides, 2002). Health care workers also need support services to prevent burn-out and a decrease in staff morale. The mother-to-child HIV transmission prevention programmes have shown the extent to which health care workers' morale is increased once they are given the opportunity to deliver a comprehensive service. One health care worker who submitted a statement in the *Treatment Action Campaign* case, testified that she felt as if the package she was giving women was naked since she was aware that treatment existed that could reduce the risk of mother-to-child transmission of HIV, but was prohibited from providing it.

For health care workers to discuss sensitive issues with patients at such a distressing time requires communication skills which should be taught during the initial training of doctors and nurses. Health care workers should not only be able to conduct an HIV test and offer pre- and

post-test counseling, but they should also provide specific adherence and risk-reduction counseling in the case of PEP. Since such a large percentage of women who want to access PEP after rape will already be HIV positive and not be entitled to this, health care workers should be sensitive to their particular needs and provide appropriate counseling and referral. The psychological support required by a woman who has been raped and, within hours of the incident, for the first time found out her HIV status, needs urgent attention. It has been recommended that HIV testing and pre-test counseling in severely traumatized cases be delayed for 24-48 hours (Denny, 2002). Rape should be treated as an emergency irrespective of whether or not there are any visible injuries.

Accessible services:

Ideally any person who have been raped should have easy access to 24 hour, one-stop services. Such facilities should ensure reasonable access to same language personnel and transport facilities.

The Thuthuzela Centre at Jooste Hospital in Manenberg, Cape Town, was initiated as a pilot project in June 2000. It serves rape survivors and aims to provide a comprehensive service that gives them dignified treatment and ensure effective prosecution. Once a person who has been raped reports the crime at any participating police station, an ambulance is immediately called to take her to the Thuthuzela Care Centre and she is escorted to a special room to wait for the ambulance. The Centre is housed in a local hospital with a medical examination room, bathing facilities and a small kitchen. Again the survivor is made comfortable and examined in a private room. She is offered an HIV test and provided with PEP if she chooses it. After the examination she is given a chance to bathe, change into fresh clothes and eat. The health care worker then counsels the woman on side-effects and adherence and the need to return for the results of an HIV test. She is referred to community groups near her for further counseling. The health care worker will call an investigator to take a statement from the survivor. The woman is then taken home by the investigating officer or ambulance driver (Pithy, 2001). Prosecutors are also closely involved in the process and often guide investigating officers or personally speak to rape survivors at this early stage of the proceedings. A similar pilot project has also been set up in the Eastern Cape.

Adequate medical treatment:

Sexual assault should be treated as an emergency, even in the absence of visible injuries. Any person who has been raped requires psychological support and adequate medical care. Women should be told of the need for emergency contraception[18] as well as their right to have an abortion and how to obtain one if they present late or if emergency contraception failed.

All facilities should offer rapid in-house HIV antibody testing as well as STI screening and treatment and antiviral therapy to prevent HIV infection. It is important that measures are put in place to ensure adherence to the 28 day antiretroviral regimen and to encourage women to return for HIV testing and blood tests to detect negative reactions to the medication. Women should be adequately counseled on side effects and how to treat them. The difficulty of taking medication for injuries as well as to prevent STIs, HIV *and* pregnancy, should be acknowledged and an individualized approach should be followed which addresses the needs of each survivor. Advice on the risk of HIV infection and the regimen prescribed, often depends on the rape itself: whether there was a single or multiple perpetrators, genital or other injuries, anal or vaginal penetration, ejaculation or multiple acts of penetration. This requires that health care workers listen attentively and sensitively to rape survivors. The delay between rape and medical care is problematic since it negatively affects the efficacy of prophylaxis. It is therefore essential that women be referred from police stations to health centers immediately, and that they receive immediate assistance at health facilities. The approach of the University of the Western Cape indicates a willingness to deal with this problem by prioritizing health facility access and treatment in rape cases.

Sufficient information to ensure informed choices:

Knowledge is key to enabling young women to enforce their rights. Literature on rape and HIV should be understandable in all languages and for people with all levels of literacy skills. As information on sexual and reproductive health increase, it is entirely possible that existing health service delivery points will prove inadequate to deal with the demands of young people, an important factor which should be addressed.

Education and information materials on HIV and gender-based violence should be sensitive to the systemic inequality experienced by women. At the moment few sources of information adequately link HIV and sexual violence in a way that provides actionable information for

young women. In this regard various studies have pointed to the effectiveness of peer education as a means of encouraging discussion on HIV and sexual violence and improving attitudes towards those who are living with HIV/AIDS.

