World Health Organization

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VAW HIV Programming Idea 11: Providing comprehensive post-rape care including HIV post-exposure prophylaxis (PEP)

What it involves: Providing comprehensive post-rape care including HIV PEP to survivors of rape who seek care within 72 hours can help reduce the risk of HIV infection *(131, 137–139)*. Comprehensive post-rape care addresses the full range of health, psychosocial support, and police and legal justice needs of rape survivors. In the immediate term, it includes PEP for HIV and other STIs, emergency contraception, assessment and treatment of injuries and women-centred care (see programming idea 10). Longer-term needs for survivors include support for adherence to PEP, focused therapy for mental health care (e.g. depression, drug and alcohol use problems) *(131)*. Health providers also play a critical role in collection and documentation of forensic evidence that can support criminal prosecution of perpetrators, if the survivor wishes to pursue this *(137)*. Survivors who decide to pursue criminal charges may need referrals to legal services and support for navigating the criminal justice system *(68)*. Therefore, provision of comprehensive post-rape care requires strong coordination and referrals between the health, police, justice and social services.

Summary of the evidence: Studies show that PEP is more effective when delivered as part of comprehensive post-rape care services *(140,141)*. Comprehensive post-rape care remains inaccessible to the majority of rape survivors worldwide. Reasons include: limited availability of services; stigma and insensitivity faced by survivors; a lack of information and awareness about services; delays due to poor police procedures; limited coordination between police and medical services; and a lack of funding allocated to these services *(142)*. Evidence on effectiveness of PEP in preventing HIV is limited to a few studies. Policy discussions may need to reflect whether to offer PEP routinely (e.g. in high HIV prevalence settings) or after a risk assessment (e.g. in low HIV prevalence settings) *(131)*. Effectiveness of PEP depends on adherence, which may be a problem for women due to side-effects of the drug and the emotional consequences of rape. There is limited evidence on effective approaches for improving adherence support. A study from South Africa in which psychosocial support was provided to rape survivors, showed no impact on adherence to PEP *(143)*. Examples of post-rape care interventions are provided in Annex 1.9.

Conclusion: The approach is rated as not-applicable (N/A) in terms of its impact on preventing violence as it responds to women who have already experienced violence. WHO guidelines recommend offering comprehensive post-rape care services, including HIV PEP, to survivors of rape and so is regarded as effective in relation to improving HIV-related outcomes.

Annex 1.9. Examples, programming idea 11: Providing comprehensive post-rape care including HIV post-exposure prophylaxis (PEP)

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Development, implementation, evaluation and scale-up of comprehensive post-rape care services, Liverpool VCT care and treatment Kenya *(188)*	Survivors of rape presenting at three district hospital sites with HIV (VCT) facilities	Establishing a standard of care for rape survivors including: protocols for physical exams, legal documentation, clinical management and counselling; client flow pathways and job aids; post-rape care package including essential drugs (PEP, emergency contraception, STI treatment) and evidence collection kit; protocol for a chain of custody for evidence; data collection and monitoring tools Training providers focused on changing their attitudes towards gender equality and abuse, strengthening their skills in history taking, clinical care, documentation and counselling	Monitoring data collected from 784 rape survivors who sought services between 2003 and 2007; conducting a costing of services. Outcomes: uptake of PEP, receipt of trauma counselling, client satisfaction and cost-benefit analysis	In the pilot phase from 2003–2007: 84% survivors seen at the sites arrived within the 72-hour window for the receipt of HIV PEP 99% of those who were eligible received drugs Survivors who received initial trauma counselling were more likely to complete HIV PEP medication The cost per person was estimated at USD 27 per patient, in line with services such as HIV counselling and testing Limitations: No pre-intervention or baseline data, indicators limited to a few output indicators, no measurement of HIV sero-conversion and adherence	A number of policy changes have been made at the national level including: national guidelines for medical management of rape, establishment of universal data collection form for presentation of evidence to courts, national training manuals and additional indicators in national monitoring and evaluation frameworks. The application of this approach has been scaled up to 13 facilities including the national referral and teaching hospital. A participatory policy development process, political commitment and flexibility to develop creative solutions have been key to the success of the programme
Refentse model for post-rape care South Africa *(189)*	Survivors of rape presenting at a 450 bed rural hospital in South Africa	A nurse-driven five-part intervention focused on: establishing a sexual violence advisory committee including hospital staff and senior management; adoption of a hospital rape management policy based on national rape management guidelines; training of service providers on common myths, clinical care and strengthening referral mechanisms; establishing a designated examination room; and conducting community awareness campaigns including distribution of information pamphlets at key HIV education community events	Pre-post intervention design that included a review of 334 hospital charts of survivors between 2003 and 2006, interviews with 109 patients and 16 service providers Outcomes: improvements in quality of post-rape care (forensic history and exam, provision of emergency contraception, STI treatment, referrals); the provision of PEP (access to VCT, provision of and completion of a full 28-day course); and efficiency and utilization of the service (number of service providers seen on first visit and volume of rape cases presenting to hospital per month)	Compared to pre-intervention, patients were: More likely to understand that the purpose of PEP was to prevent HIV infection More likely to have received the full 28-day course of PEP on their first visit and more than three times as likely to have taken a full 28-day course of PEP The time interval between assault and taking the first dose of PEP decreased from 28 hours to 18 hours Significantly more likely to report good quality of care (i.e. counselling was helpful, health worker's attitude towards them was good and examination was conducted in private) Limitations: For ethical reasons, no comparison group could be included. Therefore, changes could have anyway occurred over time. Generalizability may be limited due to selection bias (e.g. those who sought services may have been more empowered)	The results indicate that it is possible to improve quality of comprehensive post-rape care including HIV PEP and integrate this within a public sector hospital, using existing staff and resources. The results also highlight that with additional training, nurses can play an expanded role in providing quality post-rape care The study highlights the importance of a hospital policy to provide an institutional framework, the importance of improving hospital infrastructure and training to provide quality care and reduce delays in seeking and obtaining treatment. The study also highlights the need to strengthen referrals and linkages with other sectors – especially the legal and social services for adequate medico-legal care, and additional counselling and support for survivors