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Practice paper

Implementing the right to post-exposure prophylaxis for HIV prevention in a broken system: lessons from a community-based organisation in South Africa

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What is known on this subject

- HIV and sexual assault pose huge public health challenges to the South African healthcare system.
- Post-exposure prophylaxis (PEP) for HIV prevention after sexual assault is a right under South African laws, and can be accessed at various designated sites.
- Failure by most survivors to access and adhere to PEP is due to various barriers to access, including capacity and lack of knowledge among both survivors and service providers.

What this paper adds

- It describes the challenges and unique barriers in the delivery of post-rape services in an under-resourced rural area.
- It highlights innovative strategies aimed at addressing the challenges and increasing the uptake, adherence to and completion of PEP.
- It offers a potential model for replication in under-resourced areas in the provision of post-rape services.

ABSTRACT

The Thohoyandou Victim Empowerment Programme (TVEP) is a non-governmental organisation that was established in 1997. The organisation facilitates the provision of urgent medico-legal and psychosocial support to survivors of sexual and gender-based violence at two trauma centres at public hospitals in rural Thohoyandou, Limpopo. South Africa's sexual offences legislation confers the right to post-exposure prophylaxis (PEP), within 72 hours, to prevent HIV infection among rape survivors. However, various institutional and practical challenges obstruct access and/or adherence to this treatment within the crucial time limit. Although these challenges include lack of awareness about PEP among both survivors and professionals, the main problem is the inability of individual provider institutions to meet patients' needs, especially in rural areas.

This paper describes the framework within which PEP is provided in South Africa, rape survivors' experiences of accessing PEP, and the response of TVEP. The latter has continuously adapted its services to overcome these obstacles and adopted strategies aimed at holding providers accountable to their mandates. TVEP's Zero Tolerance Village Alliance Programme (ZTVA) is aimed at the education and capacitation of community members with regard to their rights and responsibilities as they pertain to sexual assault, domestic violence, child abuse and HIV/AIDS. TVEP promotes a multi-sectoral approach involving the departments of justice, social services, health and non-governmental organisations (NGOs) to ensure the provision of holistic treatment, care and support to rape survivors.

Keywords: HIV, post-exposure prophylaxis (PEP), rape, South Africa

Introduction

In 1997, the Thohoyandou Community Policing Forum together with the South African Police Services (SAPS) initiated the establishment of a Victim Empowerment Committee (VEC) in accordance with the provisions of the National Crime Prevention Strategy. With seed funding from the Department of Health, the SAPS and local business, the first 24/7 One Stop Trauma Centre was opened at a regional hospital in September 2001, and 'Break the Silence' campaigns were initiated. The committee was registered as the Thohoyandou Victim Empowerment Programme (TVEP) in January 2002. Further information about TVEP can be accessed via their website (www.tvep.org.za).

According to Essof (2009), the municipality that is served by the organisation has 585 000 people, one regional and two district hospitals, 48 clinics and 7 police stations. Throughout its 15-year evolution, TVEP has consistently boasted a team of 40 or more staff and 30 or more local volunteers, of whom all but five have been historically disadvantaged South Africans. Voluntary Service Overseas and the US Peace Corps have provided volunteers on a rotating basis to assist in building in-house capacity.

At present, TVEP's objectives include the following:

- the creation of a supportive environment for survivors of sexual assault, domestic violence, child abuse and the HIV/AIDS pandemic
- the education and capacitation of community members about their rights and responsibilities as they pertain to sexual assault, domestic violence, child abuse and HIV/AIDS
- the rehabilitation and empowerment of survivors of sexual assault, domestic violence, child abuse and HIV/AIDS
- the provision of holistic survivor support services to ensure that justice is served
- oversight to ensure that the State delivers on policy mandates.

As part of its activities, TVEP facilitates the provision of urgent medico-legal and psychosocial support to survivors of sexual and gender-based violence at two trauma centres at public hospitals. Based on TVEP Monitoring and Evaluation data for 2012, the centres see an average of 70 survivors on a monthly basis. Children under the age of 18 years usually represent an average of 24 survivors, while women of reproductive age represent a monthly average of 42 survivors. Men also report sexual assault at the two trauma centres, and they usually represent an average of 5 survivors. In most instances, these men will be survivors of sexual assault while in prison or state detention.

This paper focuses on one aspect of the Centre's work, namely the provision of post-exposure prophylaxis (PEP) for victims of rape.

