HEALTH POLICY INITIATIVE

GENDER-RELATED BARRIERS TO HIV PREVENTION METHODS:
A Review of Post-exposure Prophylaxis (PEP) Policies for Sexual Assault

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

As highlighted during the 2008 U.N. General Assembly High Level Meeting on HIV/AIDS, it is essential that HIV programming be responsive to gender disparities. The President's Emergency Plan for AIDS Relief (PEPFAR) is committed to addressing gender by (1) working to reduce gender inequalities and gender-based abuse and violence, (2) expanding priority gender activities, and (3) integrating gender considerations throughout all programming areas (OGAC, 2007). PEPFAR supports five high-priority gender strategies to reach its prevention, treatment, and care goals: increasing gender equity, addressing male norms and behaviors, reducing violence and coercion, increasing women's and girls' access to income and productive resources, and increasing women's legal protection. These strategies recognize that gender-based barriers often affect women's and men's access to services and include increasing gender equity in HIV/AIDS activities and services, along with reducing violence and coercion.

Globally, women, men, girls, and boys face gender-based violence (GBV). While GBV and one of its forms—sexual assault—overwhelmingly affect women, the extent to which men and other vulnerable populations are affected has been under-studied. Taking this into account, both women and men may experience violence as a risk factor for acquiring HIV, as well as gender-related barriers to accessing HIV prevention or other healthcare services. As researchers and program implementers explore the ways in which GBV is linked to HIV, it has become increasingly important to ensure that survivors of sexual violence have access to necessary HIV prevention methods, such as post-exposure prophylaxis (PEP). However, gender-based barriers related to costs for services and adherence often impede survivors' ability to access health services and programs. Policymakers and program implementers must begin to examine and reduce these barriers and thereby reduce sexual assault survivors' risk of acquiring HIV.

While PEP has been recommended to prevent the transmission of HIV following sexual exposure, policies to implement this recommendation are limited. To assess this issue, the USAID | Health Policy Initiative, Task Order 1 reviewed PEP policy documents related to sexual assault for the PEPFAR focus countries. While few PEP-specific policies exist, 13 of 14 focus countries reviewed include PEP for sexual assault in their antiretroviral (ARV), HIV, or sexual violence guidelines.[1] Table 1 lists the 13 countries that provide PEP and the key aspects of relevant policies/guidelines that reveal potential gender barriers that may affect sexual assault survivors' ability to access PEP (see the main body of this report for details).

Table 1. Key Aspects of PEP Policies and Guidelines in 13 PEPFAR Focus Countries

	Eligibility: Explicitly includes men and women	Legal Require-ments: Police report required	HIV Testing: HIV test required	Facilities: Specific facilities for PEP provision noted	Providers: Specific providers for PEP provision noted	Cost: Free	Adherence and Follow-Up: All PEP doses provided at first visit
Botswana	√		√				
Côte d'Ivoire			√				
Ethiopia	√		√				√
Guyana			√	√		√	

[1] At the time of this writing, of the 15 PEPFAR focus countries, Haiti's information could not be accessed, and Vietnam did not include PEP for sexual assault in its *Guidelines for Diagnosis and Treatment of HIV/AIDS* (2005). These guidelines currently are being updated.

	Eligibility: Explicitly includes men and women	Legal Require-ments: Police report required	HIV Testing: HIV test required	Facilities: Specific facilities for PEP provision noted	Providers: Specific providers for PEP provision noted	Cost: Free	Adherence and Follow-Up: All PEP doses provided at first visit
Kenya	√		√	√			√
Mozambique			√				
Namibia	√		√		√		
Nigeria	√		√				
Rwanda	√		√				
South Africa	√		√		√		√
Tanzania	√		√				
Uganda	√		√		√		
Zambia	√		√				

The policy review has identified specific gender barriers that can affect whether PEP is provided to all sexual assault survivors. It is clear that, while the majority of PEPFAR focus countries have guidelines that provide for PEP for sexual assault, they generally lack detail and do not account for gender issues. As such, these guidelines rarely address gender barriers that may affect their implementation. While many of the issues related to gender, such as criteria for access, are included in some of the guidelines, they often are not elaborated, and even the attention to PEP for sexual assault—in comparison with occupational exposure—is insufficient. Ministries of health and other agencies responsible for HIV programs need to make a concerted effort to recognize these gender barriers and respond to them through national guidelines. These guidelines should make gender explicit by addressing these issues, as well as other gender issues that may be identified in a particular country context. Furthermore, guidelines need to include a gender analysis of barriers to accessing PEP. This will prompt necessary dialogue on the gender issues, such as the best way to address HIV testing. Finally, national governments need to ensure that better practices are incorporated, expanded, and evaluated.

Institutions and programs should consider the gender barriers explored in this review when creating new PEP guidelines and, where current guidelines do exist, they should implement protocols and procedures to ensure that they address such barriers. By doing so, PEPFAR focus countries will be better positioned to increase access to high-quality PEP services for sexual assault survivors.

ABBREVIATIONS

ARV	antiretroviral
ART	antiretroviral therapy
EC	emergency contraception
GBV	gender-based violence
HAPCO	HIV/AIDS Prevention and Control Office
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IGWG	Interagency Gender Working Group
ILO	International Labor Organization
NAC	National AIDS Committee
NAPS	National AIDS Program Secretariat
OECD	Organization for Economic Cooperation and Development
OSAGI	Office of the Special Adviser on Gender Issues and Advancement of Women
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PRC2	post-rape care form 2
RADAR	Rural AIDS and Development Action Research Program
RH	reproductive health
STI	sexually transmitted infection
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
VCT	voluntary counseling and testing
WHO	World Health Organization

I. BACKGROUND

Gender and Development

Gender's place in development has changed as this concept has evolved over time. The UN International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women in Beijing (and its five-year review) played a significant role in this evolution. Previously, policies and programs were seen as addressing gender when they referred to women, and women were seen as targets to meet so that development programs could achieve their goals. These international conferences brought about new global commitments to address gender, which called for a focus on both women and men. This change recognized the importance of gender relations in development policies and programs. Countries pledged to

> "Gender refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality."
>
> — OECD, 1998; IGWG, 2009

- Promote women's empowerment and gender equity;
- Put aside demographic targets to focus on the needs and rights of individual women and men, promoting a comprehensive reproductive health and rights approach;
- Involve women in leadership, planning, decisionmaking, implementation, and evaluation; and
- Involve men in taking responsibility for their sexual and reproductive behavior and their social and family roles.

> "A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health…"
>
> — United Nations, 1999

In particular, the Fourth World Conference on Women in Beijing promoted gender mainstreaming as a way of designating methods and institutional measures for achieving gender equality. Gender mainstreaming is an approach that treats gender considerations as core factors to be incorporated throughout policy formulation, planning, evaluation, and decisionmaking procedures. Program implementers also began endorsing gender integration, which refers to strategies applied in program and policy assessment, design, and evaluation that take gender norms into account and compensate for gender-based inequalities that create barriers to health for men and women. Programs and policies responsive to the differences between men's and women's needs, roles, responsibilities, and constraints often are termed gender sensitive.

Sensitivity to gender issues helps to promote development program objectives, program sustainability, and gender equality. Gender-sensitive approaches recognize and address the relations between women and men, women and women, and men and men that affect reproductive health (RH) goals and rights. Perspectives on how to integrate gender into RH policies and programs vary with the social and cultural environment and program goals and can be informed through gender analysis.[2]

[2] There are many frameworks and materials for undertaking gender analysis and gender integration. These include the following: *Learning and Information Pack: Gender Analysis* (UNDP, 2001); *A Manual for Integrating Gender into Reproductive Health and HIV Programs* (Caro et al., 2003); and *Exploring Concepts of Gender and Health* (Health Canada, 2003).

HIV and Sexual Assault

Gender-based violence (GBV) is a public health problem that can increase women's vulnerability to acquiring HIV. A 2005 World Health Organization study found that of 15 sites in 10 countries—representing diverse cultural settings—the proportion of ever-partnered women who had experienced physical or sexual intimate partner violence in their lifetime ranged from 15 percent in Japan to 71 percent in Ethiopia (Family Violence Prevention Fund, n.d.).

> Gender-based violence is "any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females."
>
> — IASC, 2005

Gender-based violence does not affect women only; experts recognize that men and other vulnerable populations also face GBV—often in the form of sexual assault.[3] Thus, men and others may experience violence as a risk factor for acquiring HIV, as well as gender-related barriers to accessing HIV prevention or other healthcare services. This issue has been under-studied, partially due to gender norms that presume only women face sexual assault and other forms of GBV. While men do experience GBV, data are limited. Available data reveal that women experience higher rates of GBV than men (IGWG of USAID, 2008). For these reasons, this review primarily focuses on women, except where there is documentation of gender-related barriers that affect men's access to PEP services.

Sexual assault is a crucial form of GBV; along with other forms, it can increase the likelihood of women acquiring HIV (Harvard School of Public Health, 2006; Krug et al., 2002). For example, gender norms that give men decisionmaking power often limit women's ability to negotiate condom use or when they have sex. This is more likely when the partner is abusive. In addition, fear of violence often prevents women from undergoing HIV testing, disclosing a positive status, or receiving treatment. Furthermore, partners with household and economic control may limit women's ability to access treatment.

Sexual assault survivors are at particular risk for acquiring HIV as a result of vaginal lacerations and trauma, which increase the risk of becoming infected (Jansen et al., 2002; Republic of Kenya, 2004). Forced anal penetration of both adults and children carries a higher risk of transmission than other sexual practices (Republic of Kenya, 2004). According to the *Kenya National Guidelines of Medical Management of Rape/Sexual Violence*, the HIV prevalence among male rapists in Kenya generally is considered to be higher than that of the general population—although actual figures are not known because the number of arrests is minimal (Republic of Kenya, 2004). Because sexual assault survivors are at risk for acquiring HIV, prevention efforts such as post-exposure prophylaxis (PEP) are crucial interventions. Thus, addressing barriers that women and men face in accessing services is important for HIV prevention. Accordingly, this review focuses on gender-based barriers that prevent sexual assault survivors from accessing PEP.

What Is PEP for HIV Prevention?

PEP for HIV is a method of preventing disease, in which people who have been exposed to HIV take antiretroviral (ARV) medication for a short time immediately, or as soon as possible, after exposure. PEP has been shown to reduce the risk of HIV transmission after potential exposure. According to the World Health Organization (WHO), it should be administered for 28 days, starting within 72 hours of exposure (WHO, 2003).