Improving cost:

In September 2002, the Treatment Action Campaign and other civil society organisations lodged a complaint with the South African Competition Commission against the excessive pricing by two pharmaceutical companies: GlaxoSmithKline (GSK) and Boehringer Ingelheim. GSK manufactures AZT and Lamivudine, antiretrovirals used to prevent HIV infection from needle stick injuries and rape, as well as to treat people living with HIV. The papers of the applicants, compare the price of these medicines in the private sector, the international best price offer of the branded product, the WHO qualified generic price and the best international price for the generic (TAC, 2002b, par 44):

Product	***Price sold to private sector***	***International Best Price Offer – branded product***	***WHO pre-qualified generic***	***International Best Price Offer – generic***
AZT (300mg)	ZAR 9,70 (US$ 0,92)	(ZAR 6,30) US$ 0,60	(ZAR 2,59) US$ 0,25	(ZAR 2,01) US$ 0,19
Lamivudine (150mg)	ZAR 10,67 (US$ 1,02)	(ZAR 3,36) US$ 0,32	(ZAR 1,46) US$ 0,14	(ZAR 0,95) US$ 0,09
AZT/lamivudine (300mg/150mg)	ZAR 13,33 (US$ 1,27)	(ZAR 8,93) US$ 0,85	(ZAR 3,81) US$ 0,36	(ZAR 2,93) US$ 0,28

Whilst a person who has been raped can access PEP free of charge at public health facilities, its prohibitive costs might limit the extent to which it is available at those facilities.

Since Medical Schemes must, in terms of the *Medical Schemes Act* 131 of 1998, provide those services that are available at public health facilities, PEP should now also be covered under Medical Schemes. Research conducted by the Treatment Action Campaign indicates that PEP is already offered by 96 percent of medical schemes and 80 percent offer access to HIV testing and counseling (TAC, 2002a). Unfortunately beneficiaries under medical aid schemes are often unaware of these benefits.

To ensure adequate service provision the involvement of staff at provincial and local government level in policy-making and budget allocation is essential. Health worker morale is generally low and staff providing services need to be supported and involved in planning

implementation instead of simply requiring them to provide additional services (Klugman & McIntyre, 2000).

The *Medicines and Related Substances Control Amendment Act* 90 of 1997, which was the subject of a drawn-out court case by the Pharmaceutical Manufacturers Association, provides for generic substitution of medicines that are no longer under patent, a pricing committee to ensure transparent pricing mechanisms, parallel importation and international tendering for medicines used in the public sector. This Act has the potential to facilitate cheaper access to antiretroviral medication as well as other essential drugs.

CONCLUSION

There is a real need to focus on ensuring that young women are able to access PEP. Apart from safer sex messages, little attention is paid to informing young women of their health rights and how to act on it. Currently females aged 15-39 in South Africa die primarily of HIV infection (STATSSA, 2002). Any measure that could prevent HIV infection should be actively pursued. In addition, the needs of people living with HIV, especially young women, cannot be ignored and every effort should be made to provide them with treatment. Universities and other tertiary institutions should attempt to provide access to PEP after rape and other health services to their students. HIV testing and counseling should be encouraged and health information should be widely distributed. All this should happen within a human rights framework that discourages any form of discrimination against people living with HIV/AIDS and people who have been subjected to sexual violence. The window of opportunity available to tertiary institutions to reduce the risk of HIV infection in students who have been raped, should not be missed. The benefits of such a health intervention far outweighs any possible disadvantages and could provide women who have been raped with an opportunity to reclaim their lives.

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Medical Schemes Act 131 of 1998

Medicines and Related Substances Control Act 90 of 1997

South African Constitution 108 of 1996

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[2] On 17 April 2002 the South African Cabinet released a statement on HIV/AIDS indicating a significant change to the government's stance on HIV/AIDS. With regard to rape survivors the statement noted that "government will endeavour to provide a comprehensive package of care for victims, including counseling, testing for HIV, pregnancy and STIs. In this regard, survivors will be counseled, including on the risks of using anti-retrovirals as preventative drugs, so they can make an informed choice. If they so choose (as is the case of needle-stick injuries), they will be provided with such drugs in public health institutions." A corresponding protocol was released at the end of May 2002, requiring provinces to implement PEP once the necessary ground work has been done.

[3] *Minister of Health v Treatment Action Campaign and others* CCT 8/02, judgment 5 July 2002, http://www.concourt.gov.za, see also the Treatment action Campaign website for more information about this and other campaigns: http://www.tac.org.za

[4] It also broadened the scope of what is legally required at private health care level in terms of the *Medical Schemes Act* 131 of 1998 which obliges private institutions to provide as a minimum, that which is available at public health care level.

[5] Refer to the *Pan-African HIV/AIDS Treatment Access Movement's Declaration of Action*, released by activists from 21 African countries that met in Cape Town, South Africa from 22-24 August 2002. For more information visit the Treatment Action Campaign website http://www.tac.org.za.

[6] A Medical Research Council evaluation of medico-legal services in Gauteng revealed that service provision at medico-legal clinics do not meet minimum standards of care. Concerns include access problems, insensitive treatment of rape survivors, inadequate training and disparities between facilities (Suffla, 2001).

