‘RIGHT OR PRIVILEGE’: AN INVESTIGATION INTO THE PROVISION OF POST EXPOSURE PROPHYLAXIS (PEP) TO SURVIVORS OF SEXUAL ASSAULT TO REDUCE THE CHANCES OF CONTRACTING HIV/AIDS. A CASE STUDY OF 7 CLINICS AND 1 HOSPITAL IN LUSAKA, ZAMBIA

Abstract

This dissertation, written by a former policeman who headed Zambia’s VSU (Victim Support Unit), investigates the plight of female (i.e., women and girls) sexual assault survivors who risk contracting the deadly HIV/AIDS virus, largely because the State, through its silence (i.e., lack of policy, legislation or administrative measures), fails to inform them of potentially life-saving PEP treatment that is available to them at State health centres. The writer collects and analyses a wide range of material and relevant data using a combination of gender-sensitive methodologies (especially the Women’s Law Approach) which highlights, through the eyes or ‘lived realities’ of the survivors themselves, the disparity between the actual benefits they receive and those they are promised in terms of their human right to enjoy, inter alia, good health, information and life in terms of local, regional and international HR instruments which bind Zambia. Finally, legal, educational, social and administrative reforms are suggested to help rectify this unfortunate state of affairs.

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LIST OF ACRONYMS

1. **AIDS Acquired Immune Deficiency Syndrome**
2. **ART Antiretroviral Therapy Treatment**
3. **ARV Antiretroviral(drugs)**
4. **CBD Central Business District**
5. **CDC Centre for Disease Control**
6. **HIV Human Immunodeficiency Virus**
7. **PEP Post Exposure Prophylaxis**
8. **STI Sexually Transmitted Infection**
9. **UTH University Teaching Hospital**
10. **VCT Voluntary Counselling and Testing**
11. **WHO World Health Organization**
12. **VSU Victim Support Unit**
13. **YWCA Young Women Christian Association**
14. **ZARAN Zambia AidsLaw Research and Advocacy Network**

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CHAPTER ONE

1.0 INTRODUCTION

The research looks at the provision of PEP treatment to survivors of sexual assault in some selected health centres and one hospital in Lusaka, the capital of Zambia. Many sexually assaulted survivors face a lot of challenges in accessing PEP treatment in health centres. The study looks at the provision of PEP treatment in the era of HIV/Aids. This was done by looking at what kind of legislation, policies and other administrative measures are or are not in place in accessing PEP for survivors of sexual assault. In order to understand the difficulties faced by survivors, a number of methods and methodologies were used to collect data and this was also done by looking at what the human rights instruments provide and what our national Constitution has for women who are sexually assaulted. International human rights are a bench mark on which the study is based because the right to health is one of the basic rights that need to be enjoyed by everyone regardless of sex.The study further provides some solutions on how PEP can be effectively accessed and made available to survivors of sexual assault.

1.1 BACKGROUND TO THE STUDY

In the world today, it is not surprising to read and hear about a woman or girl that has been sexually assaulted. The majority of sexual assaults take place in private and most of the time go unnoticed. The era of HIV/AIDs has brought a new dimension from which sexual assault has to be looked at. A lot of myths still surround the sexual assault of women in our society despite laws that have been put in place that criminalise this act. Sexual assault could be linked to the fact that our society from time inmemorial has deliberately turned a blind eye to this behaviour to an extent that it has now got out of hand. The belief among men to go and conquer and the selfish ego that men have to exert any form of power over women has led to a number of sexual assaults. The men argue that women ‘ask’ for it and that when she says “no”, she really means “yes”. The era of HIV/AIDs has brought with it an added frightening dimension to sexual assault: Some of the rapist and defilers could be HIV positive hence the likelihood of infecting innocent victims with this deadly disease. The discovery of PEP treatment that could reduce the chance of survivors contracting HIV is a welcome development. What remains now is to ensure that all survivors of sexual assault are put on this treatment as soon as possible to reduce the risk of contracting HIV. The challenges that face women and girls are many, starting from home, school, workplace, the market and even

the streets. Women and girls have been sexually assaulted by people that they trust like fathers, uncles, brothers, teachers and police officers. In this era of HIV/AIDS it makes the whole issue more problematic because the rapist or defiler might be infected with HIV, making it possible for the victim to contract the disease. In order to reduce the risk of victims contracting the disease there is some treatment that can be administered to the victim of such a crime. The health centres do provide treatment called post exposure prophylaxis (PEP). A lot of women and girls are either raped or defiled in Zambia (the majority of cases occur in Lusaka) yet very few of them know that PEP treatment is available at medical centres. It is against this background that this research was conducted to find out if survivors of sexual assault have benefited from this treatment and if they have not, why not?

WHAT IS POST EXPOSURE PROPHYLAXIS (PEP)?

Post exposure prophylaxis (PEP) is the short term antiretroviral treatment that reduces the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse.[1]In order to mitigate the chances of contracting HIV, women and girls that are sexually assaulted should be given this treatment within the shortest possible time after exposure. This treatment is usually administered after a victim has undergone some testing and counselling. This treatment goes on for a period of 28 days after which a survivor of sexual assault should go back for the second testing.

HOW PEP WORKS IN SEXUAL ASSAULT.

For HIV infection to take place, the Human Immuno-deficiency Virus (HIV) needs to penetrate the genital tissue (mucosal membrane) and establish itself in the cells of the lymphatic system which controls the body's immune response. Once the virus has penetrated the tissues, it takes about 48 hours to establish itself in the lymph nodes. It takes approximately 72hours before the virus gets into the blood system. The 72 hours delay presents an opportunity to prevent the HIV exposure from becoming an HIV infection through antiretroviral drugs that interrupt the virus's growth (viral replication)[2]

[1] World Health Organisation,Post exposure Prophylaxis, http/www.int/hiv/topics/prophylaxis/en/ accessed 2/9/2008

[2] Sauti Ya Siti, special issue on violence and HIV/ AIDS, halt the spread of AIDS. issue no.28, December 2004, ISSN 0856-230x

1.2 STATMENT OF THE PROBLEM

There are more women and girls sexually assaulted in Lusaka than the rest of the country. The commonest types of sexual assault are; defilement for young girls below the age of 16years, indecent assault on girls below the age of 14 years, incest and rape. These crimes are usually committed by persons that are known to the victims such as fathers, uncles, brothers, teachers, police officers, etc.. For example, in 2006, the police recorded a total number of 1400 cases of defilement throughout the country and Lusaka recorded 642 and was the highest. This already poses a great challenge to the victims as reporting victims that are close to them is difficult. The reporting of these offenders makes it a hindrance for the victims to seek medical attention as they are required by law to pass through police stations in order to obtain medical forms that are a prerequisite for treatment at the health centres where PEP treatment is available. Furthermore, the distance to the health centres is another problem and also the ever increasing cost of transport adds to the problem that the victim is facing. Although there has been an indication of the availability of PEP treatment in the health centres very little has been done to inform members of the public about PEP treatment.

Therefore, the sad truth is that the simple act of immediately reporting a sexual assault to the police (a step which so many victims are, for a multitude of reasons, reluctant to take) is literally a matter of life and death if it turns out that their attacker was HIV positive. For it is only by making such a report that victims, who are otherwise quite ignorant of PEP treatment, place themselves within a system that allows them to benefit from it (i.e., by increasing their chances of not contracting HIV/AIDS) within the crucial 72 hour period after possibly contracting it during the sexual assault.

1.3 AIM

The overall aim of the study is to investigate the availability of PEP treatment to female survivors of sexual assaults in order to reduce their chances of contracting HIV/AIDs. This will then provide a platform to look at (1) how survivors access treatment and the challenges that are faced by both victims and medical staff and (2) what kind of legislation, policy and administrative measures are in place to provide PEP treatment to female sexual assault victims.

1.4 OBJECTIVES

In order to carry out this study a number of objectives were put forward as follows;

1. To find out the prevalence of sexual assault on women and girls in Lusaka.

2. To assess the extent to which PEP is readily available and accessed by survivors of sexual assault.

3. To find out if the survivors of sexual assault have any knowledge about the use of PEP to combat HIV.

4. To find out the challenges medical personnel face in administering PEP to survivors.

5. To examine ways and means of improving the provision of PEP to survivors of sexual assault.

6. To make recommendations for legislative, administrative and policy reforms to ensure that female sexual assault survivors access PEP.

1.5 RESEARCH TOPIC AND ASSUMPTIONS

1.5.1 TOPIC

The title of the topic of the research is:

“Right or Privilege”, an investigation, into the provision of PEP, to female survivors of sexual assault to reduce the chances of contracting HIV/AIDS. Case study of 7 clinics and 1 hospital in Lusaka.

1.5.2 ASSUMPTIONS

1. There are more women and girls that are sexually assaulted in Lusaka than the rest of the country.

2. PEP is not readily available and accessed by survivors of sexual assault in some clinics in Lusaka.

3. There is lack of information among survivors on the use of PEP which reduces the chances of contracting HIV/AIDs.

4. There are challenges faced by medical personnel in administering PEP to survivors of sexual assault.

5. There is a need to improve the ways and means of providing PEP to survivors of sexual assault.

6. There is no legislation, administrative and policy on PEP provision to survivors of sexual assault.

1.6 RESEARCH QUESTIONS

The major research questions were;

1. Is the sexual assault of women and girls more prevalent in Lusaka than anywhere else in Zambia?

2. Is PEP accessed by survivors of sexual assault? If not, why not?

3. Is there a lack of information on the use of PEP by survivors?

4. What challenges do medical personnel face in administering PEP?

5. Are there any ways and means of improving PEP provision to survivors of sexual assault?

6 Is/are there any policy, legislation or administrative measures in place which promote/s access to PEP?

(Note that these research questions were used as a basis to formulate the questions I asked various people I interviewed in this research. They occur at the end of this work.)

1.7 SCOPE OF THE STUDY

The study was based in Lusaka were I stay. It is the capital of Zambia. This made it easy for me to access my respondents as I was able to drive and sometimes walk to get to them. The institutions that I targeted were clinics, namely; Kabwata, Makeni, Mutendere, Kalinglinga, Chawama, Kamwala and the University Teaching Hospital (UTH). These clinics are situated in middle and high density areas, while the UTH is the main referral health centre for the country and serves the entire nation. I also selected respondents from the police, NGOs, ordinary people and survivors of sexual assault. I conducted individual interviews, group interviews and also looked at documents.

CHAPTER TWO

2.0 LITERATURE REVIEW

Many women and girls surfer in silence at the hands of their abusers when it comes to sexual violence as most of them are vulnerable and are unable to defend themselves against these attackers. Abuse that specifically heightens the risk of girls contracting HIV infection includes sexual assaults by family members, particularly the shocking and all too common practice of abuse by men that are charged to assist or look after them, including teachers[3]. The abusers in most cases are normally people that are known to the victim. Barnett and Whiteside have argued that rape and gang rape are the most vicious and potent methods of spreading HIV/AIDS. The rapist might be a person that is already infected and the chances of him infecting his victim are very high. This sexual violence contributes to the spread of HIV/AIDS and other sexually transmitted infections in various ways.[4]The inability to negotiate for safe sex in situations of sexual assault, the physical injuries that may accompany a sexual assault and the fear of ostracism all combine to increase women's vulnerability. Women and girls that are sexually assaulted may not report the assault in time for them to get medical attention and that in itself increases the chance of them contracting HIV/AIDS if the attacker is HIV positive.