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[3] There are important debates about how the violence men experience can be gender related but different from the gender-related violence women experience.

PEP is recommended in cases of occupational and nonoccupational (including sexual assault) exposure to HIV. Occupational exposure is nonsexual, defined as "percutaneous, mucous membrane, or non-intact skin exposure to blood or body fluids." It occurs during the course of an employee's work (WHO and ILO, 2005), such as accidental needle pricks by healthcare workers. Providing PEP in cases of occupational exposure is part of ensuring a safe work environment for healthcare and other workers. Policies often determine how PEP is provided in relation to occupational exposure. PEP for nonoccupational exposure or sexual assault follows similar guidelines to PEP for occupational exposure but often is not covered in great detail in policies.

Recommendations for Administering PEP

The following recommendations summarize key points from WHO's *Guidelines for Medico-legal Care for Victims of Sexual Violence* (2003):

- Have a designated, trained person with the appropriate skills and expertise dispense PEP.
- Offer patients a baseline test for HIV that includes appropriate pre- and post-test counseling. If there are no appropriate facilities for confidential HIV testing and counseling on site, refer the patient to a specific, confidential voluntary counseling and testing (VCT) site.
- Assess risk factors for acquiring HIV through the sexual assault (see Box 1). Health workers should refer to local protocols, where they exist, to evaluate the risks and benefits of initiating or refraining from PEP treatment and should work with the patient to decide if PEP is the right option.[4]
- Counsel the patient on PEP, including the following:
  - Limited data exist regarding the efficacy of PEP[5]
  - Possible side effects
  - The need for strict adherence to the medication
  - The length of treatment
  - The importance of follow-up (if the initial HIV test results are negative, patients should have the test repeated at 6, 12, and 24 weeks after the assault)
  - The need to start treatment immediately for the greatest effect

Box 1. Risk Factors for Acquiring HIV from Sexual Assault

The likelihood of acquiring HIV from sexual assault depends on several factors, including the following (WHO, 2003):

- Type of assault (i.e. vaginal, oral, anal)
- Vaginal or oral trauma (including bleeding)
- Whether ejaculation occurred and location on or in the body
- Viral load of ejaculate
- Presence of STI(s)
- Presence of genital lesions in either the victim or perpetrator
- Intravenous drug use by perpetrator
- Frequency of assaults
- Number of perpetrator(s)
- HIV status of perpetrator(s)
- High prevalence of HIV in the area
- Whether a barrier contraceptive method was used

Given the potential benefits of PEP, there is growing interest in expanding it as a prevention method. The United States government has identified PEP as a key intervention as part of the President's Emergency Plan for AIDS Relief (PEPFAR). In July 2007, USAID updated its Agency statement on the gender aspects of PEPFAR, explicitly acknowledging that "[A]ddressing gender issues is essential to reducing

[4] Because they are often low-HIV prevalence countries, developed countries often undertake risk assessments to determine the provision of PEP. Developing countries with high HIV prevalence rates often do not undertake the same type of risk assessments to determine their provision of PEP (WHO and ILO, 2005).

[5] The efficacy of PEP for prevention of HIV has been shown in occupational settings but remains unproven in the nonoccupational setting. The evidence for HIV-PEP efficacy is indirect and based on the findings of studies on primates, post-natal infant studies, and a single healthcare worker case-control study (WHO and ILO, 2005).

the vulnerability of women and men to HIV infection" (U.S. PEPFAR, n.d., a). In addition, PEPFAR counts reducing gender-based violence and coercion as one of its five gender strategies, along with increasing gender equity in programs and services. The original authorization of PEPFAR legislation recognized that men's and women's concerns must be a central component of any activity. In particular, the legislation refers to sexual assault in Section 101: E, reading, "specific strategies developed to meet the unique needs of women, including the empowerment of women in interpersonal situations, young people and children, including…those who are victims of…rape, sexual abuse, assault, and exploitation" (108th Congress of the U.S., 2003). The new authorization of PEPFAR expands the "commitment to cross-cutting integration of gender equity in its programs and policies, with a new focus on addressing and reducing gender-based violence" (U.S. PEPFAR, n.d., b). As sexual assault survivors are at risk for acquiring HIV, especially in generalized epidemics, strengthening PEP services for survivors of sexual assault is a crucial PEPFAR intervention.

Despite the recognition of the importance of PEP interventions, there is a limited understanding of how PEP for sexual assault is included in national guidelines or policies, and how they actually are implemented. These policies directly or indirectly affect the ability of health professionals to address GBV in their daily work, as well as sexual assault survivors' ability to access necessary treatment.

There is no explicit framework for undertaking a gender analysis of the existing guidelines, yet previous work on HIV and GBV reveals that addressing gender barriers is crucial for programs and policies to meet their goals (IGWG, 2004; ICW, 2004a). Thus, this review focuses on assessing potential gender barriers within PEP guidelines for sexual assault.

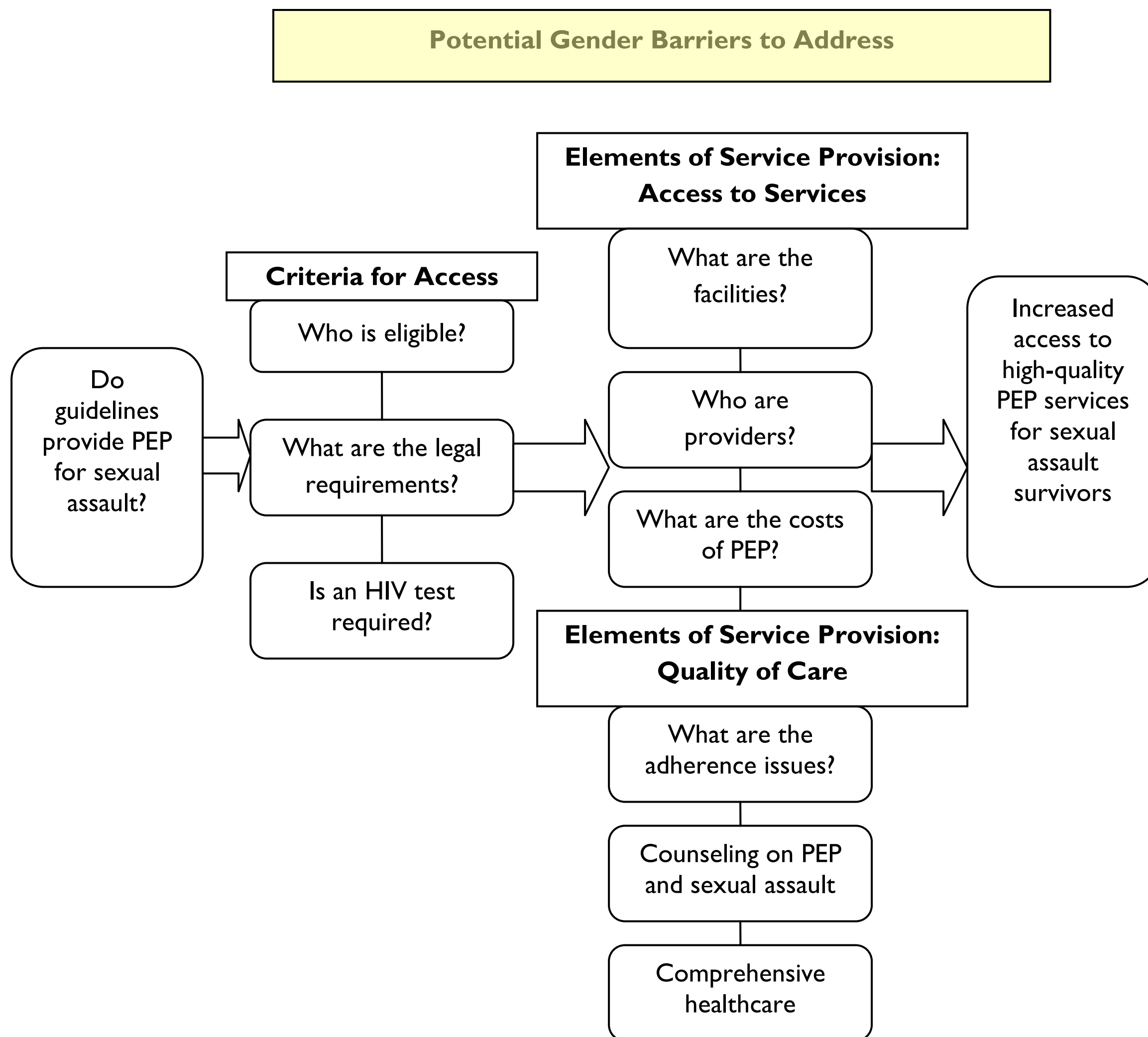
Methodology

Framework: Gender Analysis of PEP Guidelines for Sexual Assault

This review is based on a framework (see Figure 1) developed by the Health Policy Initiative. The project developed it by reviewing key documents (WHO and ILO, 2005; Roland, 2005) to identify core elements of providing PEP for sexual assault and then focusing on elements important to providing PEP where gender constraints may present barriers to women and men accessing services. The framework includes these elements, which are categorized according to criteria for access and those related to service provision. This framework served to structure a gender analysis of PEP policy documents at the national level. In the context of gender analysis, "gender" refers to socially constructed roles, behaviors, and activities that society considers appropriate for men and women. Gender analysis was conducted based on the key question, "What effect will gender norms and gender relations have on implementation of the policy?" Gender relations can be defined as the ways in which a culture or society defines the rights, responsibilities, and identities of men and women in relation to one another.

While both females and males experience gender barriers to accessing PEP services, they often encounter different barriers. For example, women's limited access to income and resources and restrictions on mobility present a significant barrier to women in need of PEP services. However, women and men share a common set of issues related to accessing PEP, such as stigma and discrimination. Their experiences with stigma and discrimination vary due to gender norms. In this review, the gender analysis focuses on identifying the key gender barriers for women and men in each of the elements related to service provision or criteria for access. Identifying key gender barriers can lead to a better understanding of how they can and should be addressed in policy responses.

Figure 1. Framework: Gender Analysis of PEP Guidelines for Sexual Assault



The framework identifies three key areas of potential gender barriers related to PEP policies and guidelines for sexual assault. The first area examines whether a country's existing national HIV-related guidelines include PEP for sexual assault. (See Annex A for a list of which PEPFAR countries—excluding Haiti—provide for occupational and nonoccupational PEP.) The second area focuses on potential gender barriers related to criteria for access, which were informed by reviewing international standards for PEP related to sexual assault (CDC, 2005; WHO, 2003) and identifying where gender norms may have a particular effect on policy or program implementation. These potential barriers include the following:

- Who is eligible to receive PEP—men and women?
- What are the legal requirements to receive PEP? For example, are sexual assault survivors required to report to police to receive PEP?
- Is an HIV test required to receive PEP?