Post-exposure prophylaxis (PEP)

Rape is both a public health problem and a human rights problem in South Africa (Christofides *et al*, 2006). The high prevalence rates of HIV/AIDS and sexual violence in South Africa create a dangerous synergy that puts survivors of sexual violence, particularly rape, at risk of HIV infection. One way to prevent the spread of HIV is to administer PEP, which is defined by the World Health Organization (2007) as short-term antiretroviral treatment aimed at reducing the possibility of HIV infection after potential exposure, either occupationally or through sexual intercourse. It consists of a 28-day course of antiretroviral drugs which has been shown to be efficacious in reducing the risk of HIV transmission. PEP medication is designed to block the replication of HIV after initial exposure to the virus (Smith *et al*, 2005). However, for this to happen and thus provide protection from HIV infection, the medication must be taken within 72 hours of HIV exposure, although scientists agree that the sooner the drugs are initiated, the better (Fong, 2001). In line with the South African laws, PEP and medical advice about PEP should be available free of charge at public health establishments that have been designated by the Department of Health.

Problems in the initiation and delivery of PEP

South Africa has a progressive legal framework that is intended to ensure rape survivors' access to urgent treatment and care. The roles of key personnel, such as police officers and nurses, are clearly specified. However, the provision of PEP is hampered by various challenges, including lack of information and resources. Hospitals are required to coordinate all services for rape survivors, not only within normal working hours but also after hours, during public holidays and at weekends when fewer staff are on duty. In an effort to address the lack of knowledge among communities, TVEP introduced its flagship intervention, the Zero Tolerance Village Alliance (ZTVA) project. The overall aim of the ZTVA is to provide a holistic approach to the eradication of gender- and child-based crime by setting up help desks in 14 clinics that provide educational workshops on women's rights, support sur-

vivors of domestic and sexual assault, and facilitate access to health and justice services. With the awareness workshops being conducted in the heart of communities, the two hospitals in the area would not be able to cope with the demand for post-rape medico-legal services. It is against this background that TVEP partnered with the hospitals to establish two 24/7 one-stop trauma centres. These have proved to be particularly important after hours, during public holidays and at weekends when the hospital is operating with skeleton staffing levels. TVEP employs Victim Advocates (VA) at the trauma centres to provide survivors with debriefing, information and referrals where necessary.

Many healthcare workers do not provide sufficient information on how to take PEP (Abrahams *et al*, 2010), and also do not hand out drugs to treat side effects, such as anti-emetics for nausea, at the survivor's initial visit to the hospital. In TVEP's experience, survivors not only skip individual doses of PEP, but also stop taking PEP altogether because of the severe side effects of the drugs. Numerous studies have reported the practical challenges of delivering PEP, especially in poor, mostly black and disempowered communities.

These challenges include lack of knowledge about PEP among police officers and hospital staff. Vetten and Haffejee (2005) describe the long waiting times experienced by survivors who need to access care, especially at night and at weekends, due to staff shortages, lack of specialised training and limited provision of psychosocial support for survivors. Christofides *et al* (2005) have highlighted problems relating to the lack of prioritisation of sexual assault cases in hospitals. Around 32% of healthcare workers in their study did not view rape as a serious medical condition that requires urgent medical care.

A shortage of vehicles for transport, long waiting times at hospitals and police stations, and limited, over-stretched hospital staff all contribute to delays both in initiating PEP and in attendance at follow-up appointments (Mokwena *et al*, 2007). In rural areas, individuals may have to travel long distances to access PEP and there are fewer health practitioners available to administer it. In some parts of rural Limpopo, certain communities are inaccessible by road, making it impossible for survivors to reach a hospital, as these are usually very far from where they live. In some instances the cost of transport is an obstacle to access. TVEP currently provides survivors with a free return ticket that enables them to obtain free transport to hospitals where they access PEP and long-term counselling and support.

Another concern is that police officers delay the initiation of PEP by taking statements before transporting rape survivors to hospital. TVEP has tried to address this delay by negotiating a protocol which stipulates that the medical examination and administration of treatment must take priority over the investigation of the crime. This protocol has been accepted by the inter-sectoral stakeholder group, which consists of members of the key government and civil society agencies involved in the provision of post-rape medico-legal services (i.e. medical doctors, nurses, social workers, the police and justice representatives).

TVEP has also ensured that the trauma centres have space for a police officer to be stationed on the premises, as this allows police officers to take statements at the hospital, after the examination. However, some members of the South African Police Services (SAPS) seem to be unaware of the protocol and insist on taking a statement before taking the survivor to hospital.

Despite these initiatives and the stakeholder meetings, there seems to be a lot of confusion among some police officers in the Thohoyandou Policing District over the eligibility criteria for accessing PEP. Some officers and even some health practitioners still insist that opening a police case is a requirement for obtaining PEP. This has probably resulted in many survivors failing to access PEP, because the majority of rape cases are never reported.

TVEP's approach to facilitating the timely delivery of PEP

In the absence of government interventions to address these challenges, TVEP has attempted to address the gap between theory and practice in the provision of PEP by adapting and developing its services and engaging with health, police and other relevant services.