The physical injuries that may accompany a sexual assault can increase the risk of HIV/ AIDS infection and STI transmission. Nolen explains that the problem with HIV is that its transmission in blood, sexual fluids and breast milk preys on our most intimate moments. In situations like rape and defilement, the victim may experience bleeding and tearing of the genital area and this creates a passageway for the HIV virus to enter the bloodstream[5]. In rape situations or defilement the woman or girl is not normally prepared for the sexual encounter and as such the issue of tearing will be very high and if the attacker is positive the chances of the victim contracting HIV is very high.

Women and girls in Africa are dying in their millions, partly because of their second class status which makes them vulnerable to violence and unsafe sex (D'Adesky 2004). According to D' Adesky, the low social status of women and girls makes it impossible for most of them

[3] The communication Initiative Net work, Suffering in Silence:The links between Human Rights and HIV transmission in Zambia,htt://www.comminit.com/en/node/211228/36 accessed 2/15/2008
[4] Stop violence against women, A project by Minnesota Advocates for Human Rights,htt://www.stopvaw.org/sexual-assualt-hiv-aids-and-stis.html.accssed 2/19/2008
[5] ibid

to seek treatment from health centres due to the stigma that is attached to sexual assaults. Society at large will ostracise women and girls that are sexually assaulted making it impossible for them to get any kind of redress. In the fight against AIDS, protecting women and girls from sexual abuse and ensuring their equal rights under the law are as crucial as keeping the blood supply clean (D'Adesky 2004).She further points out that the only way to ensure that women and girls are protected is to have their rights recognised as equal to that of men. This can be done by domesticating all international conventions on the rights of women into our national constitutions. Women and girls must protected from abusers if their chances of survival are to be guaranteed in society in this era of HIV/AIDS.

A further factor compounding the problem is that in some regions in Africa there is a tendency for men to seek "clean" adolescent or preadolescent extramarital sex partners. This practice may reflect both a male strategy for avoiding AIDS and the widespread myth that sexual intercourse with a virgin can reverse the diseases course (Irwin, et al2003). This practice of men having sex with young virgins has put the girls at risk of contracting HIV because of the multiple partners that the men might have and the fact that their HIV status is not known. These myths about rape function to maintain the inequality between the sexes (Bart and O'Brien 1985). The young and often physically immature girls that might engage in such relationships may experience a lot of tear as they are not yet ready for sexual encounters and thus risk contracting HIV.

The observation made by Irwin,et. al. about the myths surrounding sexual assault are used by some HIV positive men who have sexual intercourse with young girls in order 'to cure them of HIV'. The risk of infection due to rape is largely due to the violent nature of rape and women are exposed to micro injuries which create numerous sites of entry for the virus[6]. Sauti Ya Siti's magazine article provides some insights on the need to protect women and girls from HIV/AIDS resulting from sexual assaults. These sexual assaults have the potential of infecting innocent women and girls with HIV/AIDS. Furthermore, there is a need to provide PEP treatment to survivors of sexual assault. This treatment should be given based on the fact that most of sexual assaults that take place have the potential of spreading HIV/AIDS through its female survivors. The provision of PEP treatment is the best possible way of protecting women and girls victims of sexual assault and ensuring that their right to effective and efficient health care is achieved.

[6] Sauti Ya Siti, special issue on violence and HIV/AIDS, Halt the spread of AIDS, issue no.28,December 2004 ISSN 0856-230x

The issue of PEP provision has been going on in some countries whilst others are only trying to get started. In the United States, since 1998 additional data about the potential efficacy of PEP have been gathered from human and animal studies[7]. Although from the beginning PEP was largely administered to health workers who could have come in contact with patients that were HIV positive, a shift occurred and treatment began to encompass even women that were sexually assaulted. The most direct evidence supporting the efficacy of post exposure prophylaxis is a case control study of injuries to health-care workers[8]. A number of studies accessed on the internet discuss the use of PEP in sexual assault cases. One author, Smith, for example, gives some insights into the use of PEP in America. He points out that a group of workers were put on PEP treatment after exposure to HIV and the observational studies showed that they later tested negative. This could be a further reason why PEP treatment has been used by medical personnel to try and reduce the chances of contracting HIV/AIDS. Further, Smith explains that sexual assaults have multiple characteristics which increase the risk of HIV transmission if the assailant is infected and therefore the victim should seek medical attention within 72hours of exposure[9]. This also justifies why PEP treatment should be made available in order to mitigate against the spread of HIV/AIDS.

In the United States there is considerable awareness of PEP and interest in its use among potential patients. There are problems, however, which have been associated with treating sexual assault victims with PEP. They include: patients' non-adherence to treatment; late reporting of the alleged assault; patients' and clinicians' lack of awareness of the availability or efficacy and safety of PEP[10]. Although the United States may seem to be an advanced and well-developed nation, it lacks a standard or consistent policy and/or guidelines that should be followed by all clinicians on the treatment of PEP. In a survey done throughout the United States and Canada, approximate 20% had a written policy on PEP use and 33% had prescribed it for children and adolescents. Different prescribing practices were reported in a survey of 27 European Union countries, in which 23 had guidelines for occupational PEP use but only 6 had prescribed it for sexual use[11]. In order to overcome these problems a lot of

[7] Damnk. Smith et al,antiretroviral post exposure prophylaxis after sexual assault, injection-drug use, or other nonocuptional exposure to Hiv in the united states, file/c;documents abd stettings/bomonde/desktop/PEPCDC 2005 accessed (1/11/2008)
[8] ibid
[9] ibid
[10] Ibid

[11] ibid

education on adherence and about the potential side effects, providing access and ongoing encouragement and consultation by phone or visits have been offered.

In Africa, in an effort to fight the spread of HIV, some countries, including Kenya and South Africa, have instituted PEP treatment for the survivors of sexual assault. In Nairobi the Women's Hospital is a unique private institution which caters especially for women's health care needs and provides free medical treatment to survivors of sexual abuse.[12]The hospital provides consultations and tests to confirm the assault and also provides survivors with medication to prevent the transmission of HIV/AIDs. The centre provides follow ups and offers trauma counselling to all survivors of sexual assault. However, the centre also treats male survivors of sexual assault. The health centre has to date treated an excess of 1 700 cases of sexual assault mainly targeting victims from low income sections[13]. As much as high quality service is offered to ensure a high quality of life for survivors, a lot of survivors only present themselves after 72 hours by which time it is TOO LATE for PEP treatment to prevent HIV infections. Although Kenya has made some progress in PEP treatment, a lot of challenges are still faced including, very little awareness, very little information, very little knowledge about PEP following sexual trauma[14]. Edwin who authored the article on PEP following sexual assault in Kenya and Thailand came up with similar observations that were noted in the American situation as regard to PEP use. The problems that have been noted have been the issue of poor adherence to treatment and because of poor resources PEP treatment has not been followed. As much as PEP can be made available to survivors of sexual assault, adherence to treatment is one of the major reasons why survivors do not complete their treatment.

In South Africa, rape is a leading health and human rights problem and high rates of HIV/AIDs in a country that focuses on the transmission of HIV after rape and it has received substantial attention over the past several years (Christofides, et al 2006). He further says that internationally, there has been a growing interest regarding the provision of post exposure prophylaxis of antiretroviral drugs to reduce the risk of HIV infection following rape. This interest has evolved in the light of scientific evidence that such drugs can be both safe and effective when used following exposures, such as needle stick injuries to health care

[12] Sauti Ya Siti ,special issue on violence and HIV/AIDs, Halt the spread of AIDs ,issue no.28 December 2004 issn 0856-230x
[13]ibid
[14] Bernard J.Edwin ,2007/7/23 Pep following sexual assault in Kenya and Thailand-more awareness and follow up.http//www.aidsmap.com/en/news/5B29C9D0-B373-4288-8f3A-BF11FE288876.asp accessed 2/15/2008

workers .The effectiveness of PEP to survivors of sexual assault is further supported by the findings in animal models of genital track exposure to HIV.

The South African government's pledge in 2002 to provide PEP to sexual violence survivors could become a model for other states to meet human rights obligation to protect rape survivors, even though significant obstacles to obtain PEP still prevail[15]. Schleifer, whose work was accessed on the internet, carried out an investigation in 2003 in South African and found out that government's failure to provide adequate guidelines on or training about PEP left the police, health professionals, counsellors and rape survivors without basic information about it. Where 'the first contact person' (i.e., the first official person within the PEP delivery system with whom the victim makes contact) does not have vital information about PEP treatment, the victims were denied their fundamental basic right to health and this could lead to infection of HIV if raped by an infected person. The biggest drawback in the South African situation was the government's opposition to antiretroviral drugs (ARVs) continued after the program launch, which dissauded some service providers from offering PEP in the belief that it was against government policy[16]. The government's opposition to ARVs definitely had a huge impact on the provision of PEP to survivors of sexual assault. Health care is every person's human right and survivors that are denied PEP might have become infected.

However, some survivors of sexual assault have been willing to access this treatment despite government's opposition to PEP. Schleifer further points out that there have been other problems associated with providing sexual assault survivors with PEP treatment, ranging from: survivors' lack of information; unaccompanied children not being given treatment; police and health professional failing to follow national instructions; problematic investigations and treatments and social and cultural barriers to PEP treatment.[17] The provision of PEP in South Africa has not been an easy for either survivors or service providers, alike. A lack of information about PEP is a major issue in both Kenya and South Africa. In order to address this problem in the case of South Africa a number of measures have been suggested. The South African government, in compliance with its obligation to protect its female citizens from sexual violence and its consequences, should urgently

[15] Schleifer R A. Sexual violence survivors rights to post exposure prophylaxis: south Africa ,a case study, http/gateway.nlm.nih.gov/meeting Abstracts/10228774.html accessed on 2/9/2008
[16] ibid
[17] ibid

implement its PEP program. It should: (1) launch a public education campaign on PEP services; and (2) provide training on PEP and sexual violence to the police, health professionals and other service providers; and (3), put in place procedures to obtain the prompt consent to PEP treatment and HIV testing for children.[18]

By comparison, in Tanzania, very few people know about the post-sexual exposure prophylaxis pregnancy and sexually transmitted infections as well as post exposure prophylaxis to reduce the risk of HIV infections[19].This situation does not give very much hope to survivors of sexual assault. The provision of PEP is not very common in Tanzania and it is very expensive which means that very few survivors can access the treatment. The government should provide PEP treatment especially to low income people both in urban and rural areas.

The situation in Zambia is not very different from the Kenya or South Africa although Zambia has no specific policy on the provision of PEP treatment to sexual assault survivors. The national HIV/AIDs/STI/TB policy does not provide for any kind of treatment of PEP to survivors of sexual assault. The policy on HIV in Zambia is that PEP treatment and access is available to care givers[20]. This already makes it difficult for the survivors of sexual assault to access the PEP treatment as it is not mandatory for the state to provide this basic human right to health. The provision of PEP in Zambia is restricted to health providers who might have been accidentally exposed to HIV at work. Health workers are now taught strict protective measures that help minimise the chances of their being infected with HIV from patients or from handling their body fluids.[21] The above situation reveals the value judgment that is in play in the State's policy decision to allocate PEP treatment between competing needs. As a matter of policy, the State makes PEP treatment accessible to a relatively small group of medical health providers (whose contamination rates are relatively low, largely as a result of low-risk 'indirect' infection) while it denies it to a much larger group of sexual assault survivors (whose contamination rates are extremely high, largely as a result of high-risk 'direct' infection).