Drawing on existing literature and research on gender barriers related to accessing HIV services and treatment (IGWG, 2004; ICW, 2004a), the Health Policy Initiative identified the following areas related to service provision:

- Types of facilities that provide PEP and how this affects one's access to services
- Type of providers allowed to administer PEP
- Costs for PEP
- Adherence issues and quality of care in general

By making a concerted effort to examine and address the gender-related issues in these areas, countries will foster an enabling environment for increased access to PEP for all sexual assault survivors.

Country Focus

The Health Policy Initiative sought to locate relevant national policy documents on PEP and sexual assault for each of PEPFAR's 15 focus countries. Where resources could not be found electronically, the project contacted its field offices, USAID Missions, and other contacts to gain assistance in locating the documents. This report covers 13 focus countries (Botswana, Côte d'Ivoire, Ethiopia, Guyana, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia).[6]

Policy Focus

In undertaking this review, the project searched for policy documents that allow for provision of PEP for sexual assault. The majority of the documents found to include such a provision were national guidelines related to ARV treatment (see Annex A). Several national policies on HIV that also include PEP for sexual assault lacked the amount of detail found in the ARV guidelines. If there were multiple policy documents covering this provision, the project reviewed all of them. In a few cases, provision for PEP for sexual assault was included in country-specific guidelines on management of rape. In Kenya, these guidelines were produced by the Ministry of Health's Division of Reproductive Health.

II. POTENTIAL GENDER BARRIERS TO ACCESSING PEP

Do Guidelines Provide PEP for Sexual Assault?

The review begins by determining whether PEPFAR focus countries have policy documents that include PEP provision for sexual assault and, if so, what they comprise. The Health Policy Initiative found that the majority of the countries do account for such provision, with 13 countries including PEP for sexual assault in national guidelines related to treatment of HIV or sexually transmitted infections (STIs).

The guidelines vary in their recognition of sexual assault in their countries and how it is related to HIV transmission, resulting in different levels of commitment to care for sexual assault survivors. Three countries—Kenya, Uganda, and Namibia—pay the most attention to the issue of providing PEP for sexual assault through the inclusion of definitions of sexual violence/assault, data on violence in the country, an overview of the risk of HIV from sexual assault, and statements on the need to provide guidance on PEP. Botswana and Zambia pay some attention to the issue. While these countries' guidelines do not explore the issue of sexual assault as much as those of the first set of countries, they do acknowledge the importance of sexual assault in relation to the risk of HIV transmission. Among the countries that pay the least attention to the issue, some—Côte d'Ivoire, Guyana, Mozambique, Nigeria, Rwanda, and Tanzania—allow for PEP for sexual assault but rely on the occupational exposure sections of their guidelines to provide details for administering PEP, such as dosages.

Most Attention to the Issue

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[6] At the time of this writing, Haiti's information could not be accessed, and Vietnam did not include PEP for sexual assault in its *Guidelines for Diagnosis and Treatment of HIV/AID*S (2005). These guidelines are currently are being updated.

Several countries offer specific guidance related to sexual assault. Among the most detailed is Kenya's *National Guidelines on Medical Management of Rape/Sexual Violence*. These guidelines include a definition of sexual violence based on WHO's work, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting including but not limited to home and work" (Republic of Kenya, 2004, p. 1; WHO, 2002). While this definition refers to women, the guidelines acknowledge men's risk of experiencing sexual violence and the link to HIV acquisition.

Because the guidelines focus exclusively on sexual violence, the Ministry of Health's commitment to addressing violence is clear. While the Division of Reproductive Health produced Kenya's guidelines, they acknowledge the need to focus on HIV prevention in relation to sexual assault:

> "Of additional concern is the emerging evidence worldwide that sexual violence is an important risk factor contributing toward vulnerability to HIV/AIDS. The national plan for mainstreaming gender into the HIV/AIDS strategic plan for Kenya has identified sexual violence as an issue of concern in HIV transmission…" (Republic of Kenya, 2004, p. iii).

Uganda's guidelines, *The National Policy Guidelines on Post-Exposure Prophylaxis for HIV, Hepatitis B, and Hepatitis C*, explicitly recognize that "there is need to provide HIV-PEP for nonoccupational exposure as occurs in sexual assault by suspected HIV-infected persons" (Republic of Uganda, 2007, p. 3). These guidelines argue the importance of addressing PEP in the broader community to support sexual assault survivors:

> "Sexual offenses expose victims to HIV and other STDs, making the existence of PEP policy guidelines for purposes of training health providers, for provision of antiretroviral medicines, and for creating awareness about HIV-PEP among the communities so that those who may need the services can access them. These policy guidelines create a framework for providing information that will guide health providers, law enforcement officers and the community as to when and where to refer victims of sex abuse, assaults, home carers and other forms of accidental exposure to HIV infection" (Republic of Uganda, 2007, p. 3–4).

These guidelines also provide specific data as evidence for addressing the issue, reporting that 303 girls were "defiled" between January and June 2006 in Uganda (Republic of Uganda, 2007). The guidelines also note that there are no readily available national population-based prevalence data available in Uganda. One study found that 52 percent of women interviewed reported incidents of sexual "touching," and 42 percent reported having been raped as children (Stavropoulos, 2006). Qualitative studies undertaken in Uganda indicate that sexual violence occurs both within the family and in the wider community.

Like Kenya, Namibia has a document to guide service providers on post-rape care. The *Guidelines for Service Providers on the Combating of Rape Act of Namibia* provides recommended steps for working with sexual assault survivors for police, prosecutors, magistrates, medical professionals, and social workers and counselors.[7] The guidelines include a definition of rape, the *Combating of Rape Act 2000*, and specific guidance on administering PEP to sexual assault survivors. They also include PEP guidance, which is an excerpt from the national *Guidelines for Antiretroviral Therapy*.

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[7] The guidelines developed for the medical profession did not receive formal approval from the Ministry of Health and Social Services but were included in the document because they were developed with the assistance of a range of medical professionals during the course of several workshops.

Some Attention to the Issue

Two countries, Botswana and Zambia, do not provide as much detail as the countries previously cited but do acknowledge the relationship between sexual assault and HIV transmission. Botswana's guidelines refer to the risk of acquiring HIV, reading, "The risk of acquiring infection from a single sexual exposure may be small, but as this kind of exposure commonly involves violence and genital tract trauma, it is more likely to produce HIV infection" (Ministry of Health, Botswana, 2005, p.45). Zambia's *National Guidelines on Management and Care of Patients with HIV/AIDS* also recognize that rape victims are at a high risk of acquiring HIV due to high HIV prevalence rates in Zambia. The guidelines determine that "PEP should generally be given when the source of exposure is known to be HIV-infected or when there is information that they are likely to be HIV infected, if the HIV status is not known. This is true especially for a high prevalence area like Zambia" (Republic of Zambia, 2004, p. 138).[8]

Focus on Occupational Exposure

Most of the guidelines pay minimal attention to sexual assault. They tend to provide more information on PEP related to occupational exposure. For example, Côte d'Ivoire's guidelines specify that prophylaxis is free for public sector healthcare personnel in case of accidental exposure to blood but do not specify this for sexual assault survivors. The guidelines include sexual violence by rape under "treatment in case of accidental exposure to HIV" but provide minimal guidance on this and more details on occupational exposure. They simply read, "the same chemical prophylaxis is used in the cases of sexual violence and the condom breaking" (Republique de Côte d'Ivoire, 2005, p. 21). Likewise, Tanzania's *National Guidelines for the Clinical Management of HIV/AIDS* recognize occupational exposure—in hospital settings—as the most common mode of exposure to HIV. However, they do refer to sexual assault as the other most common method of exposure.

Similarly, guidance for Guyana, Mozambique, Rwanda, and Nigeria pays very little attention to PEP for sexual assault survivors. Mozambique's guidelines give information about dosages but do not discuss the issue further. Rwanda, Guyana, and Nigeria provide more information on occupational exposure—including specific dosages—than sexual assault exposure. For example, Nigeria's guidelines have three pages on occupational exposure and only one paragraph related to sexual assault. Nigeria's guidelines state the following:

> "In the event that there has been sexual abuse or rape, it is recommended that the victim be counseled for post-exposure prophylaxis if the victim is negative. If the victim test[s] positive, the victim should be managed accordingly. It is also important to determine the HIV status of the perpetrator. If this is not possible the perpetrator is assumed to be HIV positive and the victim treated as a case of high-risk exposure. In the event of rape it is important to arrange for on-going counseling and support" (Federal Ministry of Health, 2007 draft, no page numbers included).

Criteria for Access

Who Is Eligible?

What are the gender issues?

Policies and guidelines determine eligibility for accessing PEP.[9] When conceptualizing sexual assault, many people picture women as the main victims of sexual assault due to common ideas of gender norms

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[8] This discussion was not limited to sexual assault but also referred to occupational exposure.

[9] When looking at who is eligible for PEP for sexual assault according to these policies, it is important to note that the majority of guidelines have no provisions for children. While assessment of the guidelines related to children was not in the scope of this review, it is an issue of critical importance. Studies show high levels of child abuse, with children being more likely to present to health facilities or police than adults (RADAR, Population Council, and Tshwaranang Legal Advocacy Centre, 2007). Thus, the

that portray men in positions of power and control. According to these gender norms, only women experience sexual assault. However, there are other vulnerable populations to consider. For example, male victims of sexual violence actually have a higher risk of acquiring HIV from an assault because they usually are penetrated anally (WHO, 2003). Incarcerated males are at a particularly high risk.

Gender norms about sexual behavior and sexual violence create barriers for women, men, and other vulnerable groups in reporting sexual assault or seeking care. However, violence against both women and men is under-reported due to stigma and discrimination. Because of differing gender norms, men and women experience this stigma and discrimination differently. For example, men may be reluctant to report acts of sexual violence to the police due to embarrassment about being victims (WHO, 2003). Similarly, male survivors tend to be hesitant in accessing counseling due to the perceived and actual stigma related to the abuse (Population Council, 2008). In addition, there is a misconception that only homosexual men are raped and that heterosexual men would never rape another heterosexual man (WHO, 2003). A woman may experience stigma after reporting sexual assault, particularly if the perpetrator is her partner and gender norms dictate that women submit to their partners. These are all key groups at risk of sexual assault and are potential clients for PEP. Given this, PEP policies need to be written in a manner that accepts all of these groups.