However, police officers and healthcare workers can only be expected to fulfil their duties if their departments equip them to do so. Internal transfers and promotions can mean that inexperienced officials are expected to handle PEP provision. It is against this background that TVEP advocates for the restoration of Sexual Offences Courts. These courts reinforce the establishment of a victim-centred court system that is prompt, responsive and effective. They are staffed by specialised and skilled people whose duties are dedicated exclusively to sexual offences. Consequently, these courts reduce the cycle time in finalising sexual offences cases, and contribute to efficient prosecution and adjudication. Over the years these courts have either been closed or have had their scope expanded to include other types of cases as well as sexual offences.

TVEP's advocacy is conducted by staff within the Zero Tolerance Village Alliance (ZTVA) programme.

This programme also provides community members and state duty bearers, such as teachers, nurses and police officers, with information on various issues relating to sexual and gender-based violence, including access and adherence to PEP. Through this programme, survivors are provided with information about PEP that enables them to ask police officers or healthcare workers about PEP in instances where these individuals fail to inform the rape survivor about the availability of PEP.

The introduction of hospital-based VAs ensures that survivors are provided with the complete 28-day PEP regimen and anti-emetics at the initial visit to the health facility. As a result, they do not have to come back to collect the remainder of the drugs. Rape survivors are also given a package containing food supplements, which may prevent or mitigate the side effects of the drugs (Bhana, 2004), as well as underwear, a face towel and a toothbrush. In addition, survivors receive a free return bus ticket so that they can visit the trauma centre if they need any further support. During the subsequent 28-day period, the VAs make three home visits to the survivor to assess their home situation, respond to any questions the survivor may have, identify any obstacles to adherence, and assess the need to recommend the removal of the survivor from their home and place them in one of the safe houses located within the Chief's *kraal* at each village. This is most likely to happen when the perpetrator is an intimate partner of the survivor, or in cases of incest. It prevents secondary traumatisation and gives TVEP VAs easy access to the survivor to provide the necessary adherence counselling, paralegal advice and other ancillary services such as food supplements. The high rate of PEP adherence (greater than 80%) at TVEP reported by Christofides *et al* (2006) could be attributed to the holistic treatment, care and support provided by the VAs.

The location of the safe houses in the Chief's *kraal* is testimony to the buy-in and ownership of the efforts to prevent domestic and sexual assault by some traditional leaders in the Thulamela municipality. The Chief's *kraal* is a safe zone respected by communities to the extent that a perpetrator will not be able to enter and forcibly remove or intimidate the survivor. These sites also provide the kind of homely domestic environment that is necessary for healing, as opposed to the clinical environment of a health institution.

Staying at the Chief's *kraal* also provides the survivors with an opportunity to develop confidence, and a sense of security. It indicates that they have the support of the community should they wish to pursue any legal action against the perpetrator. Community support is critical in traditional and patriarchal communities where women are always blamed for rape and accused of bringing it upon themselves (e.g. because of the way they are dressed, the fact that they were walking alone at night, etc.).

Such a holistic approach addresses the survivors' resource constraints as well as their need for emotional support, which is well documented in the literature (Vetten and Haffejee, 2005). This multi-pronged strategy has ensured that rape survivors who are supported by TVEP have a much higher rate of adherence to PEP than survivors who do not receive such support (Christofides *et al*, 2006).

As it is a civilian organisation operating in a government hospital, it is critical to note that TVEP employees have the autonomy and independence required to hold duty bearers accountable to their delivery mandates and to report any malpractice. Perhaps the success of the TVEP trauma centre model could be attributed to this autonomy and independence. At other sites, nurses would be expected to hold each other accountable to their delivery mandates or, worse, they would be expected to hold senior colleagues, such as doctors, accountable to their duties.

Conclusion

Although South Africa's Sexual Offences Act enshrines the right to PEP for rape survivors, there are various practical challenges that impede optimal access and adherence to such treatment. This has led TVEP to adapt its services to respond to the needs of survivors as they emerge. Some of the strategies employed by TVEP to improve rape survivors' adherence to PEP could easily be implemented by healthcare facilities, such as putting systems in place which will ensure that survivors always receive anti-emetics at their initial visit to the health facility. Other TVEP initiatives, such as home visits, bus vouchers to ensure that survivors can come back for retesting and adherence counselling, and the provision of food supplements for 28 days, may be difficult to implement, as they are outside the mandate of the Department of Health. However, these strategies could be implemented through inter-departmental cooperation between relevant departments, for instance, through cooperation between the Department of Health and the Department of Social Development. After all, only an integrated approach will significantly improve rape survivors' access to and adherence to PEP. It is critical that the government adopts and replicates this model to ensure sustainability, as TVEP is dependent on donor funds, and thus the continuation and upscaling of this holistic service is often constrained by the availability of funds.

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