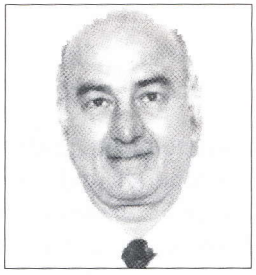
HIV and the rape victim –

allaying the feelings of 'deadly uncleanness for life'

Ray W R Lunt
MB BCh; MSc

S Afr Fam Pract
1995;16:782-785

KEYWORDS
Physicians, family;
Rape;
Fear;
Ethics, medical;
HIV seropositivity;
Criminal law.



Curriculum Vitae

Ray has enjoyed being a lifelong learner. Journeying through an understanding of Chemistry to BSc, Organic Chemistry to Honours and then a Masters in Biochemistry. This understanding in the basic chemistry of life has always been valued by him and lead to enthusiasm for medicine and man's ability to conquer disease. MBBCh confirmed the boundless nature of man's scientific ability. Thus understandable disease orientation continued in pathology but the application of man's ability in clinical medicine was found to be in its infancy. MFGP(SA), the Medunsa course and Balint have all contributed to his value of the person in patient, doctor and soceity. Ray believes that it is here that our future and hopes for South African social upliftment lie. Ray loves his family and being a family physician.

29 Daffodil Way
Pinelands
7405

Summary

Fears of the HIV epidemic at present engulfing sub-Saharan Africa and spreading rapidly southwards, are worsened by the prsent violence and rape epidemic. This article looks at the task of allaying these fears where possible in the rape victim but can be applied with careful consideration to other non-rape situations and rape of one male by another male. Attentive listening is recommended and information on the small chance of seroconversion from a single episode should be given as well as safer sex methods. Of those, very few who are going to seroconvert from HIV negativity to positivity most will seroconvert within six weeks but safer sex methods to protect loved ones is recommended for six months after which the chance is minimal of seroconversion. A heirarch is presented as a treatment guideline and vaginal aspirate testing as a rapid screening indicator, which must be followed by serological laboratory confirmation.

Introduction

Rape victims have historically had feelings of uncleanness described by several authors.[1] These feelings have in the past, prior to the HIV era, been allayed by a good bath and antibiotic management where indicated.

With sub-Saharan Africa having 60% of the world's HIV cases and only 10% of the world's population[2] as well as a rising rape incidence, the fears of HIV sero-conversion post rape are very real.[3] Indeed, several HIV positive patients at present have histories of rape but rape as the sole etiology has not yet been proven here.

HIV and the rape victim

How and when can these fears be justifiably allayed?

The chance of sero-conversion from a single episode of rape is very small, less than 1%,[4] but is of little solace to a victim who feels unclean and would like, for example, normal sex with her husband and to have children by him.

What else can we do?

Surely she is entitled to removal or neutralising of the infective dose as soon as possible after the event.[3] Douching with a halogen douche[2] or the use of an antiviral pessary or cream as soon as possible after the event could ultimately help decrease both the time of exposure and the infective dose as well as decreasing concomitant infections.

Surely she also has the right to know if an aspiration of her vaginal fluid has any HIV virus in it, and if it does, what is her possibility of sero-conversion and when can she feel 'clean'? For how long should she abstain, or practice safer sex? Six months seems to be the accepted answer.[5]

If the sex offender is identified, surely she is also entitled to know his HIV status. A negative serology over a period extending from the rape to six months later would surely be most reassuring and least subject to false positives or negatives so she and her medical advisers should be informed as to whether it is positive or negative.

Worrying all rape victims with counselling may cause many unnecessary feelings of uncleanness but to ignore the problem, as is presently done, is equally unethical. One approach would be to do HIV investigations on vaginal aspirates. Such a screening test is at present available and can be done by the physician or patient in 10 minutes. The manufacturer claims no false negatives but positives need to be verified by another method which is standard practice.[6]

We must therefore take a look at the probabilities and the routine tests available.

The probability of sero-conversion on a single vaginal exposure is small (approximately 1/100) but with trauma could be 20 times higher. If both trauma and sodomy are present the chance is one in five which can't be described as small. The probability of a rapist being sero positive will vary as the epidemic grows but even if a low figure of 5% is taken then the probability of sero-conversion from an unknown rapist is 1%.