As some healthcare providers may have assumptions or preconceived notions, based on gender norms, of the types of people experiencing sexual assault, the correct terminology in policy documents is crucial to expanding the perception and understanding of the diverse characteristics of a sexual assault survivor. Keeping this diversity in mind when formulating policies and programs can help providers respond to the needs of all sexual assault survivors. Documents that refer to survivors as exclusively female are not gender sensitive and serve to reinforce providers' or program implementers' perceptions that men are never sexual assault victims. Policies that do not dictate the characteristics of eligible populations encourage VCT counselors and other healthcare providers to be open minded about the range of clients who may need or seek PEP and the unique set of barriers they may face in doing so.

What do the guidelines say?

Overall, 6 of the 13 countries explicitly pay the most attention to this issue, referring to both men and women in their guidelines. Five other countries use gender-neutral terms such as "individual" or "patient." One country's guidelines refer only to women in some text but use gender-neutral language elsewhere.

Most explicit attention to the issue

Five countries—Kenya, Namibia, South Africa, Tanzania, and Uganda—specify sexual assault survivors eligible for PEP as "men and women" and "girls and boys," revealing that they recognize men's risk of sexual assault. Kenya's guidelines are clear, reading, "These guidelines are designed to cover the management of forced vaginal, anal and/or oral penetration of MEN, WOMEN and CHILDREN [sic]…" (Republic of Kenya, 2004, p. 1). The guidelines point out that they are designed to include men, even though Kenyan law does not recognize the existence of male rape. The guidelines read, "Rape is defined by the Kenyan law as having sex with a woman or a girl without her consent or with her consent if obtained under threat, force, or intimidation of any kind, fear of bodily harm or misrepresentation as to the nature of the act or by a person impersonating her husband" (Republic of Kenya, 2004, p. 1).

While Uganda's guidelines refer to "all victims of sexual offense," (p. 4) they also include an explicit statement recognizing men and boys as victims, reading, "It should be noted that although the vast majority of victims are women and girls, men and boys also experience sexual violence" (Republic of

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current focus on PEP provision for sexual assault of adults should be balanced with policies and guidelines specific to children (Population Council, 2008).

Uganda, 2007, p. 13). The guidelines also state, "Penetrative sexual assault may result in HIV transmission, and whereas this can be against anybody…" (Republic of Uganda, 2007, p. 13). Similarly, Tanzania's national guidelines refer to "HIV PEP in men and women who have been raped/sexually assaulted" (United Republic of Tanzania, 2005, p. 123). Namibia and Tanzania's guidelines state, "…all women and men…should be counseled by the examining health care worker about the potential risks of HIV transmission post rape." (Republic of Namibia, 2003, p. 31; United Republic of Tanzania, 2005, p. 123). Namibia's guidelines on implementing the Combating of Rape Act state that "any male or female of any age (including children) who claims to be a victim of rape/sexual abuse should always be treated as a possible rape victim" (Legal Assistance Centre, 2005, p. 23).

Ethiopia's guidelines make a gender assumption by referring to women only, stating "All women 14 years and older presenting to a health facility after potential exposure to HIV during sexual assault should be counseled by the examining health care worker about the potential risk of HIV infection" (Federal HAPCO, 2007, p.82). However, when discussing the patient's choice to undertake HIV testing, "s/he" is used to refer to the patient and other language is similarly gender neutral, using words such as "patient" and "victim." Out of all the policies and guidelines that address PEP provision in relation to sexual assault, Ethiopia is the only country that refers to women only.

Least explicit attention to the issue

When examining the documents, most of the countries use gender-neutral terms, such as "individual," "victim," and "patient." For example, the guidelines from Botswana and Zambia refer to "individuals"; those from Rwanda, Nigeria, and Zambia refer to "victim";[10] and documents from South Africa, Namibia, and Uganda refer to "survivors." Tanzania, Rwanda, and South Africa also use "patient."

None of the country policy documents explicitly include other vulnerable groups that face sexual assault, such as transgenders, lesbians, or men who have sex with men.

What Are the Legal Requirements?

What are the gender issues?

Globally, some countries mandate that sexual assault survivors report the assault to police before accessing healthcare services or as part of the process of receiving healthcare services. Since PEP is time sensitive and must be taken within 72 hours of sexual assault, requiring survivors to report the assault may interfere with receiving medication in a timely fashion. This is particularly true if the police must determine whether a rape took place before the survivor can access healthcare. In South Africa, a study from a rape intervention project found that women experienced an average delay of 12 hours at police stations (Kim, 2000). Furthermore, requiring women or men to report to the police may compound an already traumatic situation. Gender norms act as barriers for both women and men in seeking healthcare for and reporting sexual assaults. As a result, both men and women may face stigma and discrimination from families and communities. This can manifest itself in different ways for men and women, in accordance with gender norms. For example, others may blame a woman for the assault and for bringing shame to the family. In some cases, police may perpetrate additional violence on a male or female assault survivor (U.N. General Assembly, 2006). In addition, men and women who live in situations of chronic violence may face even more violence if the perpetrator finds out an assault has been reported. According to the WHO/ILO guidelines on PEP, reporting a sexual assault should never be a condition for receiving post-exposure prophylaxis or any other services after sexual assault (WHO and ILO, 2007).

[10] Some women's activists prefer to use the term "survivor" instead of "victim" to emphasize the resiliency and strength one needs to recover from rape. The author mostly has used "survivor" except when quoting policy documents.

What do the guidelines say?

None of the countries' reviewed have guidelines that mandate reporting the assault to police before obtaining PEP and other health services.[11] For the most part, they refer to this reporting as an option. Four of the countries—Botswana, Guyana, Kenya, and Namibia—refer to working with the police in providing care for sexual assault survivors. For Kenya and Namibia, the documents that include discussion of the police are guidelines specifically related to rape; in Namibia, the guideline has not been adopted officially by the government.

Most attention to the issue

One of the policy documents reviewed—Guyana's—refers to sexual assault being reported to the police. However, it does not specify who should do the reporting, stating, "If rape is reported [generally] or suspected, the police should be informed" (Ministry of Health, Guyana, 2006, p. 92). The overall discussion of the police focuses on a collaborative, multisectoral response to sexual violence, reading,

> "Training will be provided for police, medical professionals, and legal professionals on sexual violence, including investigation methods and the importance of reinforcing the message that sexual violence is always unacceptable…All cases of sexual abuse reported to the police must be referred to medical institutions immediately where the attending health professional can administer prophylactic treatment…To be effective the treatment must be started as soon as possible, and in any event no more than 24–48 hours after the rape, therefore police officials and other relevant parties must receive training to ensure that cases are referred immediately" (National AIDS Program Secretariat, 2006, p. 8).

Documents from Botswana, Kenya, and Namibia also address the issue of police. Both Kenya's and Botswana's guidelines discuss reporting the assault to police but do not require survivors to do so. Kenya's document states that rape survivors should be encouraged to report to the police immediately after receiving medical attention, but that this is an individual's choice and one should not be forced to do so. The guidelines read, "If the client has not been to the hospital, it is important that they go there immediately after reporting. Other procedures such as writing a statement can be undertaken after initial treatment has been received" (Republic of Kenya, 2004, p. 12). The guidelines also present standards for police, stating, "Police should encourage and assist any one presenting to the police station following rape/sexual assault, to attend the nearest health facility as soon as possible, preferably before legal processes commence as both PEP and emergency contraception (EC) become less effective with time" (Republic of Kenya, 2004, p. 12).

Botswana's guidelines advise educating police on sexual assault. They state,

> "For maximum benefit, police education is essential. Survivors of rape should be brought to hospital as an emergency before detailed questioning takes place in order not to delay PEP. At the same time, health professionals should make their own decision for PEP based on a history of penetrative sexual violence and not be bound by the police's decision on whether rape has taken place or wait for a police report" (Ministry of Health, Botswana, 2005, p. 46).

Finally, Namibia's guidelines for service providers on rape state, "The first police priority should be the safety and well-being of the complainant. This means making sure that the complainant gets access to any

[11] Because sexual assault is a multisectoral issue, it is possible that other policy documents provide conflicting information and may state that survivors are required to report to police before obtaining health services. Further analysis would need to be done to make this determination. Similarly, it is possible that practice does not follow policy; some countries may insist on survivors reporting to police first, even if that is not clearly stated in relevant policies. Undertaking policy implementation analysis would be helpful to further explore this issue.

medical attention required, including medication to prevent HIV, other sexually transmitted diseases and pregnancy" (Legal Assistance Centre, 2005, p. 9).

Least attention to the issue

The other nine countries' documents do not mention the police at all in their sections on PEP for sexual assault. While it is a positive finding that these documents do not mandate reporting to the police, they could follow the example of the other four countries and include a discussion of working with the police on this issue.

Is an HIV Test Required?

What are the gender issues?

International standards state that sexual assault survivors should be offered confidential HIV testing and counseling as a baseline (WHO, 2003), but this should be neither mandatory nor a prerequisite for providing PEP drugs, and the testing results should be held in the strictest confidence (WHO and ILO, 2007). It is recommended that facilities unable to offer confidentiality or counseling refer survivors to appropriate sites for these services. This could include VCT, sexual assault counseling, or both, depending on the client's need. However, the feasibility of these services is questionable, as most survivors are pressed for time to receive PEP and may not be able to move between facilities easily. International standards encourage sexual assault survivors to undergo HIV testing, because, if survivors already are HIV positive, taking PEP may cause them to become resistant to HIV medication (WHO and ILO, 2007). For that reason, these standards do not recommend that survivors undergo a PEP regimen if they already are positive and must receive other treatment. International standards also recommend testing the perpetrator or exposure source for HIV—although this is not usually feasible in the case of sexual assault and applies more to occupational exposure. For sexual assault, this practice is not very common in developing countries (WHO and ILO, 2005).

While there is agreement that service providers should offer HIV testing before PEP, there is disagreement over whether this testing should be mandatory. Gender and HIV research and programs have shown that VCT is rife with gender issues (POLICY Project, 2006; Eckman et al., 2004; ICW 2004c). It is questionable whether women or other vulnerable groups really experience informed consent and counseling related to HIV testing, especially in the context of prevention of mother-to-child transmission (PMTCT) programs. Women who test positive can be vulnerable to negative reactions from partners, families, and communities. Evidence shows that disclosure of a positive status can result in additional violence, blame, stigma and discrimination, and abandonment (WHO, 2004; Kyomuhendo and Kiwanuka, 2008; ICW 2004c). Thus, although the increased availability of ART may have increased HIV testing, expected or feared stigma and discrimination still present a barrier to uptake of the testing (ICW, 2004c; Sambisa, 2008). In South Africa, service providers have reported that many sexual violence survivors and their parents or guardians have refused HIV testing because of the stigma and fear attached to HIV and discrimination against PLHIV and their families (HRW, 2004). When they refused HIV testing, they were denied PEP (HRW, 2004).