[7] Lynette Denny in presentation to Joint Monitoring Committee on Improvement of Quality of Life and Status of Women revealed that preliminary assessment of data from the Western Cape provincial rape protocol shows that many women do not report rape. Only 50 percent of women present at a medical facility within 24 hours of rape. Forty percent of women are raped by more than one perpetrator and more than 60 percent have evidence of general bodily injuries and/or injury to the genital tract. Less than half off women return for follow up.

[8] For example Kwa Zulu Natal Province has a prevalence rate of 33,5 percent of Antenatal clinic attendees, Gauteng 29,8 percent, Eastern Cape 21.7 percent, and the Western Cape 8,6 percent.

[9] It is estimated that 1372 or 13,8% of the University of the Western Cape's student population is HIV positive. In terms of its HIV/AIDS policy staff and students have access to free testing and counseling related to HIV/AIDS during normal working hours, support groups are encouraged and condoms are freely available at various locations. The University has committed itself to the provision of HIV prophylaxis "where clinically appropriate in cases of potential exposure to HIV and when these are not provided by the state medical services as a result of rape or assault that occurs on campus." In terms of Appendix 2 of the University's HIV/AIDS policy, incidents must be reported to the local police or on campus security and survivors should be referred to a doctor to ascertain risk of HIV exposure and determine if prophylaxis is necessary. If the student consents, PEP is administered as a precautionary measure within 4-8 hours but preferably within 1-2 hours of exposure. The student must be fully informed of advantages, disadvantages and side effects. The favoured PEP regimen is AZT (Zidovudine) 200mg every 8 hours and 3TC (Lamivudine) 150 mg every 12 hours for 4 weeks, plus Indinavir 800mg every 8 hours if exposure especially hazardous. Treatment must be prescribed and emergency starter packs may only be issued under order of authorized health personnel. Three day emergency starter-packs of AZT and 3TC will be available at the campus health center or chief fire officer for after hours access only if not provided by an outside facility and on recommendation of a doctor. PEP will only be provided to a person who is HIV negative. The University Rape Protocol places a duty on personnel to whom the rape was reported to make sure access to PEP is obtained preferably within 2 hours of assault. Various staff have undergone rape crisis training at residences and campus protection services and there is a referral list to organizations who work with rape survivors.

[10] Section 7(2) states that "(t)he state must respect, protect, promote and fulfil the rights in the Bill of Rights.

[11] The policy noted that "historically the management of rape survivors has been sub-optimal on many levels that include:

- Lack of access to adequate facilities for examination and treatment.
- Inadequate knowledge and understanding and/or guidelines on the management and consequences of rape.
- Poor quality performance and documentation of the forensic examination resulting in poor quality evidence presented to the courts thus contributing to the low conviction of rapists.
- Secondary traumatisation of survivors by fragmented, dysfunctional systems resulting in survivors who are either sub-optimally cared for or not cared for at all.
- In some areas District Surgeons have provided a forensic service but not a clinical one, resulting in survivors being referred to other institutions for treatment of sexually transmitted infections and pregnancy prevention, this caused unacceptable delays and increased trauma to the survivors.
- Examination of the survivor in an emergency room or trauma unit has meant that the person has to queue for services resulting in delays and increased psychological trauma."

Equipment and drugs needed include a private or designated room, equipment and stationary for forensic evidence, and AZT register and preprinted forms, access to emergency care and a telephone, emergency contraception, syndromic management of STIs, AZT, paracetemol, tranquilizers, access to bath/shower and/or toilet facilities, emergency clothing and/or underwear, sanitary towels, soap and towels, posters, pamphlets and information about rape, counseling and human rights and a directory of local resources. Treatment guidelines for the use of AZT for prevention of the transmission of HIV in the management of survivors of rape accompanies the policy. (Western Cape Department of Health, 2000)

[12] The *Beijing Declaration* and *Platform of Action* has been endorsed by the vast majority of governments and it has been maintained that it embodies "globally accepted policy norms and recommendations" (Eriksson, 2000, p178).

[13] *Government of the Republic of South Africa and others v Grootboom and others* CCT 11/00, judgment date 4 October 2000, 2000 (11) BCLR 1169 (CC) available at http://www.concourt.gov.za

[14] *Minister of Health v Treatment Action Campaign and others* CCT 8/02, judgment date 5 July 2002, http://www.concourt.gov.za

[15] Article 12 (1) states that "States Parties to the present Covenant recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Article 12 (2) continues "steps to be taken by States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: © the prevention, treatment and control of epidemic, endemic, occupational and other diseases, (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

[16] Article 16 (1) states that "every individual shall have the right to enjoy the best attainable state of physical and mental health. Article 16 (2) continues that "States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

[17] Section 9(3) provides: "The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth." Section 9(4) provides: "No person may unfairly discriminate directly or indirectly against anyone on one or more of the grounds in terms of subsection (3)."

[18] A recent study indicated that only about one if four women attending public sector clinics have heard of emergency contraception and few knew whether it was available at the specific facility they were questioned at (Smit, 2001).