This may look small but is probably resulting in at least one person per month becoming HIV positive as a result of rape in the Cape Town area. Surely this is something that needs further investigation and should be taken into account by the judiciary.

Patient centredness requires confidentiality and the fact that the victim has to lay the charge and subject herself to the investigations and the concept of 'justice must be seen to be done' argues against false charges being laid. If the victim refuses HIV investigations she may have these feelings of 'a deadly uncleanness for life'. Whereas being tested for HIV by vaginal aspirate may allay these fears in 90% of cases. Those that have HIV +ve vaginal aspirates can be douched but may have these fears for six months before a negative serology could allay these fears.

Those that sero convert surely have a right to know[2] and if in a relationship, have an obligation to inform their consort according to the South African Medical and Dental Council.[7] This is not universal, two countries in the world[2] deny the consort this knowledge. The spouse stands a 30% probability of sero-conversion but is far more if other sexually transmitted diseases are present, so in all but the above two countries[2] it is encumbent on the doctor to inform them.

"I feel like a slut."

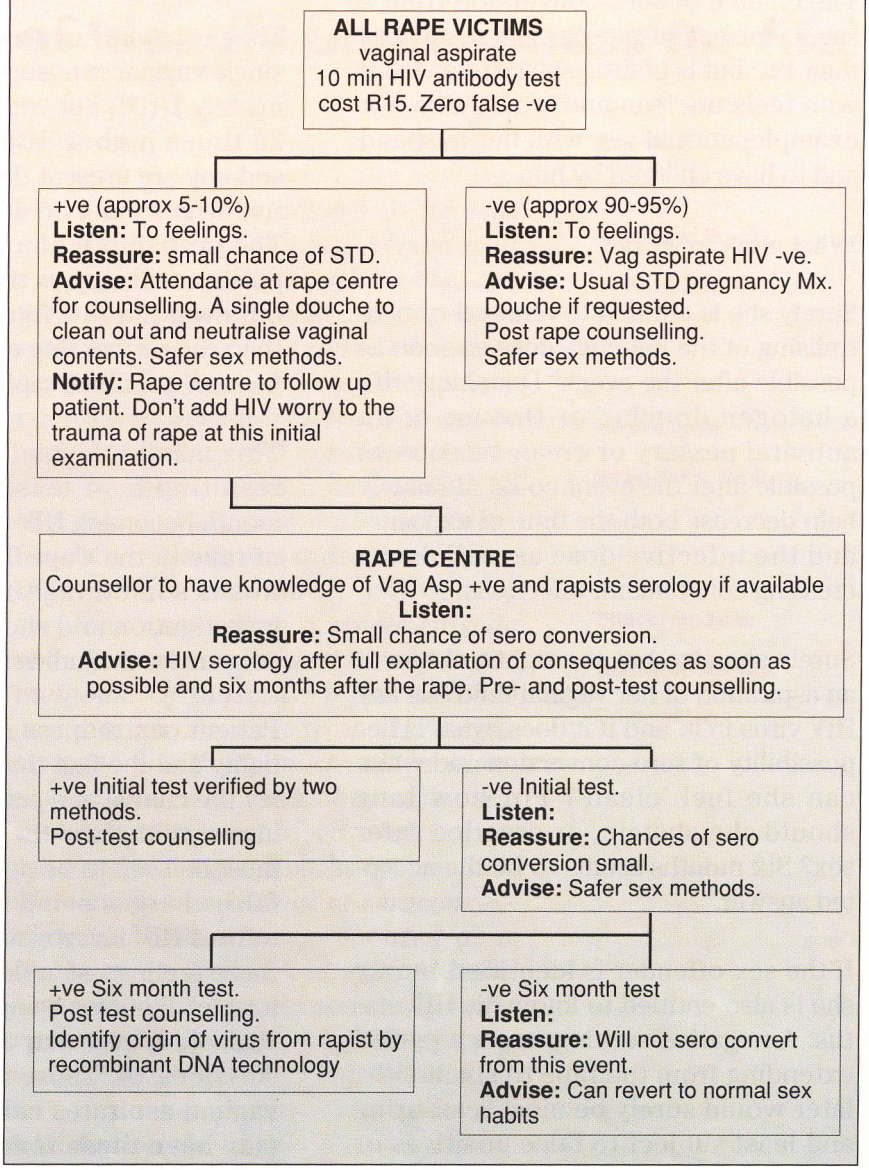
Women have the right to know if the HIV virus is present in their vagina.