Some guidelines, such as those from WHO, state that HIV testing, while recommended, should never be mandatory or serve as a precondition for receiving PEP (WHO and ILO, 2007). For many sexual assault survivors, being presented with an HIV test during a particularly traumatic time can be overwhelming (Raising Voices, 2008). Also, since time is of the essence,

Box 2. HIV Testing

"Baseline HIV testing need not precede administration of PEP, as testing can cause undue delay in administration of the first dose. Also, many rape survivors will not be psychologically prepared for HIV testing, and testing can add considerably to their emotional distress…If the client is not psychologically ready, the baseline HIV test can be delayed by up to three days after commencement of PEP."

—Kenya's National Guidelines: Medical Management of Rape/Sexual Violence, p. 5

survivors may feel as though they are being pushed into a test during a traumatic time; in reality, they may not be fully prepared to undergo this test and deal with the results. Many survivors are not emotionally ready to receive a positive HIV result at that point, so many experts argue that HIV testing should be deferrable or optional (see Box 2). A compromise on this issue is for providers to administer PEP to survivors before they have taken an HIV test or before they know the results. While this still mandates a test, it gives survivors time to process and receive other counseling. According to WHO/ILO guidelines, sexual assault survivors who request that HIV testing be delayed should be given a PEP starter pack and asked to return within three to four days for follow-up (WHO and ILO, 2007).

What do the guidelines say?

The guidelines of the countries reviewed call for HIV testing when providing PEP for sexual assault. However, five countries pay the most attention to HIV testing as a gender issue. These countries—Ethiopia, Kenya, Namibia, South Africa, and Zambia—make allowances for survivors who may want to delay HIV testing. Three countries—Botswana, Rwanda, and Zambia—are vague about whether HIV testing is mandatory. Two countries—Tanzania and Uganda—specify that PEP should not be administered without an HIV test, thus paying the least amount of attention to related gender issues. Nigeria's guidelines imply that PEP will not be provided without an HIV test.

Most attention to the issue

Required, but with allowances for testing. Several countries—such as Ethiopia, Kenya, Namibia, South Africa, and Zambia—recognize the circumstances surrounding the mandatory post-assault HIV testing and give more flexibility to survivors. Kenya's guidelines emphasize that providers should follow established national HIV testing guidelines to ensure informed consent. The guidelines advise providers to have patients sign the back of the lab form to indicate informed consent. They note that "baseline HIV testing need not precede administration of PEP, as testing can cause undue delay in administration of the first dose. Also, many rape survivors may not be psychologically prepared for HIV testing, and testing can add considerably to their emotional distress" (Republic of Kenya, 2004, p. 5). Taking this trauma into account, the guidelines allow for healthcare providers to delay the baseline HIV test by up to three days after commencement of PEP if the client is not psychologically ready. However, they still state that baseline HIV testing is necessary within 72 hours of starting PEP.

Zambia's guidelines stipulate, "If PEP is to be given, initiation should not be delayed for results of standard HIV serologic testing" (Republic of Zambia, 2004, p. 138). However, there is no further detail. While Namibia's ART guidelines state that voluntary HIV testing—if possible, rapid testing—should be made available and should be done for all who choose PEP, the guidelines also recognize that

> "It may be difficult to obtain informed consent for HIV testing shortly after the rape. The importance of an HIV test should be explained, as a 4-week course of AZT/3TC may induce resistance to these drugs and compromise future ARV treatment. All rape survivors who present within 72 hours to be offered a 3-day course of AZT/3TC while HIV test results are awaited or consent for testing can be obtained" (Republic of Namibia, 2003, p. 31).

Ethiopia's guidelines also point out the importance of knowing the victim's HIV status prior to any ARV treatment. The guidelines state

> "It is the patient's choice to have immediate HIV testing or, if s/he prefers, this can be delayed until 72 hours post examination visit (management guidelines on sexual assault provide for a 3-day starter pack of PEP for those who prefer not to test immediately, or those who are not ready to receive results immediately). However, encourage the patient to be tested" (Federal HAPCO, 2007, p. 82).

According to South Africa's guidelines for management of HIV and STIs after sexual assault, voluntary rapid HIV testing should be available and given to all patients opting for PEP. In addition, rape survivors should sign a consent form for both testing and ARV prophylaxis. While the guidelines state that it is the patient's choice to have immediate HIV testing, they also say that if the patient refuses an HIV test, no ARV prophylaxis will be provided. If the patient prefers, this can be delayed until 72 hours after the examination visit. National ART guidelines state that "Management guidelines on sexual assault include provision for a three-day starter pack for those who prefer not to test immediately or who are not ready to receive results immediately" (National Department of Health, South Africa, 2004, p.74).

Call for, but vague about mandatory testing. Other countries include the need for an HIV test but are vague about it being mandatory. For example, Rwanda's guidelines state, "If an HIV-negative person is raped by a known HIV-positive individual, post-exposure prophylaxis should be given as quickly as possible. The victim should be tested as soon as possible" (Republic of Rwanda, 2007, p. 111). If the status of the patient is unknown, he/she should take a rapid test immediately. Similarly, Zambian guidelines advise that healthcare workers should "determine HIV status in the afflicted individuals" but do not include additional information about whether an HIV test is required. Botswana's document states that the providers should ask victims to take an HIV test. If this test is positive, the survivor should stop PEP and receive appropriate counseling. If the test is negative, healthcare providers should give the assault survivor one month of PEP and offer follow-up testing, as for needle stick injuries.

Least attention to the issue

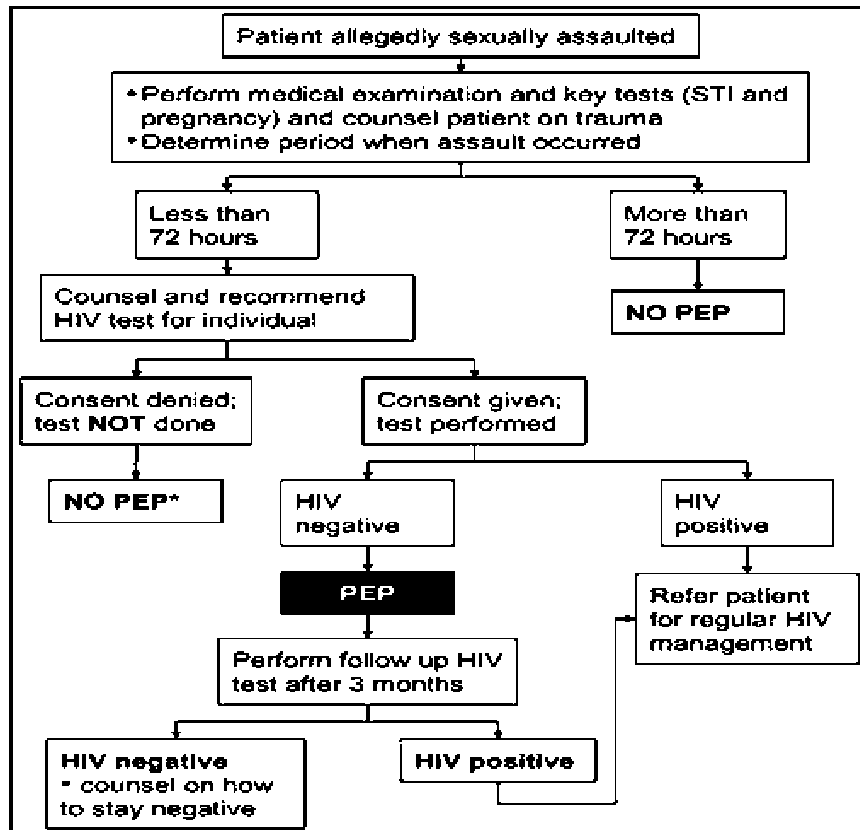
Overall, all of the PEPFAR focus country guidelines include HIV testing before administration of PEP to sexual assault survivors. Some countries, such as Uganda and Tanzania, clearly state that clients who do not wish to undergo an HIV test should not receive PEP. Uganda's guidelines read,

> "Upon occurrence of any incident, the HIV…infection status for both the exposed person and exposure source should be established by relevant laboratory diagnostic tests. This should be carried out after informed consent has been obtained as required by existing laws and regulations…testing is not required for person(s) known to be infected…While awaiting results of the diagnostic test, PEP should be started for the exposed person and stopped if the source is found not to be infected or if the exposed person is found to be positive. PEP should not be offered to exposed persons who decline the diagnostic test" (Republic of Uganda, 2007, p. 15).

Likewise, *Tanzania's National Guidelines for the Clinical Management of HIV* clearly state, through the PEP algorithm (see Figure 3), that patients who do not consent to an HIV test cannot receive PEP. The guidelines state the following:

> "For those whose status is unknown, a HIV test should be required. It is important that this be enforced to prevent the potential for resistant developing should the individual be HIV positive and therefore the virus be exposed to ARVs just for the PEP period. In addition, PEP for such individuals would not be effective in preventing primary infection since they are already infected. Only those who are found to be HIV negative should receive PEP" (United Republic of Tanzania, 2005, p. 123).

Figure 3. Tanzania: Post-exposure Prophylaxis After Sexual Assault



Source: *Tanzania's National Guidelines for the Clinical Management of HIV,* 2005, p. 95.

While Nigeria's guidelines do not state explicitly that HIV testing is required, this is implied in the following:

> "In the event that there has been sexual abuse or rape, it is recommended that the victim be counseled for PEP if the victim is negative. If the victim tests positive, the victim should be managed accordingly. It is also important to determine the HIV status of the perpetrator. If this is not possible the perpetrator is assumed to be HIV positive and the victim treated as a case of high-risk exposure. In the event of rape it is important to arrange for on-going counseling and support" (no page number given).

Elements of Service Provision: Access to Services

What Are the Facilities?

What are the gender issues?