[18] ibid
[19] Sauti Ya SITI ,special issue on violence and HII/AIDs. Halt the spread of AIDS, issue no.28 December 2004 ISSN 0856-230x
[20] See Access to Anti retroviral (ARV) drugs measures 7.3(h) of the national Aids policy of Zambia.
[21] Dr Mannasseh Phiri , The Post newspaper, post life style ,Sunday November 4, 2007, page vi

In 2006 the Police in Zambia recorded a total of 1400 cases of defilement and 255 cases of rape[22]. The numbers provided by the police of reported cases of sexual assault cannot be a true reflection of the reality on the ground in view of the fact that certain sexual crimes (especially those involving abuse of authority) are of such a nature that victims are often reluctant to report them to the police for various reasons. These statistics, however, do give us an indication that women and girls are victims of sexual assault and that their rapists or defilers could be HIV positive: hence, the need to provide PEP treatment to survivors of sexual assault. Although Zambia has no direct policy on PEP treatment, the Ministry of health has been using a reference manual to provide services to sexual assaulted females and males. All women (and men) who are victims of sexual assault (rape) should be counselled about the potential risks of HIV transmission before PEP can be administered.[23] This, to some extent, does give relief to victims of sexual assault as some kind of treatment will be given to reduce the risk of contracting HIV. However, Doctor Mannasseh Phiri who wrote an article in one of the private newspapers, points out that the lack of a direct policy on PEP to survivors of sexual assault, coupled with the late reporting of an assault still remains a great challenge to the provision of PEP to survivors. The lack of a policy and reporting by survivors of sexual assault makes it difficult for health personnel to administer PEP at the right time and this definitely increases the risk of survivors contracting HIV/AIDS. There is a need to train all services providers, such as the police, as they are among the first contact persons met by a sexual assault survivor and there is also the need to have a PEP policy that is known to all medical staff and put in motion without delay.[24] Once a policy is put in place it will be the duty of the government through the Ministries of Health and Information to make sure that the policy is disseminated to all citizens in the country.

[22] Source 2006 cases reports made to police victim support unit in Divisions
[23] See module 8,post exposure prophylaxis after sexual assault, management of antiretroviral Therapy , A reference manual for health workers, November 2004 edition
[24] Dr Mannasseh Phiri ,The Post News paper ,Post life style, Sunday November 4,2007 page vi

CHAPTER THREE

3.0 RESEARCH METHODOLOGIES AND METHODS

3.1 INTRODUCTION

The main purpose of carrying out the research was to investigate the availability of PEP treatment to survivors of sexual assault in order to reduce the chances of contracting HIV/AIDS and it was conducted in seven clinics and one hospital in Lusaka. In order to investigate the availability of PEP treatment, a number of methods, such as individual interviews, were used to collect data and information from people, such as medical personnel and survivors themselves. I also used a number of methodologies such as the grounded theory in order to gain an insight into the problems that survivors face. A methodology is merely an operational frame work within which the facts are placed so that their meaning may be seen more clearly (Leedy 1981). The research thus explored these facts so that the survivors' actual lived reality and experience in the field would be made known.

3.1.1 THE RESEARCHER'S PERSPECTIVE: A CONFESSION.

I must confess from the onset that I have a bias in the research, in the sense that I have been working in the police for the past 5 years or so, heading a unit called the Victim Support Unit (VSU). The bias that I have is in favour women, due to the fact that I was informed at different fora that PEP is available and that it was accessible to survivors of sexual assault. I saw no reason why survivors of sexual assault should not access free medication. This opinion did not, however, prejudice my objectivity in looking at the issues raised in the research; rather, it gave me an added advantage of appreciating the real context in which survivors find themselves and why they fail to assert their right to protect their health. The VSU deals with issues of violence against women, children and the elderly. Some of the crimes with which the Unit deals are sexual offences, property grabbing and family disputes. It was whilst working with this Unit that I heard of PEP treatment and that it was available at health centres to sexual assault survivors, as long as they presented themselves within 72 hours. As I was one of the first officers (working in the VSU) to come into contact with and help these victims, I had a particular desire to research this topic in order to give me a better insight into what they experience at health centres and to ascertain whether PEP treatment is readily available to and accessed by them.

3.1.2 WOMEN'S LAW APPROACH.

The woman's law approach is based on the reality of women's life. The approach uses concepts and theories that are analysed by utilizing empirical data about women's lived experiences and integrating them into a frame work of legal analysis, (Bentzon, et al 1998). This grassroots' approach takes into account women's lived experiences as a starting point. In order to understand the actual lived experience of survivors of sexual assault in relation to PEP treatment, a number of interviews were conducted from key informants and the survivors themselves. This kind of interaction provided a platform to understand why survivors of sexual assault do not easily access PEP treatment.

The women's law approach also helped me to look at some of the assumptions that I had. The assumption on availability and accessibility of PEP treatment to survivors of sexual assault was best tackled using the women's law approach. The approach provided me with an insight into the availability and accessibility of PEP treatment. By talking to survivors and some of the medical personnel I found out that survivors of sexual assault do not access the treatment at all. As confirmed by medical personnel in the 7 clinics visited during the study, PEP treatment is available, but the reality of survivors on the ground is that because of not having a specific piece of legislation in place, survivors of sexual assault have been discriminated against as this kind of crime is mainly targeted at a particular sex. Women's law approach is women-centred, with a view to establishing how laws may have a different impact or may affect men and women differently (Dengu-Zvogbo et al,1994).

The study used a grounded and empirical research on woman's experiences in utilizing the law on PEP treatment aimed not only at improving such utilization but making it a point that woman enjoy their fundamental rights to health. The utilization of the women's law approach also made it possible for me to understand that survivors of sexual assault also lack information on PEP treatment. The lack of information on the use of PEP treatment by survivors of sexual assault was one of the assumptions that I had. Using the above approach it was easy to note that survivors of sexual assault lack information on the use of PEP. This information on the use of PEP was obtained from the actual stories that survivors and other informants provided. To explore more of the inequality between men and women in their access to medical care I also considered the feminist perspective as well. The women's law approach provided me with an opportunity to talk to the actual survivors on how they access PEP treatment and find out what problems they face in trying to access this treatment. To

have these insights I also had to interview parents of young girls that had been defiled so that I could discover the actual experiences on the ground. The medical personnel also provided vital information on why the survivors of sexual assault are unable to access treatment on time.

3.1.3 FEMINIST PERSPECTIVE

The feminist perspective to law was used to look at how different legislation, polices and other administrative arrangements could have a negative effect on the survivors of sexual assault in accessing PEP treatment. According to (Dahl 1987) as long as we live in a society where men and women have different paths in life, different living conditions, different needs and opportunities, legal rules will necessarily affect men and women differently .This is true with the treatment of PEP to survivors of sexual assault. The assumption that I used for the feminist perspective was that there is lack of policy, administrative measures and legislation on the provision of PEP treatment to survivors of sexual assault. The policy does not have any provision for the treatment of survivors of sexual assault.

The Zambian National Aids Policy does not mention the provision of PEP to sexually assaulted women and only leaves it to the medical personnel whether to administer it or not. The feminist perspective provided me with an opportunity to look at the policy on HIV. This also allowed me to interview the medical personnel on what policy was in place for the provision of PEP treatment to survivors of sexual assault. This clearly shows that women are being treated differently to men in the access of health care as the majority of people affected by this kind of crime are women. It was sad to find out that because of lack of a clear policy on PEP provision, information on the availability of PEP in clinics does not exist. As such women that are sexually assaulted have been indirectly denied their human right to healthcare. Life-saving information about the existence of PEP treatment is denied to the people who need it most. This shows that there is an indirect discrimination of women based on their sex. Although the right to information is not directly denied, very few women have access to information in the sense that men own the majority means of information dissemination systems. Therefore, they only provide information that would suit them. The lack of a policy on PEP treatment to sexual assault victims might be an omission not necessarily discrimination.

3.1.4 GROUNDED THEORY.

The principle of grounded theory allowed me to embark on the research with a more open mind. (Bentzon et al, 1998) states that a researcher should not have a confined ambit of the study by the imposition of one of the grand or meta theories. It was important to look at the factual experiences of survivors of sexual assault in relation to PEP treatment. This was done by conducting individual interviews with the medical personnel, survivors themselves, police officers and some NGOs who work closely with sexually abused women. By using the grounded theory I was able to test how my assumptions were holding out in the field. This provided me with a framework to rethink and come up with new assumptions to suit the emerging issues in the field.

When dealing with medical personnel I had to change my assumptions to find out what challenges they faced, as opposed to whether they were aware of PEP treatment. By doing so, I was able to get as much information as possible from them as to why some survivors of sexual assault fail to access PEP treatment, as well as what might be preventing them from providing PEP treatment to survivors of sexual assault. This approach allowed me to see the actual experiences of survivors of sexual assault, how they access PEP treatment and what problems they encounter in the process. I had to visit the health centres to see for my self what actually took place. If I had not used this approach I could have missed out on a number of other emerging themes in the field. The grounded theory approach provided me an opportunity to understand why women fail to access PEP treatment as a result of family barriers as well as what prevents medical personnel from administering the treatment. The grounded theory also enabled me to solicit suggestions on the best way to improve the provision of PEP treatment to survivors of sexual assault. The assumption that I had was that there are ways and means of improving PEP treatment to survivors of sexual assault. To discover the best possible suggestions I had to interview the medical personnel who administer this treatment and as well as the survivors of sexual assault, the beneficiaries of the treatment.

3.1.5 LEGAL PLURAISM

In the context of this research legal pluralism is the recognition that law has many multiple sources and that there are other sources, outside law that generate important and significant regulatory norms, (Wlsa,1994). These sources of law have a great influence on how they regulate the society in which people live and how they conduct their day to day lives. Using

this approach I was able to understand why survivors of sexual assault could not access PEP treatment from the health centres regardless of the availability of treatment. If survivors of sexual assault make a report to a police station they are given a medical form to take to health centres for PEP treatment. This, however, is not as simple a process as it seems or should be because it is fraught with many factors that come into play and interact with each other actively to prevent survivors from benefiting timeously and, therefore, crucially from PEP treatment. These factors include: pressure to reconcile with the abuser, the desire for compensation and the hostile environment of police stations. These factors, which are deeper manifestations of certain practises, make it impossible for survivors of sexual assault to seek medical attention at the right time.

In exploring these plural or multiple dimensions of the different informal (as opposed to formal) rules which govern people's lives, a useful tool is the concept of semi-autonomous social fields, as it is in the semi-autonomous social fields, that the different norms that internally or sometimes independently of the state law that regulate society, are to be found (Wlsa, 1994). By using the legal frame work it was possible to understand why survivors of sexual assault do not access PEP treatment. Legal pluralism enabled me to understand that apart for the general law of reporting all cases of sexual assault to the police, other means are used to settle such matters outside the police, including using family members. The customary way of handling sexual assault still plays an important aspect in the lives of women and as such this might have a negative effect when it comes to accessing PEP. The legal pluralism approach also provided me with data to understand why police stations do not record very high numbers of sexually assaulted females. The customary way and sometimes using religious means of settling sexual crimes have resulted in women not wanting to report such cases to the police.

3.1.6 HUMAN RIGHTS APPROACH.

The rights of every individual have to be respected, be they a woman or man. In this research I focused on the right of survivors of sexual assault in accessing PEP treatment which is an exercise of their right to health. The Universal Declaration on Human Rights provides among other things equal access to public services of which health services which survivors of

sexual assault are entitled to access[25]. Using this approach I detected that survivors of sexual assault had problems, such as long distances and high costs, in accessing these public health centres. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) provides for the state parties to take appropriate measures, including, enacting legislation, modifying or abolishing existing laws, regulations, customs and practices which constitute discrimination against women[26].

