Lessons learned on providing PEP for SGBV in Africa
What is SGBV?

“any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or any acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including by not limited to home and work”

Source: WHO, 2002
Why is SGBV an HIV issue?

- Forced sex rarely includes condom use  
  ▫ Age, gender and violence of assault associated with higher likelihood of transmission

- Following assault, untreated survivors more likely to engage in risky sexual behavior

- IPV associated with higher HIV risk and lower care-seeking and ART continuation

- Human rights imperative
The African regional SGBV network

• 9 countries, 17 partners
  • Zambia, Zimbabwe, Malawi, South Africa

• Supported by Swedish-Norwegian HIV/AIDS Team and PEPFAR

• PEPFAR partners adding SGBV services to existing HIV programs
Goals of the SGBV network

• Strengthen comprehensive treatment services for survivors of sexual violence.

• Produce and document lessons learned to strengthen programs throughout the region.
- Review of all literature on SGBV in Africa
- Key programming booklet intended as a resource for programmers
- www.svri.org
Framework of Comprehensive Care

**Medical**
- Management of sexual violence at 1st point of contact with the survivor.
- Sensitive approaches to managing child survivors of sexual violence, and encouraging and enabling presentation by male survivors.
- Screening for signs and symptoms of violence during routine health consultations.

**Justice System**
- Collection of forensic evidence and creation of a chain of evidence that can be used during prosecution.
- Strong links between medical and police facilities to enable incidents to be referred in either direction.

**Community**
- Psychological counselling.
- New or strengthened community-based prevention strategies that are relevant and appropriate for the local context.
- Physical, psychological, and emotional violence between domestic or intimate partners addressed through messages communicated during the prevention strategies.
Medical Management ‘Package’

- Treatment of injuries and clinical evaluation

- Prophylaxis for:
  - Pregnancy, emergency contraception (EC)
  - Sexually transmitted infections (STIs)
  - HIV, post exposure prophylaxis (PEP)

- Forensic examination, evidence collection and documentation

- Trauma counseling
The Regimen

- Theoretical efficacy for SGBV
- Most effective if taken within 72 hours of exposure
- 28 day course, with significant side-effects
- Follow-up testing at 3 and 6 months
Areas of Debate

- Dual and triple therapy?

- Pre-treatment HIV test necessary?
  - What are the implications of delivering a “stat dose” at intake?
At the present time, routine prophylaxis for HIV is a matter of considerable controversy and not a universally accepted standard of practice.

The risk factors for acquiring HIV from a sexual assault will determine whether or not PEP should be offered to a patient.

PEP standard of care in many African countries

  
  “The national plan for mainstreaming gender into the HIV/AIDS strategic plan in Kenya has identified sexual violence as a concern in HIV transmission, particularly among adolescents”

- South Africa (2005), Malawi, Zambia
Services in Coast General Hospital GBVRC
(source: International Center for Reproductive Health)
Lessons learned on improving PEP for SGBV survivors
Lesson 1:

Success of PEP programs relies on functional relationship between police and health sectors
The survivor’s first point of contact may not be a health facility

- In Zambia and SA, 91% of all cases reported to police first
  - 80% within 72 hours
  - less than half as many presented for medical care
  - 24% received PEP at health facilities

- Referrals are inhibited by limited knowledge and linkages
  - Transportation costs may act as a disincentive to visiting a second point of contact.
Strategies for linking police and legal services

• One-stop-shops for post-rape care (SA TCCs)
  ▫ Pros: greater access to comprehensive services
  ▫ Cons: resource intensive, urban bias

• Police provision of emergency contraception
  ▫ Zambia study demonstrated police can effectively provide EC and referrals to survivors
  ▫ Can this be done with adult PEP?

• Decentralizing SGBV health care to district and local levels
Lesson 2:

Within health facility, “most obstacles to providing PEP are institutional rather than patient-driven”
Barriers within health facility

- Limited service delivery protocols and guidelines for PEP, SGBV care

- Knowledge of PEP relatively high among providers, but experience limited

- Numerous referrals across hospital departments
  - In Acornhoek study, VCT was the 7th referral within hospital

- VCT, pharmacies often not available after hours
  - In one Kenyan hospital, 65% report on Monday
Strategies for improving PEP provision within health facilities

- Develop policies/protocols

- Centralize all SGBV services, including VCT, in one private, accessible area of hospital
  - Mean door to dose time:
    - Acornhoek study decreased from 28 to 18 hours

- Ensure trained VCT and adherence counselors are available when needed
  - Training opportunity in January
Lesson 3:

Targeted strategies are needed to address the special needs of child survivors
Majority of Reported Cases are Children (Zambia, 2000-2004)
Majority of *Reported* Cases are Children (Kenya, 2003-2004)
No clear models for providing PEP to children

- Younger girls physiologically more vulnerable to infection

- Pediatric PEP considered “specialized” service, VCT counselors reluctant to provide

- No specific data on adherence for children
Lesson 4:

Ensuring adherence is the core challenge of successful PEP provision
Adherence in Kenya: MOH/ LVCT data

Delivery: Quality of PEP delivery (n=292)

- Continued PEP: 59%
- Late presentation: 14%
- Lost to referral: 11%
- HIV+ at baseline: 5%
- No to HIV test: 11%
Barriers to Adherence

- Side effects
- Incorrect/incomplete understanding of the regimen
- Transportation constraints
Strategies for increasing adherence

- Reducing transportation barriers
  - Providing all 28 days at first visit
    - SA Acornhoek: increased from 29% to 71%
  - Transportation vouchers
    - SA TVEP: Adherence rates as high as 90%
- Providing a dedicated emergency contractive pill
- Delivering specialized adherence counseling
What resources are available to strengthen PEP for SGBV programs?

- Illustrative guidelines, protocols, research on www.svri.org

- Technical assistance opportunities through network partners
  - Medical management training in January
  - ICASA satellite session

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