Because there is a small window within which PEP may be effective (within 72 hours of exposure), sexual assault survivors need to have access to PEP at all hours. Without 24-hour access, they may not obtain PEP in time. With such a limited timeframe, survivors must be able to acquire the medication at a range of healthcare facilities and at all hours. They also need to know which facilities can provide this service. Because sexual assaults often occur at night, it is important that qualified healthcare workers are available at sites to administer the medication. This is particularly important when survivors may have traveled far to reach a site and are still within the 72-hour time period. Women are of particular concern here, as they are more likely to have limited mobility and may have gone to great lengths to travel such distances. Where facilities do not provide PEP or do not have the necessary staff available to do so,

healthcare staff must be able to provide referrals. As the WHO/ILO guidelines note, providing initial and follow-up PEP services at locations close enough to the people who need them is likely to be one of the biggest challenges facing PEP delivery systems (WHO and ILO, 2007). Thus, national policy documents should identify optimal service delivery sites in each setting (e.g. urban, rural, etc.) to indicate specifically where survivors can access services.

What do the guidelines say?

The guidelines provide little insight into the types of facilities at which PEP is administered for sexual assault survivors. Most of the documents simply refer to health facilities without further detail. Kenya refers specifically to the types of departments that manage post-rape care, which includes PEP; its guidelines are specific to rape, however. In addition, Guyana acknowledges survivors' need for PEP services at all hours, as the guidelines state that PEP should be available 24 hours a day.

Most attention to the issue

Kenya's national guidelines provide the most specific references to where PEP is to be administered for sexual assault survivors. The guidelines state that the client flow charts for management of PEP are applicable for casualty and outpatient department/HIV clinics. In addition, the Post Rape Care Form 2 (PRC2) applies to ARV/PEP/comprehensive care clinics and includes documenting the provision of PEP.

Only one country, Guyana, calls attention to the need for PEP at all hours, its guidelines stating, "The basic ARV regimen for PEP should be available 24 hours a day, including nights and weekends, in all healthcare facilities" (Ministry of Health, Guyana, 2006, p. 91). However, the guidelines include this provision in the occupational exposure section and are not clear as to whether the 24-hour availability applies to sexual assault survivors.

Least attention to the issue

The majority of the policy documents that include PEP for sexual assault are vague about the sites to which the guidelines apply. Most of the documents do not refer to any type of service delivery site; two refer to health facilities but are not more specific. For example, Ethiopia's guidelines read,

> "All women 14 years and older presenting to a health facility after potential exposure to HIV during sexual assault should be counseled by the examining health care worker about the potential risk of HIV infection" (Federal HAPCO, 2007, p. 82).

Who Are the Providers?

What are the gender issues?

National policy documents can help to ensure delivery of high-quality services to sexual assault survivors by providing clear guidance on who is qualified to administer PEP. In addition, a minimum level of clinical expertise needs to be defined at each level of provision, as providers need to be aware of the scope of their responsibility (WHO and ILO, 2007). This clarifies healthcare providers' roles, which can help implementers to identify whether sites have enough people to fill this role. It is important for facility managers to take this into account to ensure that someone is always available to administer PEP. This is important when considering women's limited mobility, as they may not be able to easily reach a referred site.

In addition, sexual assault survivors seeking this service are particularly vulnerable and need to be approached with care, especially those, such as men or certain types of women (e.g., married women or sex workers), who do not match the provider's perception of a sexual assault survivor. Healthcare workers who come into contact with sexual assault survivors should receive training to "guarantee providers' appropriate attitudes and actions and clients' privacy and confidentiality" (IGWG of USAID, 2008). Furthermore, the inclusion of HIV makes it even more important to ensure that there is no stigma

or discrimination. All of these issues are important to consider to ensure that survivors have access to high-quality care.

What do the guidelines say?

As stated above, most of the policy documents are vague about the health facilities in which PEP is available; they are similarly vague about the type of providers qualified to administer PEP. Three countries—Namibia, South Africa, and Uganda—provide the most detail about the types of providers who can administer PEP; the rest of the countries do not deal with it at all.

Most attention to the issue

Uganda's guidelines are the most specific, pointing out that healthcare managers at different levels are responsible for the organization and running of health facilities in terms of administering PEP services. The document also outlines the various roles of different staff healthcare sites, as the following details:

> "The managers will also play a crucial role in facilitating consultations and referrals as well as ensuring a safe working environment…Trained healthcare workers will evaluate the client and initiate treatment, liaise with healthcare managers for timely referral/consultations; ensure that counseling and relevant laboratory investigations and subsequent follow-up of the client are done. Laboratory personnel will conduct the relevant investigations in a timely manner and complement other members of the team for effective and timely management of clients. Counselors will offer counseling to the client regarding the risk and consequences of exposure, the benefits and possible side effects of the medicines used in PEP and maintain follow-up counseling and psychosocial support" (Republic of Uganda, 2007, p. 19–20).

Uganda's guidelines go a step further than all of the other policy documents, defining healthcare providers in the glossary as, "…persons [e.g. employees, students, contractors, attending clinicians, public safety workers, or volunteers] whose activities involve contact with patients or with blood or other body fluids from patients in a health-care, laboratory, or public-safety setting" (Republic of Uganda, 2007, p. vii).

The preface to Namibia's Guidelines for ART stipulates that "specialists and medical officers in the public sector" will be required to complete the ministry's training program on these guidelines before being allowed to prescribe ART. It is not clear, however, to which specialist or medical officers the guidelines refer. Namibia's guidelines for service providers are more specific, reading,

> "Victims should be seen within all public health facilities, such as clinics, doctor's surgeries and hospitals…A medical doctor should see and treat the rape/sexual abuse victim. More senior medical staff should if possible examine suspected rape cases on admission or in the casualty department…If no doctor is available at the clinic or hospital, the nurse or administrative staff (if no nurse is available) must organize a referral to a clinic, hospital or medical health facility where a doctor is available" (Legal Assistance Centre, 2005, p. 23).

Finally, South Africa's guidelines clearly state that they apply to both the public and private sectors, as "Health care providers and clinicians in the public and private sector are encouraged to familiarize themselves with the content of these guidelines so that we, together, provide the best possible and safest care for those with HIV and AIDS in South Africa" (National Department of Health, South Africa, 2004, Foreword). It reads further,

> "These guidelines serve to assist the clinic team in the management of patients on antiretroviral drugs as outlined in the Comprehensive Plan for HIV and AIDS Care,

Management and Treatment. The approach adopted is that of the continuum of care, with a holistic patient focus in an integrated health system…This system will be integrated from primary to tertiary levels, as well as from the clinic to the community and from pre-diagnosis to palliation, whichever is appropriate. The focus is at the primary level within the context of the district health system being implemented throughout the country" (National Department of Health, South Africa, 2004, Introduction).

Least attention to the issue

Guidelines for the remaining 10 countries do not refer to the type of healthcare provider qualified to administer PEP in cases of sexual assault. This omission reveals a potential lack of clarity as to who should be present when survivors seek PEP services. The following section of Botswana's guidelines provides more detail in relation to occupational exposure:

> "Any individual sustaining a needle-stick injury…will be required to report it immediately to the duty-supervising officer…the recipient of the injury will then be referred to the AIDS counselor designated to document such cases and provide counseling for them. If the injury occurs after hours, counseling will be done by the supervisor with assistance, where necessary, from the senior doctor on call…" (Ministry of Health Botswana, 2005, p. 41).

The section on sexual assault contains no such details about which provider should provide which service, for example,

> "Survivors of rape who present with a history of rape within the previous 48 hours with a history of penetration should be offered PEP. They should also be asked to take an HIV test, and if positive, the PEP should be stopped and appropriate counseling done. If the test is negative, they should be given one month of PEP and offered follow-up testing for needle stick injuries above. A register of drug use should be kept" (Ministry of Health Botswana, 2005, p. 45).

What Are the Costs of PEP?

What are the gender issues?

As in many other cases, costs associated with medical services can be a barrier to those seeking healthcare. Costs of services are a gender issue for women because men and women often have disparate resources. Generally, women have less financial decisionmaking power in their families, in addition to fewer economic and productive resources. There have been reports from programs for HIV-positive women of men receiving priority over women in families when both need ART; also, sometimes men steal medication from women (ICW, 2004a). In some cases, women also feel guilt or pressure to share ARVs with family members (ICW, 2004a). In the case of sexual assault, survivors may be unable to pay for services or are deterred by the prospect of having to pay and, as a result, may not seek services. This barrier can be overcome by national policies or guidelines that provide free PEP to patients. Beyond provision of free medical services, women may lack resources for associated costs, such as travel to reach a clinic and food to take with the medication.

What do the guidelines say?

There is no coverage of cost for PEP-related or other post-sexual assault medical services in the PEPFAR focus countries' policy documents. Only Guyana states that PEP is free to sexual assault survivors. Two countries—Côte d'Ivoire and Ethiopia—acknowledge the issue, but only in reference to occupational exposure, not to sexual assault. Documents from the remainder of the countries do not mention the cost of PEP.

Most attention to the issue
Only one country commits to making PEP free to sexual assault survivors. Guyana's national policy on HIV states that "PEP must be made available to all rape survivors on a free and accessible basis" (National AIDS Program Secretariat, et al., 2006, p. 8). However, this is not included in the *National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children*, and there is no additional detail in the national HIV/AIDS policy.

Least attention to the issue
Côte d'Ivoire and Ethiopia clearly state that PEP is provided free in cases of occupational exposure. Côte d'Ivoire's policy states that PEP is free for public sector healthcare personnel, but does not specify cases of sexual assault. The rest of the countries reviewed do not include reference to the cost of PEP.

Elements of Service Provision: Quality of Care

What Are the Adherence and Follow-up Issues?

What are the gender issues?
To increase the likelihood of PEP being effective, patients must follow the drug regimen outlined by their healthcare providers. To enhance the likelihood of this outcome, providers can offer adherence counseling—subsequent counseling sessions scheduled to coincide with PEP clinic follow-ups. Sexual assault survivors have low rates of adherence to PEP (Republic of Kenya, 2004), due partially to their trauma. A study in South Africa reported several patients saying that they had been in no state to listen to instructions about treatment following their assault (Vetten and Haffejee, 2008). Similarly, service providers have found it difficult to give information about PEP to traumatized patients (Wiebe et al., 2000).

HIV programs and research also have shown that women face difficulties in adhering to HIV treatment in resource-poor settings (ICW, 2004b; Kyomuhendo and Kiwanuka, 2008). Resources such as safe water and food are needed to ease the effects of taking PEP. If women lack these, they may choose to discontinue the medication. Also, many women who play active roles in the family cannot afford to be sick as a result of side effects, which often are quite severe; those who experience them may discontinue medication if they cannot cope. There is little known about men's ability to adhere to HIV treatment in resource-poor settings.