The application of this Article gave me an insight into the unfair practices that exist in the context of the provision of PEP treatment to survivors of sexual assault. The lack of clear policy, legislation or administrative measures to provide available PEP treatment to female sexual assault survivors constitutes direct discrimination against women. This discrimination results from the omission or failure by the government to put in place a clear policy, legislation or other administrative measures in place to protect survivors of sexual assault. This is an example of discrimination by silence. The Women's African Protocol provides among other things that women have the right to be protected against sexually transmitted infections, including HIV/AIDs[27]. This right to protection is far from being achieved as evidenced by the fact that because survivors of sexual assault are being deprived of crucial life-saving information about available PEP treatment, they do not access it and are infected with HIV.

3.2 RESEARCH METHODS

Information relevant to the study on the availability of PEP treatment was acquired. For comparative purposes both qualitative and quantitative data collection methods were employed. In this study the following methods were used;

3.2.1PRIMARY SOURCES

(a)In depth individual interviews

I had 41 in-depth individual interviews. This was a combination of 11 men and 30 women. I interviewed these people so that I could get as much information as possible from a cross section of people on the subject matter. Most of the respondents were willing to share information although at times I had problems soliciting information especially from sexually

[25] Article 21 universal declaration
[26] Article 2(f) Cedaw
[27] Article 14(d)African Protocol

abused women who did not want to share their experiences. Some of the individual interviews I got from the parents of the victims because the victims were too young to understand what was happening and understood very little at all.

(b) In depth interviews with key informants.

In order for me to get the required and very important data I had to target key players from the medical personnel, police officers, civic organisations and survivors themselves. The list of key respondents is as follows;

The medical personnel I interviewed consisted of: 2 male doctors, 2 female doctors, 6 nurses and 2 male clinical officers. The only problem I encountered with this group was that there were always busy attending to patients. Therefore, most of the interviews took place during lunch and after hours. The medical personnel provided vital information on PEP treatment.

The police officers I interviewed consisted of: 3 males and 4 females. They provided me with statistical data on the numbers of rape and defiled victims for Lusaka and the whole country. The interviews with the police were very beneficial because they are usually the first people with whom victims of sexual assault come into contact with the victims and they provided information on why victims might not report sexual assaults on time.

I only interviewed one member of a NGO, its executive director. She was able to explain the role her organisation played in counselling and giving human rights and legal advice to sexually abused women.

The Members of Parliament I interviewed consisted of: 2 men and 3 women. They did not know much about PEP treatment but promised that they would get in touch with the Minister in charge of health.

I interviewed 15 survivors of sexual assaults. 8 of them were below the age of 16 and because of their youth I actually interviewed their parents or other relatives. Obviously, this kind of vicarious interview did not give me direct answers from the victims themselves, although I did manage to obtain the information that I wanted. Of the other 7 survivors, most were helpful but, understandably, some were shy and felt very uneasy talking to a man about their dreadful experience.

Below is a table that shows the key informants that were interviewed during the period of the research from October 2007–January 2008.

Table 1, shows key respondents that were interviewed

	Male	**Female**
Doctors	2	2
Nurses		6
Clinical officers	2	
Survivors		15
NGOs	2	3
MPs	2	3
Police officers	3	4
Women (ordinary)		33

(c)Group discussion

I had 2 group discussions with women. The first group of catholic women comprised of 32 women. I was able to interact positively with the women and I got some information although some of them seemed not to be interested in want was happening. The second group of women were marketers. I had problems in getting information from this group as most of them were busy selling their goods. In order to get their attention I had to buy some of their wares. I needed their input in order to triangulate data received from the two groups of women. I had to interview women because they are usually the first people in whom female victims of sexual assault confide. They also usually accompany young girl victims to health centres. It must be mentioned here that because sexual assaults are most often committed against women, I needed to find out as much as I could from them.

3.2.2 SECONDARY SOURCES

Statistical data. The police and hospital provided me with statistical data that showed the numbers of reported cases of sexual assault and how many of these victims were put on PEP treatment respectively.

Library and internet research. This method enabled me to gather as much information as possible from a cross-section of different writers. Although, I have to mention here, that not much is being written about PEP treatment, especially relating to victims of sexual assault. There is, however, a great deal of material relating to PEP treatment and health care workers.

Electronic and Print Media Articles. The electronic media carried stories on sexual assault of women and girls in different parts of the country, while from the print media I was able to get an article that was written on PEP treatment. Both the print and electronic media provided me with a lot of useful information. From it I came to know that many sexual assaults take place in Zambia.

3.2.3 SAMPLING OF HEALTH CENTRES

I visited a total of 7 clinics within Lusaka and the University Teaching Hospital (UTH) which is the main referral health centre in the country. All the centres visited have a voluntary counselling and testing (VCT) facility which is one of the prerequisites for receiving PEP treatment. The health centres visited were as follows;

Kanyama clinic is on the west side of the city, in a high density area.

Chawama clinic is in the southern part of the city, in a high density area.

Mutendere clinic is in the eastern part of the city, in a high density area.

Makeni clinic is in the south west of the city and is in are farming block although the place is a low density area.

Kabwata clinic is about 7km from the CBD of the city and is in a middle-density area.

Kamwala clinic is about 4km from the CBD of the city and is also in a middle-density area.

Kalinglinga clinic is in the eastern part of the city located in a high density area.

The University Teaching Hospital (UTH) is located in the eastern part of the city and receives all referral cases from Lusaka and the entire country.

Table 2, below shows the location of the clinics from the CBD

CLINICS/HOSPITAL	LOCATION
MAKENI	SOUTH WEST
CHAWAMA	SOUTHERN
KALINGALINGA	NORTH EAST
MUTENDERE	NORTH-EAST
KAMWALA	EASTERN
KANYAMA	WESTERN
KABWATA	EASTERN
UTH	EASTERN

3.2.4 OBSERVATIONS

The observations I made of different people and institutions were very interesting because I was able to see and observe the conduct of the respondents and this was very informative. The Ministry of Health was the largest institution I visited and it provided me with a lot of respondents. I was told to leave a letter of introduction at the district health offices and to return after a few days to collect a letter of introduction to the health centres that I requested to visit. I was given the letter of introduction and the first health centre I went to was Makeni clinic, which is about 15 or so km from the CBD. This clinic is surrounded by farms and the nearest high density compound is about 10km away which is Kanyama. I had an individual interview with the female doctor who is in charge of the clinic. Judging from her explanation I could tell that she was not very comfortable talking to me about PEP treatment and that she seemed to be holding back some vital information. She later showed me the ART clinic for VCT which is the section where the PEP treatment is administered. A lot of people were there to receive drugs and other food supplements and I did not think that the place was very conducive for a sexually assaulted person to wait for attention with other patients.

All the other clinics that I visited had basically the same arrangements. The ART section of these clinics were overcrowded with people waiting to receive drugs, food supplements, checking and collecting HIV results and the medical personnel seemed to be overwhelmed with work. When I was at Kabwata clinic the sister in charge of the ART clinic pointed out the since I was from the Human Rights Commission their rights also needed to be taken into account since some of the patients and relatives that go the health centres verbally and even physically abuse them. I gave her my contact phone number and promised her that the matter would be taken up as one of our awareness topics. I have to also mention here that the atmosphere at the ART clinics are not very conducive for victims of sexual abuse and the experience of attending one for the first time must add to the trauma of being the survivor of a sexual assault. While they forced to wait for attention in a seething mass of people, they are forced not only to share the stigma of having to mix with other HIV patients but, as rape victims, they are forced to do so in the demeaning and humiliating state of being unwashed. It came as no surprise to me why very few sexually assaulted victims were recorded attending any of the seven clinics that I visited.

At the University Teaching hospital I had to make fresh arrangements since UTH is independent of these other clinics. I was given the go-ahead to see the Head of the Gynaecology Department where all women above the age of 16 years are treated that are sexually assaulted. This section is called the C03 ward. I only met the head of department in the morning before 0800hrs as I was directed by his personal assistant who told me that during normal working hours the doctor is mainly in the theatre conducting operations. I met him and I had a good interview with him and he even took me to the ward itself so that I could interview the sister-in-charge. Unfortunately she was on leave but I spoke to the second in charge. The second sister in charge explained the difficulties that they were encountering in administering PEP to victims of sexual assault and made a number of good suggestions for the way forward. I was told to come back later so that I could look at the statistical information on the number of survivors who had been put on PEP treatment. However, the person I was told to see was difficult for me to get hold of as most of the time that I went there I could not find him. I also found 3 other women whom I was told had been sexually abused but could not be put on PEP treatment because they had come to the hospital too late.

The next place I visited was the Children's Centre for Sexual Abuse at UTH based in block A. This centre was established specifically to offer PEP treatment to sexually abused girls

from 0-16 years. The hospital management felt that it was not very good for the young victims to be together with elderly women at the gynaecology ward. The place is clean as compared with all other health centres that were covered by this research and they are given a lot of privacy, toys, a television to watch and reading books to make these young victims feel at home. I was quite easy for me to get information about this place because I was one of the members that helped start this donor-funded project. The group of catholic women I met was not very helpful as most of them were more interested to get on with their own meeting. The women marketers gave very interesting comments although our interviews were often disrupted as they attended to customers and I did not want to be seen to be wasting their time. The Members of Parliament that I met in Siavonga during a sensitisation workshop were keen to learn more from me about PEP treatment and demanded to have a copy of my completed research.

The police officers I interviewed gave me all the necessary information I wanted and I have to mention here that all the officers that interviewed were my junior officers; as such, they knew what to tell me and could arrange for me to meet those sexual assault victims who were willing to do so. The most interesting group was the survivors themselves. I conducted the first two interviews in my office and they were very open and talked freely about their experience. The other survivors were not very willing to talk about the past but were able to give me the information that I needed. One of the survivors refused to even give me her name because she thought I was a reporter from one of the local newspapers. As for the young survivors I interviewed the parents or guardians. Although I got the information I needed, I really wanted to talk to the victims themselves so that I could note their reactions but even some of the parents I talked to, especially those that had very young girls that were sexually abused, broke down and I had to wait for them to try and regain their composure.

3.2.5 DATA ANALYSIS.

I used the evenings to analyse the data collected that day. This analysis of data helped me to review my original assumptions in the light of emerging issues, adjust them accordingly and formulate new assumptions. If I had not done this I could have easily missed a number of issues that I came across. Some of the new issues that came in as a result of adjusting my assumptions were (1) the issue of administrative arrangements that the medical personnel have for the treatment of survivors of sexual assault and also (2) the challenges that the

medical personnel face, such as the refusal by some parents to have their children put on PEP treatment.

3.2.6 LIMITATION OF THE STUDY.

The biggest limitation I had was to balance my work and conduct the research. As my work requires a lot of travelling I had to ask for permission from my new employers so I could spend time going out to collect data. The problems that I faced were that I did not always get my questionnaires answered by some of the respondents that I had considered very vital to the subject matter, e.g., the Public Relations Officer for the Ministry of Health who was always busy and out of town. Some of the survivors gave false or wrong addresses so it became very difficult to follow up on them and some of the survivors were not willing to give out information. Furthermore, the medical personnel were always busy with patients and time for interviews never seemed long enough as they were always rushing back to finish up with patients. Finally some clinics that I had wanted to visit became flooded due to the heavy rains and become impossible to access.

CHAPTER FOUR

4.0 RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

In this chapter I shall discuss my findings on want I found out in the field and link them to the type of method that I used to come up with those findings. I had 6 assumptions and each assumption had its own method of data collection. From the onset I have to point out that it was very difficult for me to get as many elderly survivors of sexual assault as I wanted mainly because of the incorrect addresses recorded in the police records.