A vaginal aspirate is the cheapest test and will allay fears.

HIV and the rape victim

It is generally accepted that similar ethics apply to needle stick injuries and to rape. In needle stick injuries blood is drawn from the person whose blood contaminated the needle without their consent being required so that medical management decisions can be made.[7] This must also apply where the alleged rapist is known. From the position of allaying fears this is good medical management but on the same grounds the alleged rapist would also be entitled to know his victim's HIV status if positive. What is also needed from the victim's point of view is her HIV serology soon after the alleged rape and six months later. The convicted sexual offender's status also needs to be known so as to protect the community and this means that his status needs to be known at the time of sentencing by the judiciary. A population hierarchy of the stages of allaying these fears appears in Figure 1. As is displayed in this hierarchy the cheapest adequate screening method, vaginal aspirate, is used on the vast majority of victims and only costs R15 per test. Confirmatory tests are done on only those that are indicated – R30 for an antibody to HIV test and R120 for a Polymerase Chain Reaction test (PCR). Recombinant DNA technology is only used if required by the courts for very specific identification of the person from whom the virus spread.[8-10]

Figure 1: Population hierarchy for allaying fears of HIV sero conversion in rape victims



In summary and conclusion we must be seen to be doing our best to:

- Prevent seroconversion at the first examination, as soon as possible after the event by using a single iodine douche then washing out. Creams and/or pessaries with antiviral agents such as nonoxynol-9 are indicated when there is a known hypersensitivity to iodine.
- Allay the fears of the rape victim. This is best done by identifying those at risk by vaginal aspirate and alleged rapist serology but maintaining confidentiality within the bounds of legality.
- Making sexual offenders' HIV status investigations compulsory for the protection of the community including the other prisoners.
- Counsel those at risk on safer sex practices and collecting sera for HIV testing, at the time of the event and six months after the incident.
- Counselling consorts according to the law of the land.[2]
- Decrease the incidence of rape by:
  a) media education
  b) getting convictions. Non-use of condoms may be seen and accepted by the courts as partial evidence of non consent.
  c) identification of the rapist in the cases of those victims who sero con-

Sub-Saharan Africa has 10% of the world's population, and 60% of its HIV cases.

Listening to patients' fears is of paramount importance.

vert. Virus recombinant DNA technology can do this very specifically.

- Listening to patients' fears which is of paramount importance. Advice and reassurance as indicated in this article can only follow attentive listening with unconditional positive regard and empathy.

References:

1. Lebowitz L, Roth S. I felt like a slut. J Trauma Stress 1994;7(3):363-90.
2. Schoub BD. AIDS and HIV in perspective: a guide to understanding the virus and its consequences. New York: Cambridge University Press, 1994:109-202 and 152-3.
3. Foster M, Bartlet J. Anti-HIV Substances for Rape Victims. JAMA 1989;216(23):3407.
4. Hampton HL. Care of the woman who has been raped. N Engl J Med 1995;332(4):234-7.
5. Sexual assault and STDs. MMWR 1993;42 (14):96-9.
6. Vedalab sensy-test, Binary Medical Supplies.
7. As quoted by Straus in "Patient and the Law" 3rd Edition: 11.
8. Simonds RJ, Rogers MF. HIV prevention-bringing the message home N Engl J Med 1993;329(25):1883-5.
9. Ou C, Ciesielski CA, Meyers G, et al. Molecular Epidemiology of HIV transmission in a dental practice. Science 1992;256: 1165-71.
10. Fritzgibon JE, et al. Child to child HIV transmission. N Engl J Med 1993;329:1883-5.