Women and other vulnerable groups face particularly acute stigma and discrimination when taking PEP. In addition to possibly disclosing the sexual assault, taking PEP also can be viewed as disclosure of a positive HIV status. Many survivors do not want their families or communities to know they have been assaulted. This may be particularly true with men who have sex with men and transgender persons, who may fear additional violence. Potential disclosure can limit their will and ability to take PEP. According to a Human Rights Watch report from South Africa, women who were reluctant to disclose their rape to their husbands or partners were more likely to default on their drug regimen (Human Rights Watch, 2004). In addition, survivors may present false addresses to healthcare providers to ensure that there will be no follow-up. In cases where women's partners assaulted them, taking PEP may result in additional violence by the partner, who also may prohibit women from returning for additional treatment and services (Ali, 2007).[12]

Furthermore, gender norms result in limiting women's mobility through such factors as lack of transportation, which affects their ability to return to health facilities for follow-up medication, testing,

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[12] While this source does not assess the specific effect of violence related to PEP, it does discuss violence related to women's ability to adhere to ART.

and care. Men may not engage with the provision of care after the assault due to stigma and psychological difficulties (Reeves et al., 2004). WHO recommends that patients with initial negative HIV results should have the test repeated 6, 12, and 24 weeks after the assault to ensure they have not acquired the virus (WHO, 2003). Follow-up by providers is crucial to ensuring that patients are taking and adhering to medication and are not encountering any complications. To provide follow-up, most guidelines or policies require that patients return to the healthcare site a week after first receiving PEP to receive the remainder of their PEP dosage. The WHO/ILO guidelines do offer options for taking gender norms into account when providing PEP. They note that the ability of the person potentially exposed to HIV to return to collect further doses of medicine is a key factor in deciding how to provide PEP (WHO and ILO, 2007). Thus, the guidelines outline the following options for dispensing PEP at the initial consultation (p. 26):

- Starter packs: an initial supply of medicine to last 1–7 days
- Incremental dosing: providing medicine every week or two to encourage follow-up and minimize possible waste of medicine
- Full 28-day dosing: supplying the full 28-day course of medicine at the initial visit, which may maximize the likelihood of completing the course if follow-up is a concern

What do the guidelines say?

Three countries—Ethiopia, Kenya, and South Africa—take gender barriers into account in relation to adherence and follow-up on PEP provision for sexual assault survivors. Tanzania and Namibia are the two countries that pay the least attention to these issues.

Most attention to the issue (adherence)

To address gender issues related to adherence, several countries, such as Kenya and South Africa, factor the realities of women's lives into their guidelines. These guidelines specifically refer to adherence barriers women often face. To address potential barriers to follow-up treatment and care after sexual assault, guidelines from a number of countries stipulate flexibility about the follow-up visits to obtain the remainder of the PEP dosage. For example, while the Kenya guidelines advise providing medication for one week and encourage having clients return for clinical follow-up, counseling, and adherence support, they also are flexible, stating that "Exceptions can be made if, for example, the individual lives a great distance away, and is unlikely to return" (Republic of Kenya, 2004, p.3).

Similarly, South Africa's National ART Guidelines advise that patients should be given a week's supply of AZT and 3TC and a return date for an appointment one week later for reassessment, ongoing counseling, and to review HIV test results [except for a rapid HIV test or to obtain the confirmatory enzyme linked immunosorbent assay (ELISA), where positive]. However, "For those patients who cannot return for their one-week assessment due to logistical or economic reasons, then a month's treatment supply, with an appointment date should be given. This may be particularly relevant outside of the metropolitan areas" (National Department of Health, South Africa, 2004, p. 76).

Least attention to the issue (adherence)

The Namibia guidelines do not provide extra time for follow-up and stipulate an even shorter dosage timeframe. Namibia's ART guidelines call for healthcare providers to give patients a three-day supply of AZT and 3TC and a date to return for reassessment for further counseling and evaluation. This could lead to survivors' inability to adhere to the medication, as it may be difficult for most to return to a clinic within three days. None of the guidelines from other countries address adherence-related issues.

Most attention to the issue (follow-up)

The majority of the PEPFAR focus countries adhere to WHO's standard for follow-up HIV testing, recommending that patients return at certain intervals for follow-up tests (see Table 2). In addition, Ethiopia's guidelines strongly recommend that health providers carefully monitor and evaluate PEP

implementation for inclusion of psychosocial and legal support, screening for conventional STIs and follow-up management, drug side effects, and seroconversion.

Least attention to the issue (follow-up)

While Tanzania's guidelines specify that those receiving PEP related to occupational exposure should be tested at baseline, 6 weeks, 12 weeks, and 6 months post exposure to HIV, they do not call for similar follow-up in relation to sexual assault. Tanzania's guidelines stipulate the individual returning for a confirmatory set of HIV tests three months after the PEP period to determine treatment effectiveness. The guidance does not include any acknowledgement of potential adherence issues, however.

Table 2. Follow-up HIV testing

	6 weeks	12 weeks	24 weeks
Botswana	X	X	X
Ethiopia	X	X	
Kenya	X	X	
Namibia	X	X	X
Rwanda	X[13]	X	X
South Africa	X	X	X
Tanzania	X[14]	X	X[15]
Zambia		X	X

Counseling on PEP and Sexual Assault

What are the gender issues?

Counseling on PEP and sexual assault is a critical component in determining quality of care for sexual assault survivors. GBV advocates and experts maintain that the principle of "doing no harm" should guide every decision made related to GBV programming (IGWG, 2008). That is, policy and program implementers need to ensure that all GBV initiatives respect survivors' safety and autonomy. To do so, national policy documents should include guidance on counseling—including training on counseling—to make sure that providers do not inadvertently cause additional harm to sexual assault survivors. Providers may stigmatize or discriminate against survivors through their own attitudes and beliefs about either sexual assault or the survivor, which may be rooted in gender-based assumptions. This may reinforce stereotypes about victimization.

National policy documents also should refer providers to specific guidance on post-rape procedures. If countries do not have such guidelines, it is important that PEP guidelines include recommendations for counseling specifically related to sexual assault. Survivors need this counseling to address trauma that may affect their ability to adhere to PEP and receive other types of assistance. While men and women both need trauma counseling, they may have different needs. For example, men may have concerns about their masculinity and sexuality (Population Council, 2008). The relative rarity of male survivors may also contribute to stigma and feelings of powerlessness (WHO, 2003 in Population Council, 2008).

Furthermore, when PEP policies require HIV testing, as most do, it is important to ensure proper counseling related to HIV and PEP. Testing survivors for HIV after sexual assault can serve to magnify

[13] Between 3–6 weeks.
[14] Only included specifically for occupational exposure.
[15] Only included specifically for occupational exposure.

their trauma, especially if the test is positive. Survivors also may need counseling related to disclosure, which can place them at additional risk of violence. Failure to encompass guidance on counseling, including guidance on training for counseling, can affect policy documents' implementation.

What do the guidelines say?

The majority of countries in this review include counseling on PEP in their guidance documents, but fewer mention counseling specifically focusing on sexual assault. Kenya, Tanzania, Namibia, and South Africa cover counseling on PEP and sexual assault. Rwanda and Ethiopia also include counseling on PEP in their guidelines.

Most attention to the issue

The Kenya, Namibia, and South Africa policy documents provide thorough information for providers on what to cover in PEP counseling for sexual assault survivors. For example, Kenya's guidelines stipulate ensuring that patients understand PEP-related information, such as the medication taken, the window period between exposure to and testing positive for HIV—including the possibility of transmitting HIV during this time—and the importance of following safe sex procedures until follow-up testing has been completed. The guidelines advise providers to supply condoms at this time and remind clients that PEP reduces the chance of HIV infection but does not definitely prevent it. The guidelines also state that providers should advise PEP patients of the common but temporary side effects, such as nausea, headaches, fatigue, and general aches and pains. In addition, they advise that counseling for all rape survivors cover three basic areas—trauma counseling/crisis prevention, HIV pre- and post-test counseling, and PEP adherence on an ongoing basis for up to a minimum of five sessions. The guidelines state that providers ideally should refer sexual assault survivors for long-term ongoing trauma counseling. In addition,

> "Counseling should be done by an experienced general counselor, VCT and/or DCT counselor who has been trained in trauma counseling and HIV testing in the context of sexual violence. Counseling can be undertaken in the VCT or DCT room, or other room within the hospital that provides privacy for the survivor. The client should be referred to the counselor after initial dose of PEP and EC. This will enable the client [to] make an informed choice about HIV testing in order to continue PEP. Where the survivor sees the counselor within 72 hours and PEP/EC has not been given, the counselor must ensure that these are provided before commencing counseling" (Republic of Kenya, 2004, p. 8).

Namibia and South Africa have similar detailed guidance documents on counseling related to PEP, which are largely in line with international standards. Issues to be addressed during counseling include the following (Republic of Namibia, 2003, p. 31; National Department of Health, Republic of South Africa, 2004, no page number given):

- The risk of HIV transmission is not known but exists.
- It is important for the survivor to know her/his HIV status prior to using any ARV, as using the standard PEP regimen of AZT and 3TC is not adequate therapy in a known HIV-infected person and may lead to ARV drug resistance.
- It is important to start PEP as soon as possible.
- It is the survivor's choice to receive PEP and to have HIV testing.
- For each rape survivor, blood and urine will be taken routinely to screen for syphilis, HIV, and existing pregnancy.
- If the possible risk for HIV transmission has been established, the rape has occurred within a period of 72 hours, and the rape survivor is HIV negative or results are not immediately available, ARV prophylaxis will be offered.

- The efficacy of AZT and 3TC in preventing HIV seroconversion in cases of sexual assault is not known.
- The common side effects of the drug should be explained, with particular reference to feelings of tiredness, nausea, and flu-like symptoms.
- PEP should be discontinued as soon as an HIV positive result for the survivor is known. Even in the absence of on-the-spot rapid testing, this should not take more than three days.
- The importance of [treatment] compliance should be emphasized.

Tanzania's national guidelines for the clinical management of HIV state that all women and men "presenting to a health facility after being raped should be counseled by the examining healthcare worker about the potential risks of HIV transmission post rape" (p. 123). In addition, Tanzania's algorithm detailing the process for providing PEP to sexual assault survivors (see Figure 3) indicates that patients should be counseled on trauma in the very early stages.[16]

Least attention to the issue

Ethiopia's document provides minimal guidance, stating that PEP counseling should cover the fact that the risk of HIV transmission is unknown but that such a risk exists. The guidelines also state that patients should be counseled about the risk of infection and the possibility of transmitting infection during seroconversion. Rwanda's guidelines direct healthcare providers to counsel victims whose status, and that of their perpetrator, is unknown (or refuses an HIV test or is unavailable), inform them about the risks and benefits of prophylaxis, and provide options.