4.1.1 PREVALENCE OF SEXUAL ASSAULT ON WOMEN AND GIRLS IN LUSAKA.

The first assumption that I had was that there are more women and girls that are sexually assaulted in Lusaka than the rest of the country. In order to establish the truth about this assumption I had to visit the police station to get statistical data that would show me the number of reported cases of sexual assault against women and girls for Lusaka and compare them with the rest of the country. This was done to get the actual figures that the police have and get the police's opinion of the possible reason/s for this. I interviewed 6 police personnel from the VSU, the unit that deals with cases of violence against women. The police officers informed me that a lot of sexual assault takes place but not all victims report their case to the police, some opting to settle the matter without the police. I looked at the statistics that the police had on the number of reported cases of sexual assault.

Police Officer's views.

Mr Tresford Kasala the Divisional Coordinator for the Victim Support Unit of the Zambia Police explained that:

> *"There is a lot of sexual assault that is happening out there but women at times opt to reconcile with the rapist or they just fear to come and report at the police*".

According to the police a lot more women and girls are sexually assaulted but do not make a criminal report, because if the abuser is a member of the family they do not want to have a family member arrested. To illustrate the degree of the problem of sexual assault the police provided statistical evidence as shown below in the table.

TABLE 3; Showing the prevalence of sexual assault of women and girls in Lusaka (source police VSU 2006)

Provinces	**Lusaka**	**Southern**	**Northern**	**C/belt**	**luapula**	**Eastern**	**Western**	**N/western**	**Central**
Offences									
Defilement	642	133	227	193	28	25	8	25	118
Def/idiots	4	0	0	0	0	0	0	0	0
Rape	124	11	15	64	7	3	0	13	18
Ind.ass.boys 14	0	2	0	1	0	0	0	0	0
Incest/males	8	0	0	0	0	0	0	0	0
Incest/females	0	0	0	0	0	0	0	0	0

KEY; Def/idiots=defilement of idiots

Ind.ass.boys=indecent assault on boys below 14years.

The table above clearly shows that there are more defilement and rape cases in Lusaka than in any other province in Zambia. This could be so because Lusaka being the capital city has a lot of people from different walks of life. The table also shows that more women than men are sexually assaulted. In Zambia a man cannot be raped but he can be indecently assaulted.

4.1.2 AVAILABILITY OF PEP TREATMENT

The second assumption I had was that PEP is not readily available and accessed by survivors of sexual assault in some clinics in Lusaka. In order to ascertain the availability of PEP, I had to interview survivors who are the end uses of this treatment to find out if they knew that this treatment was available. I interviewed about 15 survivors of which 8 were below the age of 16 years and the parents provided the information that I reguired. From the interviews that I had it was clear that many of the survivors did not know about the availability of PEP in the health centres.

Survivor's views

One survivor by the name of Mercy (not real name) stated that:

> "I *have heard of this kind of treatment but am not very sure if it's available in the health centres"*.

In order to get this information on availability of PEP I had to use the women's law approach so that I got the actual lived experiences of women who are sexually assaulted. The 7 clinics and 1 hospital that I visited confirmed that they had enough stocks to give to survivors of sexual assault. I used the grounded approach to ascertain the availability of PEP. I had to interview the medical staff in charge of the ART clinics that are responsible for administering PEP to survivors of sexual assault. By so doing I was able to get the actual or true picture from the staff on the ground.

Medical personnel's views

At Kanyama Clinic the sister in charge Mrs Malambo of the ART clinic had this to say on availability:

> *"We have a lot of PEP drugs in stock from the time the health centre opened a VCT section in 2005*".

The above situation is what I found in all the clinics and the hospital that PEP was available and that the government has been providing the same in all clinics that have VCT section. The second assumption also dealt the issue of accessibility of PEP treatment to survivors of sexual assault.

4.1.3 ACCESSIBILITY OF PEP

With the approaches that I had employed in the field I learnt that PEP was not easily accessed by victims of sexual assault. I used the women's law approach to uncover the lived realities of women who are sexual assaulted and found out that a lot of them had problems in accessing PEP treatment. I had individual interviews with both the survivors and medical personnel. The interviews that I had brought out a number of problems that are experienced by survivors when it comes to accessing PEP treatment.

Survivor's views

One of the survivors of sexual assault narrated that:

> *"I did not report the matter to any institution as the person who raped me is known to me, I had wanted the matter to be dealt by my family."*

The above situation makes it impossible for survivors of sexual assault to access PEP treatment as family members are involved in trying to resolve matters at the expense of treating the victim. Using the grounded theory approach I was able to find out also from medical personnel why survivors of sexual assault were unable to access PEP treatment on time. Also I had to look at the issue of Actors and Structures approach which plays an important role as families will regulate how matters will be handled.

Medical personnel's views

Mr Sampa a clinical officer and the Project manager at the children's centre which is sponsored by CDC explained that;

> *"Some of the young girls that come here are pregnant as such we cannot administer PEP treatment".*

The mere fact that the young survivors of sexual assault presented themselves pregnant at health centres meant that they could not be put on PEP treatment, but other medication could be administered to them. However, the difficulty in accessing PEP should not be entirely blamed on the survivors' failure to make a timeous report (i.e., within 72 hours of the assault) or the issue of falling pregnant, but also the factors that are beyond the control of the survivors. Mrs Katonga in charge of the ART clinic at Chawama clinic pointed out that:

> *"The ART clinic operates from 0800-1800hrs Monday to Saturday and we are closed on Sunday and public holidays*".

This situation already makes it impossible for survivors of sexual assault to access the treatment on time. The mere fact that the clinic does not operate on Sundays and public holidays, does not mean that women and girls are not sexually assaulted on those same days. The human rights approach provided an insight on how sexual assault survivors are denied access to medical treatment which is one of the basic human rights. Although the clinics operate from Monday to Sunday for a duration of 10 hours sexual assaults can take place at

any time outside those stated hours and days. This arrangement will definitely deny the survivors access to treatment.

Polices views

I also interviewed police officers at the children's centre at UTH on the issue of accessibility of PEP treatment to the young survivors. The officers informed me that as much as the treatment is accessible, there are problems because of the medical personnel that conduct the medical examinations. The officers informed me that the mere presence of male medical personnel made it impossible for the young girls to access PEP treatment as they refused to be seen by the male medical personnel. Women Constable Zimbe attached to the centre had this to say:

> *"Young girls especially those above 14years refuse to be medically examined by male medical staff as such they are not put on PEP treatment."*

The above situation already makes it impossible for the young girls that have been sexually assaulted to access PEP treatment as they feel that their privacy is been tampered with. The health centre should come up with away of assisting these young survivors who might be feeling like going through a second abuse because they cannot trust any male person and more so that the examinations are done in private.

To illustrate that the health centres have not done well in the area of accessibility, below is the table that shows how many survivors have been seen at the 7 health clinics and 1 hospital during the time of the research.

Table 4, below shows the health centres and one hospital that were visited during the period of research and the number of survivors that they had seen and what action that was taken.

Clinics	**survivors**	**PEP Given**	**PEP not Given**
Kabwata	Nil	Nil	Nil
UTH	No records		
Chawama	5	2	3
Kalinglinga			
Makeni	1	1 not completed	
Kamwala	1	1	
Mutendere	1		1tested but not given
Kanyama	10		10

The table above shows how the clinics and the university teaching hospital fared in the accessibility of PEP treatment of survivors during the period of the research from October 2007 to January 2008. This clearly shows that very few women survivors of sexual assault accessed PEP if we compare their numbers with the number of reported cases in table 4 for 2006. The information above shows that Kanyama clinic received 10 survivors but none of them were not put on PEP treatment because they reported too late at the health centre,. Chawama had 5 cases only, 2 completed the course but the other 3 failed to report back at the clinic. Makeni's only case was that of a young girl who, before treatment could begin, was removed by her mother and taken to another health centre and the results were not known. In

Mutendere's only case was also that of a child who was also withdrawn by her mother from PEP treatment before it began because her husband who had defiled the child had threatened her with divorce.

This only confirms that actors and structures in a given environment (e.g., family) has a lot of influence when it comes to PEP accessibility. The family members in this case can decide on behalf of their relatives especially when it comes to children and abusers who are family members.

4.1.4 LACK OF INFORMATION

The third assumption that I used to come up with my findings was that there is lack of information among survivors on the use of PEP which reduces the chances of contracting HIV/AIDs. In order to unearth the realities of women survivors on the ground regarding the use of PEP I used the human rights approach which provides among other things, the right to information. This approach also led me to use the grounded theory to see the actual lived realities of women survivors when it came to accessing or acquiring vital information concerning their health. To get the information required I had to interview survivors, other key informants like medical staff, NGOs who deal with sexually abused women and other people in society.

Survivors' views

I interviewed 15 survivors of sexual assault and out of this number, 7 were above the age of 16 years whilst the remaining 8 were between the ages of 0-16 years. In respect of the survivors that were below the age of 16 years, their relatives gave the interview on their behalf.

The table below will give an illustration whether a survivor knows about PEP treatment or not. The young survivors their parents or relatives gave the interview on their behalf.

Table 5, shows the number of survivors of sexual assault and their response on information on the use of PEP.

AGE	INTREVIEWED	KNOW PEP	DOES NOT KNOW PEP
0-16yrs	8		8
ABOVE 16YRS	7	3	4

The information above illustrates that the majority of the respondents do not know about PEP treatment. Even the interviews that I had with the relatives of the young girls also show the lack of information on the part of the relatives. One of the survivors aged 23 years was raped in 2007 and had this to say:

> *"Yes I was raped but I don't know that there is this kind of treatment in our clinics but it was given to me."*

This was just a confirmation that information on PEP is not known to survivors of sexual assault. The relevant international human rights instruments binding upon Zambia provide among other things for equal dissemination of information to all about health care and if this kind of information is not provided by the Government then it becomes a violation of a survivor's basic human rights. The grandmother to a 5 year old girl that was defiled by a man fit to be her grandfather narrated that:

> *"I heard of this PEP treatment the day I took my grand daughter at the clinic".*

In other words, had her granddaughter had not been sexually assaulted, this grandmother would probably have never known about PEP treatment. In order to have a lot of views on the use of PEP other key respondents were also interviewed. The table below will show the key respondents that were interviewed.

Medical Personnel's views.

I had to interview medical personnel to find out if the survivors of sexual assault had any information on PEP use. I got different responses from a number of medical staff but the majority of them indicated to me that the survivors of sexual assault, even some members of

public, do not have any kind of information on the use of PEP. Mrs Chisenga the sister in charge of the ART clinic at Kanyama clinic explained that:

> *"People around here are not aware of PEP treatment that is why we do not have any survivor that was put on this treatment"*.

The lack of information on the use of PEP makes it impossible for survivors to seek treatment that could reduce the chances of contracting HIV and as such their right to health is denied.

Members of parliament's views

I interviewed 5 members of parliament on PEP treatment. This was done to find out if they had any knowledge on the subject and, once they did find out, to make them think about helping to influence a change in government policy for the benefit of the survivors of sexual assault. None of the 5 members of parliament had heard of PEP treatment. One of the 5 members of parliament Hon. Limata of Lukulu west constituency had this to say:

> *"I have just heard of this PEP from you. I would like to have more information"*.

If members of parliament that represent people have no information on PEP, I wonder how ordinary people, including survivors of sexual assault, could have any. The Government has a duty to protect the human rights of its citizens (including their human right to enjoy good health and prevent them, as far as possible, from contracting HIV/AIDS), especially if they have the resources to do so. In this particular context, since Zambia has PEP treatment (which reduces the risk of contracting HIV/AIDS from an HIV positive sexual encounter) available for public use at its clinics, it has a general duty to inform the general public of its availability. It also has an even greater, more urgent specific duty towards female survivors of sexual assaults. Not only should the State inform these girls and women that PEP treatment is available but it should do everything in its power to ensure that eligible candidates receive the treatment. In the wake of the increased suffering inflicted upon those who do not receive PEP treatment and are likely to contract HIV/AIDS (as compared with the improved quality of life enjoyed by those who do receive it and are less likely to contract HIV/AIDS), the State's current failure to fulfil its abovementioned duties is difficult to understand.

Women's views

I interviewed a total number of about 32 women who were part of a catholic group. This group of catholic women is based in Matero police camp. I did so to find out if these women knew anything about PEP use. This gave me an opportunity to discover their levels of awareness about the use of PEP, given the fact that female survivors of sexual assault usually confide in another woman. The women had different views about PEP treatment, but the most powerful fact that I discovered was that the majority of the women did not know about the use of PEP and had not even heard about it. One of the women in the group explained that:

> *"I have been hearing about this PEP but am not sure that it can prevent HIV/AIDs."*

In other words, this lack of or low level of awareness is insufficient to create a demand for PEP treatment either by those who may one day qualify for it themselves (because they themselves become survivors of sexual assaults) or by those who are tasked to help such survivors.

4 .1.5 CHALLENGES FACED BY MEDICAL PERSONNEL

Using the grounded theory I had to change the original assumption because I realised that I could not get the desired results from the medical personnel. The original assumption was looking at the levels of awareness on the part of medical staff in PEP treatment and this seemed like a challenge to the medical staff. The grounded theory approach provided me with an opportunity of getting to the roots of the problems that medical personnel face by having direct interviews with the medical staff themselves.

Medical personnel's views

A number of challenges were identified by medical personnel who are charged with administering PEP to survivors of sexual assault. Doctor Belington Vwalika the head of gynaecology department at the University teaching hospital had this to say:

> *"The lack of a clear policy on PEP treatment to sexual assaulted survivors makes it difficult for us medical staff to administer PEP".*

The lack of a clear policy as identified by the doctor above poses a big challenge to medical staff to the extent that medical staff use their own discretion to decide whether or not to

administer PEP, as it is not mandatory for them to administer it, even if a patient is eligible to receive it. Apart from having no clear policy on PEP treatment there was also the issue of the stigma associated with PEP treatment. Mrs Pandwa the sister in charge of the ART clinic at Mutendere explained that:

> "*People still have stigma of testing and let alone receiving PEP as it is associated with HIV/AIDs drugs, the ARVs"*.

PEP treatment has been linked to HIV. Therefore, survivors of sexual assault do not to want to receive this kind of treatment, as a result of which they run the risk of contracting HIV/AIDs. Their attitude is understandable because PEP treatment and HIV/AIDS treatment both share the same facilities, perhaps because the testing procedure is the same for both.

The table below shows that a good number of defiled young girls present themselves at the children's clinic but very few complete treatments due to some of the factors pointed out above by the medical personnel.

TABLE 6 SHOWS DEFILEMENT/PEP SUMMARY FOR 2006(sourceUTH)

month	**Jan**	**Feb**.	**Mar**	**Apr**	**May**	**Jun**	**Jul**.	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Defilement cases	83	62	86	54	53	73	57	70	63	70	70	88
Number started on pep	I6	10	16	17	15	16	15	19	22	16	36	22
Never completed	13	6	9	12	11	9	8	10	13	10	17	10
completed	3	4	7	5	4	7	7	9	9	6	19	12

The table below (table 7) shows defilement cases and PEP treatment for the year 2007. **(Source paediatric section UTH and the last two months were not yet compiled by the time of the study).**

Table 7

Month	**Jan.**	**Feb.**	**Mar.**	**Apr.**	**May.**	**Jun.**	**Jul.**	**Aug.**	**Sep.**	**Oct.**	**Nov.**	**Dec**
Defilement cases	85	88	89	69	67	69	70	65	85	125		
0-5yrs										32		
6-10yrs										20		
11-15yrs										73		
Number started on pep	21	24	26	41	27	17	24	22	37	55		
Never completed	10	9	12	18	13	5	12	6	11	27		
completed	11	15	14	23	14	12	12	16	26	28		
Parents refused				2				1				
Hiv positive	3	4	2	3	2	6	5	2	2			
HIV +ve no PEP				2		1	2	1				
Pregnant	4	3	5	5	9	4	1	4	7			

Table 7 shows the number of defilement cases that were reported at the children's section at UTH. Sadly, as can be seen, only about half of those who start the PEP treatment complete it. For example in January 2007 the clinic recorded 85 cases of defilement of which 21 were put on PEP treatment, 11 completed treatment and 10 never completed the treatment.

There are many challenges facing the medical personnel who administer PEP treatment to survivors of sexual assault. Mrs Pandwa the person in charge of the ART clinic at Mutendere clinic explained that:

> "*The mother of a young girl that was defiled by the father was not put on PEP treatment because the mother feared that the husband might be arrested and she will end up divorced"*.

These sorts of threats (e.g., the threat of family break-ups) puts pressure on the medical staff as PEP cannot be administered if a survivor refuses to take treatment. This also means that the survivor will be more likely to contract HIV/AIDs.

The other challenge that could be at play is the lack of a well-coordinated monitoring system for the health personnel. If you look at the numbers of defiled cases that are seen in the two tables 6 and 7 you will notice that the number of those that have not completed treatment is quite high. This situation could be due to the lack of a proper monitoring system. Mrs Nina Nkoma, the person in charge of Kamwala ART clinic explained that:

> *"Monitoring in the past was done by health workers but of late it has become very difficult due to limited resources, manpower and transport"*.

Furthermore, a lot of other challenges are faced by medical personnel in trying to give PEP treatment. The monitoring system alone cannot work if there is no cooperation from the survivors of sexual assault. The medical personnel have failed to follow up some of these cases due to the fact that some survivors of sexual assault provide wrong addresses at the clinics. Mrs Malambo the sister in charge of the ART clinic put it this way:

> "*As much as possible we would like to follow up on our patients and see how they are doing, we face problems because the home addresses that they give are wrong and misleading"*.

NGOs' views

I had to interview some people from the non-governmental organisations as these are the people that interact a lot with both the medical staff and ordinary people in society. The one particular organisation that I chose was Zambia Aids Law Research Advocacy Network (ZARNA). This organisation undertook a research on HIV/AIDs in a number of clinics in Lusaka and one of the issues that they were looking at was the issue of PEP. The organisation had come to know of the problems that the medical personnel were facing in PEP treatment to survivors of sexual assault. Mr. Paul Sichwela the project manager of the organisation explained that:

> *"There are not enough trained medical personnel that could administer PEP and those that are trained have left for greener pasture hence the shortage of manpower in health centres"*.

The above situation makes it impossible for medical personnel to effectively administer PEP as the numbers of trained personnel have decreased in relation to the number of patients whose PEP treatment needs to be monitored.

4.1.6 IMPROVING WAYS AND MEANS OF MAKING PEP AVAILABLE

If survivors of sexual assault are to benefit from PEP treatment then the provision of PEP treatment should be improved. The assumption I had was that there is a need to improve ways and means of providing PEP to survivors of sexual assault. In order to address this problem I had to use a number of methodological approaches. I used the women's law approach to get the lived realities of women so that they could offer possible solutions to the problem as they are the ones that are directly affected by sexual assaults and run the greatest risk of contracting HIV/AIDS unless they receive PEP treatment. Furthermore, the grounded theory approach provided me with a chance of talking and interacting with the medical personnel who are the health care providers responsible for administering PEP treatment and their suggestions for improvement are also vital. The human rights approach was also used because health is a basic human right of each and every individual and any reasonable means for the state to improve the health of its citizens, especially, preventing survivors of sexual assault from contracting the deadly HIV/AIDS virus by making PEP treatment more accessible to them is of paramount national importance.

I had a number of interviews with different groups of people, including, survivors who could also offer possible suggestions as these are the persons that go through the whole process; the medical personnel who have encountered problems of PEP provision and could offer solutions and other stakeholders that have an interest in improving the system of treatment, like NGOs who try to sexually abused women and who also have contact with the medical profession.

Medical personnel

The medical personnel that I interviewed felt strongly that in order to improve the provision of PEP to survivors of sexual assault, the government should have a clear policy in place that would address the problem. The medical personnel indicated that without a policy, like the one the have for HIV/AIDs, nothing much will be achieved, as PEP treatment will not become mandatory for survivors of sexual assault. Doctor Mupeta the president for the doctors association stated that:

> "*There is need to have clear and separate policy from that of HIV/AIDs on PEP provision to sexually assaulted persons"*.

Once a clear policy is in place, it will ensure that the medical personnel will have a clear reference point should anything go wrong. The national HIV/AIDs policy only outlines that PEP should be given to health care workers and does not mention anything about sexually assaulted persons. The provision of PEP treatment can also be improved if a lot of other role players are properly trained in the administering PEP to survivors of sexual assault. In this regard the properly first contact persons could really make a big difference. Doctor Chomba the head of the paediatric section noted that:

> *"The only other way to improve the provision of PEP to survivors is to train all first contact persons in this case the police officers"*.

The police have been identified as major players in the provision of PEP as they are usually the first persons to be approached by sexual assault survivors who the police then refer to the health centres. The training of first contact persons should not only be limited to the police but all other persons that can be identified as vital stakeholders. Another area of improvement is that the procedures which await these survivors at the relevant health centres should be made more user-friendly. Some of the survivors find it difficult to follow some of the

procedures and in the process end up not receiving treatment. Mrs Chanda the second sister in charge at UTH, gynaecology department had this to say:

> *"the procedure of referring clients posed a big challenge for the victims and the ideal situation is for the first contact person at the gynaecology ward to test and administer the PEP they and then."*

As Mrs Chanda noted that once made more user-friendly, the procedures will enable a lot of survivors of sexual assault to access the treatment without suffering any further unnecessary stress.

NGOs' views

The non-governmental organisation whose executive director I interviewed works with abused women including those who have been sexually abused. The organisation has noted some of the difficulties that the survivors have in getting treatment and offered some suggestions on how to improve the availability of PEP treatment. Training of medical personnel was one suggestion. This kind of training should target all health workers. Mrs Katembi Kaumba the executive director of the Young Women Christian Association (YWCA) emphasised that:

> *"there is a need to retrain all medical workers on PEP treatment so that anyone of them can administer it, than having only a handful of them trained"*.

The retraining of all workers in PEP treatment would greatly improve PEP provision at health centres because survivors of sexual assaults could be treated by all medical personnel (and preferably at any time) which is critical, since time is of the essence with PEP treatment. It must be administered within 72 hours of possible exposure to the HIV/AIDS infection and a shortage of trained staff should be not be allowed to prevent access to life-saving treatment.

Survivors

The survivors I interview also noted that there is great need to improve the means and ways of PEP provision to survivors. The treatment of PEP can improve if all the local clinics have the medicine in place, rather than having survivors to travel long distance to access the

treatment. Mrs Chisha of Nampundwe which is about 60km from Lusaka, who spoke on behalf of her daughter aged 12years who was defiled had this to say:

> *"I would love to see a situation where treatment of PEP was given at our local clinic but we only get pain killers"*.