Comprehensive Healthcare

What are the gender issues?

Policy and program guidelines that address sexual assault should employ the comprehensive care approach. This approach responds to sexual assault survivors' variety of needs, going beyond the provision of counseling on PEP and sexual assault. According to WHO (2003), comprehensive care addresses physical injuries; pregnancy; sexually transmitted infections, including HIV; counseling and social support; and follow-up consultations. Comprehensive care recognizes the range of consequences of sexual assault and by taking a holistic approach, responds to sexual assault in a gender-sensitive manner.

What do the guidelines say?

Three of the reviewed countries—South Africa, Namibia, and Kenya—provide PEP in the context of comprehensive care for sexual assault survivors. Several countries—Botswana, Guyana, and Nigeria—pay some attention to the issue of comprehensive care. The remaining seven countries do not include discussion or reference to comprehensive care, focusing only on sexual assault survivors' risk of acquiring HIV.

Most attention to the issue

Namibia's ART guidelines and South Africa's sexual assault guidelines refer to the context of comprehensive support for rape survivors, stipulating that PEP be administered only in that context. This includes counseling of the rape survivor—including issues related to stress management—identification of support needs, and necessary referrals. In addition, both countries' guidelines stipulate that, after sexual assault, women should undergo pregnancy testing to ensure that pregnant women receive appropriate antenatal care, with discussion of the possibility of HIV transmission to their unborn babies should they seroconvert. Namibia's guidelines also include emergency contraception as a consideration.

[16] However, trauma counseling is included only in the algorithm, not in the text of the guidelines.

The foreword of Kenya's guidelines states that their aim is

> "to set standards for comprehensive care of survivors of sexual violence…Comprehensive care includes counseling, treatment and management of injuries, sexually transmitted infections, post-exposure prophylaxis, HIV care for those who are HIV positive, and pregnancy prevention" (Republic of Kenya, 2004, p. iii).

The guidelines then follow this format, providing details for each of these components, including information related to the history, examination, documentation, and laboratory work related to the survivors and the assault.

Some attention to the issue

Several countries—Botswana, Guyana, and Nigeria—pay some attention to the issue of comprehensive care. Botswana's guidelines refer to reporting to the police, acknowledging the broader context of sexual assault in which healthcare services fall. Guyana's guidelines state that

> "In all cases of sexual assault, post coital contraception, STI prophylaxis and trauma counseling should be offered" (Ministry of Health, Guyana, 2006, p. 92).

Nigeria also refers to the importance of arranging for ongoing counseling and support for sexual assault survivors.

Least attention to the issue

The remaining countries do not refer to comprehensive care at all, instead focusing directly on provision of PEP. These guidelines ignore survivors' other healthcare needs that may result from sexual assault.

III. CONCLUSIONS AND RECOMMENDATIONS

This analysis has identified specific gender barriers that can affect whether PEP is provided to all sexual assault survivors. It is clear that, while the majority of PEPFAR focus countries have guidelines that provide for PEP for sexual assault, they generally lack detail and do not account for gender issues (see Table 3 for an overview of which countries address the gender issues previously discussed in this report). As such, these guidelines rarely address gender barriers that may affect their implementation. While many of the issues related to gender, such as criteria for access, are included in some of the guidelines, they often are not elaborated, and even the attention to PEP for sexual assault—in comparison to occupational exposure—is insufficient. Countries need to make a concerted effort to recognize these gender barriers and respond to them through national guidelines. These guidelines should make gender explicit by addressing these issues, as well as other gender issues that may be identified in a particular country context. Furthermore, guidelines need to include a gender analysis of barriers to accessing PEP. This will prompt necessary dialogue on gender issues, such as the best way to address HIV testing. Finally, national governments need to ensure that better practices are incorporated, expanded, and evaluated.

Table 1. Key Aspects of PEP Policies and Guidelines in 13 PEPFAR Focus Countries

	Eligibility: Explicitly includes men and women	Legal Require-ments: Police report required	HIV Testing: HIV test required	Facilities: Specific facilities for PEP provision noted	Providers: Specific providers for PEP provision noted	Cost: Free	Adherence and Follow-Up: All PEP doses provided at first visit
Botswana	√		√				
Côte d'Ivoire			√				
Ethiopia	√		√				√
Guyana			√	√		√	
Kenya	√		√	√			√
Mozambique			√				
Namibia	√		√		√		
Nigeria	√		√				
Rwanda	√		√				
South Africa	√		√		√		√
Tanzania	√		√				
Uganda	√		√		√		
Zambia	√		√				

Based on this review, the author recommends that the national agencies responsible for HIV prevention and services for survivors of sexual assault take the below actions.

Criteria for Access

- Revise current guidelines that address PEP for sexual assault survivors to include the range of possible survivors of sexual assault and cover awareness raising for providers related to stigma and discrimination and vulnerable groups other than women.
- Undertake further research on mandatory HIV testing and other gender issues as needed (e.g., possibly providing the full dose of PEP at once); promote policy dialogue on how best to address these gender issues.
- Create national post-sexual assault guidelines for medical facilities, including provision of PEP that is consistent with national ART or other guidelines that include PEP.
- Assess provider and community knowledge of PEP policies and guidelines; build knowledge as needed.
- Research the provision of PEP for children in cases of sexual assault, including what guidelines account for children, types of sites for care, adherence counseling, and working with parents/guardians.
- Ensure national funding and mechanisms for provision of PEP (i.e., ARVs).

Elements of Service Provision

- Develop clear implementation guidelines for PEP administration for sexual assault, identifying types of facilities and providers that can provide PEP and qualifications for providers, such as training on sexual assault, VCT, PEP adherence, stigma and discrimination, and gender norms.

- Establish or expand multisectoral post-rape care guidelines; facilitate support for a multisectoral response to sexual assault care at the policy and community levels.
- Link community post-rape care services and programs (non-clinic settings) with medical professionals to improve quality of care and provide comprehensive care.
- Explore reducing costs for sexual assault survivors seeking PEP services through free provision of PEP, support for transportation, and links to local food programs.
- Research efforts on improving adherence and adapt and adopt new adherence policies as appropriate.[17]

In addition, there are a few key steps that should be taken to improve development and implementation of PEP sexual assault guidelines. It is clear that, even if good policies are in place, it is a challenge to implement them. Support from policymakers and community involvement are both especially important to ensure implementation of policies to overcome gender barriers. It is important to assess whether community members are aware of and knowledgeable about the relevant sexual assault policies and programs. For example, Uganda's guidelines state, "In general, seeking and accessing HIV-PEP services is still very low in Uganda and it is thought that majority of the affected persons or communities lack knowledge of the existence of these services" (Republic of Uganda, 2007, p. 13). Thus, undertaking a policy implementation analysis on the ground is an important next step either for determining other barriers to accessing PEP services or examining existing barriers, such as adherence, more closely. For example, the Health Policy Initiative has led a participatory process in Mexico to identify gender-related operational barriers to accessing PEP. Project staff worked with Mexican decisionmakers and providers to create interventions to mediate the identified barriers. One of the interventions focused on creating a training module for healthcare providers on GBV, most-at-risk-populations, and PEP.

Officials should consider the gender barriers explored in this review when creating new PEP guidelines. Where current guidelines exist, institutions and programs should implement protocols and procedures to ensure that these barriers are addressed. By doing so, there will be a much better chance of increasing access to quality PEP services for sexual assault survivors. For the key components of a gender-sensitive PEP policy for sexual assault (see Box 3).

Box 3. Key Components of a Gender-sensitive PEP Policy for Sexual Assault

- PEP provision to men and women for sexual assault
- Baseline HIV testing offered with pre- and post-counseling
  - Patient can initiate PEP before taking an HIV test
  - Rapid HIV test should be used, if possible
  - Ensure confidentiality
- Types of facilities that administer PEP in cases of sexual assault identified
  - Broad range of facilities and hours of operation
  - Adequate availability and accessibility of PEP
    - National commitment to providing medication
    - PEP storage space accessible at all times
- Staff allowed to administer PEP specified
  - Qualifications of staff include regular, up-to-date training on PEP and management of post-sexual assault cases
  - Staff available at facility 24 hours
- Costs clearly stated
  - Same standards as occupational exposure cases
- Counseling offered on adherence and side effects
  - Entire dose of PEP allowed at first visit
- Links created to sexual assault comprehensive care services

[17] For example, see RADAR et al., 2007. *Developing an Integrated Model for Post-Rape Care and HIV Post-exposure Prophylaxis in Rural South Africa.*

ANNEX A: RELEVANT DOCUMENTS FOR 13 PEPFAR COUNTRIES

Country	Document	Year	Occupational PEP	Sexual Assault PEP
Botswana	*Botswana Guidelines on Anti-Retroviral Treatment*	2005	Yes	Yes
Côte d'Ivoire	*Vivant avec le VIH dans le Secteur Santé*	2005	Yes	Yes
Ethiopia	*Guidelines for Management of Opportunistic Infections and Anti-Retroviral Treatment in Adolescents and Adults in Ethiopia*	2007	Yes	Yes
Guyana	*Revised National Policy Document on HIV/AIDS in Guyana*	2006	Yes	Yes
Guyana	*National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children*	2006	Yes	Yes
Kenya	*National Guidelines: Medical Management of Rape/Sexual Violence*	2004	No	Yes
Mozambique	*Guia para Tratamento e Controle das Infeccoes de Transmissao Sexual (ITS) volume II*	2006	No (separate guidelines for that)	Yes
Namibia	*Guidelines for Antiretroviral Therapy*	2003	Yes	Yes
Nigeria	*Guidelines for the Use of ARV Drugs in Nigeria*	2007 (draft, but in use)	Yes	Yes
Rwanda	*Guide de Prise en Charge des Personnes Infectees par le VIH au Rwanda*	2007	Yes	Yes
South Africa	*National Antiretroviral Treatment Guidelines* *Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault*	2004 No date	Yes	Yes
Tanzania	*National Guidelines for the Clinical Management of HIV/AIDS*	2005	Yes	Yes
Uganda	*The National Policy Guidelines on Post-Exposure Prophylaxis for HIV, Hepatitis B, and Hepatitis C*	2007	Yes	Yes
Zambia	*National Guidelines on Management and Care of Patients with HIV/AIDS*	2004	Yes	Yes

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