The distance that the survivors had to travel could make it impossible for the survivors to get the treatment. The survivors who stay far away from medical centres might not get to the health centres within the 72 hours period that is recommended, hence, missing out on treatment. The treatment of PEP should be available at any local health centre so that the survivors can access it. The cost of transport could also hinder the survivors from getting the treatment that they rightfully deserve. Another survivor said that there is not much information on PEP treatment that is why survivors of sexual assault cannot access it. As a way of improving the means and ways of providing PEP treatment is to have a massive national education campaign about the right to access PEP treatment. Marble aged 31 said:

> *"The government should conduct a lot of awareness campaigns just the same way they do for condoms on radio, television, drama and newspapers."*

The awareness campaigns should be on just a large and enduring a scale as those about HIV/AIDs. The government through the ministry of health should extend those programmes to schools for the benefit of all people especially the young people.

4.1.7 LACK OF POLICY, LEGISLATION AND ADMINISTRATIVE MEASURES.

The last assumption I had was that there is lack of policy, legislation and administrative measures in place for PEP provision for sexually assaulted females. I had to look at the policy and see what it provides for the survivors of sexual assault. The national policy on HIV/AIDs only provides for the provision of PEP to health care workers who might be exposed due to the nature of their work. The feminist perspective law approach provided an insight for me to consider why survivors of sexual assault are left out. I also looked at the legal pluralism aspect of the law. This kind of approach was used to see if there are any administrative arrangements that could be in place for the provision of PEP treatment to survivors of sexual assault. In order to get the information that I wanted I had individual

interviews with 4 doctors who all confirmed to me the lack of a clear policy on PEP treatment to survivors of sexual assault.

The issue of policy for PEP treatment was brought to light by the interview that I had with Doctor Nsakashal the in charge of Makeni clinic, she explained that:

> "*There is a policy on PEP treatment only for health care workers and nothing is mentioned for sexual assaults"*.

The national HIV/AIDs policy of Zambia only provides for the treatment of health care workers who might get occupational exposure .Section 7.3(h) of the National Aids Policy only caters for the provision of PEP to health workers who become exposed. The lack of a policy on PEP treatment makes it impossible for health workers to help effectively the victims of sexual assault. However, the situation on the ground is not hopeless as there are some administrative measures that the health centres have put in place in order to address the situation. This was only uncovered from the interviews that I had with medical doctors. Doctor Vwalika the head of gynaecology department at the University teaching hospital explained that:

> "*There are international guidelines that have been approved by WHO and we also use the reference manual for health workers on management of antiretroviral therapy"*.

The administrative measures that have been put in place do offer some kind of relief to victims of sexual assault although the provision of PEP is mostly not assured in the sense that not all medical personnel may be aware of these guidelines and have the reference manual.

CHAPTER FIVE

5.0 EMERGING THEMES

5.1 INTRODUCTION

This chapter will try and look at the emerging issues from the field that arose as a result of conducting the research, as well as interacting with all the respondents and also from my own observations. Also in the chapter I shall consider some of the human rights elements on the right to health and what legal and constitutional issues are there about PEP treatment in Zambia.

5.2 PROCEDURAL DIFFERENCES IN MONITORING

The procedures for administering PEP treatment especially when it came to the monitoring aspect seemed to be different form one clinic to another. At Kalinglinga clinic I was told that in case they put someone on PEP treatment, the victim would be given a card that would be used to see if she has been taking the drugs and that after a week the victim has to report back at the health centre so that the medical personnel could see any reactions. However, at Kamwala clinic the monitoring procedure is that the victim is given enough tablets to last for a week and after that she is supposed to go back to the health centre together with the package that contains the tablets. The purpose of going back with the package is for the medical personnel to ascertain whether the victim was taking the medication or not. However, this monitoring system lacks merit in the sense that the victim can easily empty the pack. This will be done by counting the remaining tablets. These two procedures pose a problem already for the victim if they had to be referred to the other clinic that might be nearer to them. Victims will not have gone to the nearest clinic because PEP treatment may not have been available there.

5.3 CONFIDENTIALITY IN TREATMENT

As part of my observation when I was going round to collect data from the 7 clinics and the university teaching hospital what came out very striking is the issue of confidentiality. All the 7 clinics visited had a separate wing where all cases of HIV are handled. The ART clinic as it

is called does not only receive HIV cases but also cases of sexually abuse are treated there. The ART clinic is visited by anyone who is seeking HIV treatment inclusive of survivors of sexual assault be it adults or children, male and female. At UTH although the situation was slightly better in the sense that the gynaecology section is only for females and as such survivors would feel much comfortable to be among fellow women. The only problem is that women who are sexually assaulted have to be seen by doctors from the gynaecology department and as such survivors will have to compete for the same doctors with other female patients that have gynaecological problems. In case of a serious gynaecological problem I doubt very much if a survivor of sexual assault would be given first priority. As a result survivors of sexual assault will not feel very comfortable waiting around in such places taking into account the trauma that they have to undergo after the assault.

5.4 IGNORANCE

The level of awareness of the existence of PEP treatment is still very low amongst people not only to survivors of sexual assault. This was very evident from the number of interviews that I had with people from different walks of life, be they women, survivors and legislators. For example of the 5 members of parliament that I had a chance to interview none of them had any knowledge of PEP treatment. This only shows that there is very little information on PEP treatment and this already makes it very difficult for survivors to get the treatment. Furthermore, some medical personnel are not aware of the procedures of PEP treatment. This was confirmed by Mr.Sampa who referred to a case that they received from Matero clinic where a child that was defiled on a Friday night was told to go back to the health centre on Monday morning only to be referred to UTH at the children's section despite bleeding from the attack. Mr. Sampa suggested that for people including victims to be aware of this treatment a lot of community sensitization has to take place through street drama, talk shows, musical concerts, television, and radio and a comprehensive HIV/AIDS campaign that include PEP treatment in the messages is also needed.

5.5 STIGMA AND NEGATIVE RESULTS

The issue of stigma amongst survivors of sexual assault was another of the issues that emerged. The medical personnel informed me that the mere fact that PEP treatment involves

being associated with VCT (which is related to HIV/AIDS treatment), some of the survivors were not willing to undergo testing, let alone go and start receiving PEP from the ART clinics that administers ARVs as well. This stigma comes from the community in which people live and in which survivors of sexual assault must continue to live after their ordeals and it makes the whole process of undergoing PEP treatment worse because of the cruel gossiping and back biting that takes place. This makes survivors on PEP treatment feel isolated. Further, the other issue that emerged associated with stigma is the issue of testing. The medical personnel informed me that survivors who tested negative the first time at the centres would not normally come for the second testing after the window period has expired.

5.6 ADMINISTRATIVE MEASURES

Although the Ministry of Health has no direct policy on PEP treatment provision to survivors of sexual assault, there is an administrative arrangement to provide PEP treatment to survivors of sexual assault. The head of gynaecology at UTH informed me that WHO guidelines on the provision of PEP to survivors of sexual assault are used and that the manual for health workers on management of antiretroviral therapy is used. This manual has all the guidelines and the combination of the medication that is supposed to be administered to a survivor of sexual assault. The provision of PEP treatment by medical personnel was described as a right of the patient to receive and there is no reason why it should not be given.

5.7 THE ART OF SILENCE

The other emerging issue was the art of silence on the part of the survivors of sexual assault, not wanting to disclose the assault in time and at times not disclosing it at all. The medical personnel informed me that the survivors who might present themselves at health centres to seek treatment might not tell the truth about what exactly happened. This was attributed to the fact that our society still does not want to talk about sexual matters in public and worse still to a person you hardly know. This explanation was also confirmed by police officers interviewed who echoed similar details of the failure by the survivors to report the sexual assault. This might be that the abuser is a family member, someone very close or they just wanting to put it all behind them and move on.

5.8 PREGNANCY

The issue of pregnancy came out as one of the emerging issues. The medical personnel at the paediatric section informed me that some of the victims that presented themselves are pregnant and as such PEP treatment could not be given to them. They could be given other medication.

5.9 HUMAN RIGHTS ELEMENTS.

International human rights are a set of defined entitlements that all human beings innately possess.[28]These rights protect people from certain negative actions and guarantee necessities that are deemed essential in order to live a quality life. The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) provides inter alia the elimination of all discrimination against women in the field of health care and access to health care services to ensure equality with men[29]. As far as the accessibility of PEP treatment is concerned, problems still subsist which have been explained in the above chapters. The right to health seems not to be realised because of problems of access encountered by survivors of sexual assault. This in itself becomes grounds upon which women and girls who seek medical attention are being discriminated against. International human rights law has not yet been applied effectively to address the disadvantage and the injustices experienced by women by reason only of their being women (Cook 1994). The right to health care cannot be achieved if the intended beneficiaries do not have the right information. In the case of PEP treatment the beneficiaries are the survivors of sexual assault and if the information is not provided to them then the risk of them contracting HIV/AIDs becomes very high.

The government in this case as a duty bearer has the responsibility and it has the obligation to its citizens to offer this kind of information. The Ministry of health in conjunction with the Ministry of information and broadcasting service should be charged with the responsibility to disseminate this information. The government should also work with NGOs that promote the human rights of women. These NGOs already have some publicity campaigns and they work a lot with people in the communities especially at grassroots level. The Covenant on Civil and Political Rights (CCPR) provide among others the right to seek receive and impart information and ideas regardless of frontiers[30].The right to information is further echoed in

[28] Children's rights to access HIV/AIDs related treatment and services in Lusaka, December 2006
[29] Article 12 of CEDAW
[30] Article19 of CCPR

the African Charter on Human and People's Rights (the Banjul Charter) that every individual shall have the right to receive information[31].The right to information is been denied as there is almost no effort made to ensure that people especially survivors of sexual assault know about PEP treatment. The CEDAW provides among other things access to adequate health care, information and counselling. The same Convention also provides for specific education information[32].This information and access to it are the rights of every individual and it should be made available at all times so that survivors of sexual assault can make informed choices concerning their health.

Furthermore, the Convention on the Rights of the Child (CRC) provides, inter alia, the right of the child to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and also in the same Convention it provides for the protection and or treatment of her physical or mental health[33].The only way a child or any other human being is likely to be able to attain the highest standard of health is when the treatment for any illness is accessible at any time. The African Charter on the Rights and Welfare of the Child (ACRWC) provides for all state parties to ensure the provision to all children of all necessary medical assistance and health care and also their protection from sexual abuse[34].The protection of children from sexual abuse should be of vital importance as many children have been sexually assaulted and are at risk of contracting HIV. The right to health is a fundamental right that each person, regardless of sex, should be able to enjoy. Survivors of sexual assault should not be discriminated against merely because the majority of them are women or girls; they should have equal access to medical care just like any other human being.

5.10 LEGAL AND CONSTITUTION ISSUES

The Constitution of Zambia provides for the equal protection before the law of all its citizens and also provides for non discrimination, among other things, based on sex[35].These provisions are very important as they give us a starting point when looking at the treatment of PEP to survivors of sexual assault. The facts that: many sexual assaults take place; that women and girls are their most usual victims and that very little has been done to protect

[31] Article 9(1) of the Banjul Charter.
[32] Articles 10(h) and 14(b) of CEDAW
[33] Articles 24 and 25 of CRC.
[34] Articles 14 and16 of ACRWC.
[35] Articles 3 and 11 of the Zambian Constitution

them from contracting the deadly HIV/AIDS virus, together prove that women and girls are not being protected by the law that is in place.

The Constitution further provides for non-discrimination either on grounds of sex or race. However, the opposite situation is found on the ground. Sexual assaults are mainly targeted at women and the possibility of contracting HIV/AIDS is very high if raped by an infected person. In health centres where PEP treatment is available, it is very difficult to access due to certain procedures that are not user friendly. This also brings in the issue of not having a proper policy about providing PEP treatment to survivors of sexual assault. The lack of a clear policy on PEP shows that female survivors of sexual assaults are effectively being treated like second class citizens because this crime is sex specific.

The Constitution further provides for the right to life[36]. From the Constitutional, legal and moral point of view, the twin scourges of gender violence and HIV/AIDs place a heavy burden on the state to protect women not only from bodily (i.e., sexual) violation but from the death threat (i.e., HIV/AIDS) that this carries[37]. If the government is serious about HIV/AIDs, there is no reason for not including PEP treatment in legislation. If it is not, then legislation is one of the first major ways of protecting the rights of women. Ultimately, the right to enjoy a quality life cannot be achieved if the right to health is denied. This is meant in the sense that the denial of available PEP treatment to female survivors of sexual assault directly exposes them to the risk of being condemned to suffering the rest of their lives under the death sentence of living with the HIV/AIDS infection. Women and girls that are sexually assaulted can only enjoy the right to life if all medical treatment is made available and accessible to them within the shortest possible time. In this era of AIDs and the sexual assaults that are taking place against women and girls without any immediate recourse to treatment (a breach of their right to good health), the right to life will have little meaning as many females would have contracted the deadly disease of HIV/AIDs.

However, it should be noted that although the Constitution provides for non-discrimination on the basis of sex, the provision of PEP to survivors of sexual assault might still not been provided as this could be an omission on the part of government. The national policy on HIV/AIDS also does not have any provision for PEP treatment for survivors of sexual assault. This also might be another omission that needs to be addressed by government.

[36] Article11 of the Zambian Constitution.
[37] Report on the Pep talk campaign conducted during the sixteen days of activism on gender violence 2003,17/12/2003

5.11 RECOMMENDATIONS

The findings of this study have shown the difficulty of administering PEP and the lack of information on PEP treatment. The problem is further compounded by the fact that the sexual assaults taking place put the survivors at risk of contracting HIV/AIDs when treatment is not accessed or is not even available to be accessed. In order to address the accessibility of PEP treatment to survivors of sexual assault the following measures need to be put in place so as to reduce the risk of their being infected with the deadly HIV/AIDs virus:

- The government should come up with are a clear and deliberate policy for survivors of sexual assault regarding the treatment of PEP. This policy should address issues of accessibility and availability of PEP treatment to survivors. This policy should be a public document so that any person should be able to access it and it should also be made available in the major local languages. The current national policy on HIV/AIDs/TB/STIs does not have any provision for the treatment of sexually assaulted survivors but only makes provision for medical health workers. The fact that PEP is given to health workers that have been exposed is a good starting point to ensure that all survivors of sexual assault benefit from this treatment.

- There should be a law that compels abusers to undergo mandatory HIV testing so that their status is known. This should be done in order to reduce the time medical personnel take to test the survivor and this can offer some kind of relief to survivors if the results of the abuser are found to be negative. This also should be the basis on which the abuser should be given a stiffer punishment should he be found positive.

- There is also a need to have a well trained and sensitive medical staff that will attend to survivors of sexual assault (Christofides, et al 2006). If possible all medical staff should be trained in PEP treatment as this will make it easier for survivors who will not be forced to wait for only a handful of medical staff that are trained to attend to them. The medical personnel should also be trained in psychosocial counselling so that they are able to provide quality service to victims of sexual assault so as to lessen the effects of their trauma.

- There is a need to train all first contact persons in PEP treatment so that the survivors can beat the 72 hours grace period during which they must receive PEP treatment if there is to be any hope of preventing them from contracting the HIV/AIDS infection from an assailant who might be HIV positive. The police should be trained in PEP treatment because survivors usually make contact with them first[38]. This training should also extend to some women's groups in the community as well as other NGOs that are involved with the welfare of women. The training of support groups in the community is of importance in the sense that most of the abuse takes place in the community and women might be the first contacts in whom the survivor might want to confide after a sexual assault.

- Women's rights need to be protected and as such there is a need for a massive publicity campaign about PEP treatment. This public awareness and education should be sponsored by the government. The campaign should be very comprehensive in nature in the sense that the massages that are put out should be able to offer people all material and important information about PEP treatment such as the importance of receiving it within 72 hours, its availability, accessibility, side effects, procedures etc. This public awareness should be structured in a way that even children should be able to benefit from it and should be on-going on radio, television, newspapers, posters and drama. Education about PEP treatment should reach schools and even the school syllabus, just as has been the case with HIV/AIDs campaigns. The fact that so little is known or in place for the treatment of children who are survivors of sexual assault is another worrying finding. It is absolutely vital that children be protected from contracting HIV/AIDs as a result of sexual assault and that appropriate measures are put in place for addressing this issue. Although NGOs should also be brought in to help, the government should be at the forefront of this mission as providing life-saving information to its people, women and girls, is one of its paramount duties in this era of HIV/AIDS.

- There is a need for legal literacy, i.e, of "Taking the Law to the People '' (Tsanga 2004) and women especially should be legally empowered to assert their legal rights. This will help women make good informed decisions by reporting to the police all

[38] Sauti Ya Siti, special issue on violence and HIV? AIDs, Halt the spread of AIDS. issue no.28 December 2004,ISSN 0856-230x

cases of sexual assault. Although at times individual efforts might not produce the required results, there is a need for concerted efforts for legal change to take place.

- There is also a need to consider having female doctors to attend to survivors of sexual assault as these people are still traumatised. This will reduce the feeling on the part of the survivor of being traumatised for a second time if they are forced, as they still are, to be examined by male medical personnel. This is so because the study found out that the other reason why the survivors might not access treatment is the presence of male medical personnel who conduct medical examinations.

- Health service procedures should be standardised so that it becomes easy on the part of the survivors to be referred to another health facility that might be nearer to her home (Christofides et al 2006). There should also be a standard monitoring system in place to ensure that survivors adhere to instructions and should there be any side effects these can be noticed and dealt with in the shortest possible time.

- There is also a need to have privacy when dealing with survivors of sexual assault. This privacy should start from the first contact person in this case who are usually the police and it should include personnel at the health centres. Most of the time, rape victims are in shock and take time to come to terms with it[39].This privacy should extended to health centres and survivors should not be forced to mix with other patients that go to seek medication as the survivors would not have washed and would be feeling out of place and even more traumatised.

- There is a need to strengthen support and treatment services for survivors of sexual assault including voluntary and confidential HIV testing, testing and treatment of other sexual diseases.

- PEP treatment should be available at all health centres to enable survivors to access it more easily than to have it available at only a limited number of health centres. This will also require that health centres to provide PEP treatment 24/7 as sexual assaults may occur at any time and in any place.

[39] Satuti Ya Siti, special issue on violence and HIV/AIDs, Halt the spread of aids, issue no.28, December 2004 ISSN 0856-230x

- Although there is some cooperation between NGOs and health facilities around gender violence and HIV/AIDs, this tends to be ad hoc and dependent on personalities. NGOs are well placed to assist in public education, counselling, and follow up to the provision of PEP. This needs to be done in close coordination with the health authorities. This would bring together all those concerned in this vital work in order to achieve greater awareness, information and provision of widely accessible, high quality services around PEP.

5.12 MONITORING, EVALUTION AND RESEARCH

There is a need to monitor, evaluate and research on the provision of PEP treatment to survivors of sexual assault. The fact that so few survivors who are eligible for treatment complete the entire course of PEP treatment is worrying and points to the current serious flaws in the inconsistent administration of the treatment. Improved monitoring, evaluation and research considerations should be conducted in terms of the Government's new clear policy on PEP treatment for survivors of sexual assault which needs to take into account the following considerations:

- ✓ The need to use existing data for research on why there are poor follow ups on survivors of sexual assault undertaking PEP treatment and to find solutions based on the research findings.
- ✓ Improve all medical record keeping.
- ✓ Build relationships with NGOs so that some follow up consultations may be done through home visits to survivors.
- ✓ Being able to refer survivors to their nearest health facility for follow up services.
- ✓ Paying survivors' transport costs by government for follow up consultations.
- ✓ Research into monitoring the implementation of the sexual assault policy and the management guidelines on the treatment of PEP and evaluation of the approaches to improve service delivery.
- ✓ Research is needed into strategies for the supporting of adherence to medication in different settings.
- ✓ Research should also focus on the impact of PEP's effectiveness if the doses are missed or the medication is stopped prematurely.

5.13 CONCLUSION

In conclusion, the findings support a new holistic approach for post sexual assault health services that will be provided by well trained providers and will include both counselling and medical treatment that will, to the greatest extent possible, prevent HIV/AIDs infection among survivors of sexual assault. There is a need to respond to survivors' medical needs if we are to increase the numbers of survivors who seek medical attention. This will also address the human rights needs of the victim, the training of all first contract persons and having a clear policy in place on PEP treatment. Furthermore, we need to have a very supportive environment which will encourage patients to adhere to treatment and also have a well informed community who know all about the benefits of PEP treatment. This will entail changing some negative social attitudes attributes that people have and especially close family members. Massive educational campaigns that are ongoing will be an added advantage that will help to remove some of the social barriers that survivors encounter, as discouraging them from receiving PEP treatment infringes on their basic human right to health and, because HIV/AIDS is a deadly disease, to their right to life. The research findings have provided a basis on which we can safely conclude that survivors of sexual assault have sadly been denied the right to health and that there is a lot of work that needs to be done in order to improve their enjoyment of it.

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Universal Declaration on Human Rights

United Nations International Covenant on Civil and Political Rights

United Nations International Covenant on Economic, Social and Culture Rights

INTERVIEW GUIDE FOR POLICE OFFICERS

What rank and position do you have?

How many numbers of sexual offences do you receive in a day?

Who are the most effected people with sexual offences and why?

Do you know anything about PEP if so what?

What do you advise survivors of sexual assault about PEP?

What are some of the reasons why survivors report late?

What recommendations would you put forward to help survivors access PEP easily?

INTERVIEW GUIDE FOR SURVIVIORS OF SEXUAL ASSAULT

How old are you?

When were you sexually assaulted and by who?

Did you report your assault, if so where and if not why?

Was PEP administered to you, if not why?

Was the procedure explained to you, if not why?

Where did you know about PEP?

Did you complete the course if not why?

How was the service at the clinic?

What suggestions would you offer to improve the accessibility of PEP?

INTERVIEW GUIDE FOR MEDICAL PERSONNEL

What position do you hold?

When did you start administering PEP to survivors of sexual assault?

How many survivors have you put on this treatment so far?

Is PEP readily available, if not why?

Is PEP readily accessed, if not why?

Do you have a policy on PEP provision to sexual assault survivors, if not what do you use?

What is the procedure for one to be put on PEP treatment?

What type of monitoring mechanism is in place for PEP?

Is the monitoring done if not why?

What challenges do you face in PEP provision?

What recommendations can you make on PEP provision to survivors of sexual assault?

INTERVIEW GUIDE FOR NGOS

Do you think survivors of sexual assault are aware of PEP treatment?

If so are they receiving the treatment?

If not, why not?

Do women report to you about sexual assault?

If so what kind of assistance do you give them?

How many such cases have you handled?

Do you make any follows on these cases and what has been the outcome?

What suggestions do you have for the improvement of PEP treatment to survivors of sexual assault?

INTERVIEW GUIDE FOR MPs and ORDINARY PEOPLE

Do you know anything about PEP treatment?

Where did you hear about it?

What do you know about PEP treatment?

Do you know anyone who was put on PEP treatment?

What suggestion do you have to improve the provision of PEP treatment?