SEXUAL ASSAULT AND HIV/AIDS: THE IMPLICATIONS

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UNTIL MORE RECENTLY, THE ISSUES SURROUNDING SEXUAL ASSAULT AND HIV/AIDS have received scant attention with minimal focus on discussion, research and implementation of protocol. Possible reasons for this omission include mythology and victimology, the androcentric bias, and sexual assault and gender.

Mythology and Victimology

Society tends to react to both survivors of sexual assault and people living with HIV with an 'out of sight, out of mind' attitude: they are seen as victims of events that are somehow outside the boundaries of the 'norm'. There is the myth which encourages the belief of 'innocent' versus 'guilty' victim, whereby the character status of the individual is seen as being the cause of the event. This labelling, for example, is evident by the stereotypical description of the rape survivor as being a young attractive woman hitchhiking alone, and the person with AIDS/HIV as being a down and out intravenous drug user.

The Androcentric Bias

The AIDS pandemic has usually been described in terms of being the 'gay (man's) disease', resulting in a failure to fully acknowledge the existence of women with HIV/AIDS. The scant research that exists dealing with women and HIV has usually focused on the sexual behaviours of HIV-positive sex workers, and pregnant HIV-affected women, with the study of the latter group primarily to investigate HIV transmission to the unborn rather than to examine the effects of the virus on the health of the pregnant woman (Rosser 1991).
Sexual Assault and Gender

The majority of known survivors of sexual assault in Australia are female. The notion that sexual assault is a women's issue precludes examination of this area within serious research; that is, having low priority in terms of subject matter and funding. If HIV/AIDS is seen to be classified as a predominantly 'gay disease', then it follows that sexual assault is not seen as being 'high risk' because of the heterosexual nature of sexual assault. AIDS prevention strategies have not addressed sexual assault because negotiation of safe sex cannot take place. The issue of HIV/AIDS will probably remain in the background as long as the problem of sexual assault continues to be viewed as an insignificant social concern.

Review of Existing Literature

The first comprehensive report concerning HIV testing and rape was compiled by Nikki Main in 1991. This report detailed her project which aimed at researching the issues and canvassing responses from service providers within the field. Her major findings were as follows:

- the exploration of published material indicated a notable gap in the coverage of rape and HIV transmission;
- service providers were noticing increasing anxiety expressed by survivors regarding HIV;
- there had been very little policy development of the issues to date; and
- the issues concerning the timing of HIV testing, baseline testing, use of prophylaxis, pre/post test counselling and privacy still required further clarification (Main 1991).

Other articles include a British paper detailing female survivors who had seroconverted following sexual assault (Clayden et al. 1991). The author suggests that the rate of HIV transmission could rise due to the increasing prevalence of HIV amongst heterosexuals, and the incidence of violent rapes. It is also suggested that samples of serum should be stored for testing at a later date if HIV testing is not immediately appropriate. Support for the recommendation that serum be stored for later testing has been generated by others (Forster & Estreich 1990).

The issue that anal rape can increase the risk of HIV transmission and that this aspect of rape is being increasingly reported amongst adults and children is also discussed in the literature (Lacey 1991). Further, an informal survey of a number of Sydney hospitals and sexual assault centres revealed an increase in anxiety regarding HIV, together with more frequent requests for HIV testing by survivors. The survey also found that a large proportion of counsellors interviewed preferred to discuss HIV during follow-up sessions which presented problems in relation to low follow-up rates (AIDS Networker 1990).

There have also been discussion papers relating to the possible usage of prophylaxis such as AZT, Hepatitis-B vaccine, and a spermicide containing Nonoxynol-9 (Boag et al. 1990; Williams 1990).
The Issues

In the context of service provision and policy implementation, several key issues requiring wider discussion and clarification arise. Although the following list of issues are by no means complete, they nevertheless constitute a solid core.

Baseline testing

The purpose of this particular test is to establish whether the survivor has previously been exposed to the HIV virus prior to the sexual assault. This test requires immediacy. However, due to the 'window period' factor, potential problems are inherent with this test, especially in determining the exact time at which seroconversion could have occurred. A baseline test would not be able to detect the antibodies to the virus if, for example, seroconversion could have occurred several days prior to the rape. Similar problems arise with the three-month follow-up test, since seroconversion could have occurred at the time of sexual assault or several days later. Obviously, these complexities will have implications in a court case, including a Crimes Compensation Claim.

The issue of testing also raises questions regarding the testing of perpetrators and others. Should policy be established requiring mandatory testing of perpetrators? In the case of sexual assault within the family, should other members of the family also be tested?

Baseline testing requires immediacy. Some service providers suggest that survivors are unable to make this important decision during the crisis stage following a sexual assault; others suggest that the freezing of serum would be far preferable, and would allow greater choice for the survivor. Still others argue that the added issue of HIV would be too traumatic for the survivor and that the risk of transmission in Australia is too minimal to warrant inclusion of testing within case management.

Pre/Post-test counselling

The survivor has the right to a full explanation as to what the test is, how it will be given, and the implications of the result. Some service providers suggest that survivors are unable to incorporate such information during the initial contact and, therefore, should be given such information during follow-up sessions when it is more likely to be retained. Others argue that the first contact may be the most optimal and the only time to discuss testing because of low follow-up rates. In any event, however, the survivor should have the right and opportunity to access of information, and the final decision whether to undergo testing or not must lie with the survivor.
Risk assessment

In giving a professional opinion as to whether an HIV test is warranted or not, service providers are faced with the dilemma of providing an 'at risk spectrum' that is as realistic as possible. Should testing be routinely carried out? How do service providers evaluate whether one survivor has been more at risk than another? To what extent should prior at risk behaviours be taken into consideration? To what extent should the incidence of HIV transmission be a guide to risk assessment, given that the statistics are low, but far from comprehensive?

The risk of transmission should be seen as being greater if the following co-factors are considered: presence of other STDs; the level of violence involved and damage to mucous membranes; the number of perpetrators involved, the number of assaults that took place; and anal rape.

Confidentiality

In what ways can survivors be assured that confidentiality will be maintained and what measures can agencies implement to ensure this?; for example, the use of a number code system for serum samples. Who will have access to positive test results now that a positive HIV status is mandatorily notifiable?

Use of prophylaxis

The use of the anti-viral drug AZT (which acts by slowing down the replication of the HIV virus, but not destroying it) is now widely used in the treatment of HIV infection. Some studies suggest that the use of AZT may inhibit initial replication of HIV if administered immediately following transmission. To date, however, there is no solid data to confirm this. Most hospitals in Australia offer AZT treatment for health care providers following needle stick injuries. It has been argued that sexual assault survivors should also be given the same choice and have access to AZT as a prophylaxis.

However, several concerns regarding the use of AZT have arisen, such as how service providers assess whether the risk of HIV transmission is great enough to warrant treatment with AZT. In addition, since the prophylactic efficacy of AZT is still unknown, there remains considerable debate regarding its potential usage. AZT can potentially produce side-effects of which less is known about in women. Further, the administration of AZT requires close medical monitoring; maintenance of contact between service provider and survivor could become problematic especially when follow-up rates tend to be low.

Conclusion

The foregoing discussion has attempted to summarise some of the major issues regarding sexual assault and HIV/AIDS, a subject that is still very much kept in the background.

Investigation of the available literature has indicated a gap in the level of research and knowledge of this area. The development of protocols has only recently commenced; the majority of sexual assault agencies in Australia do not, as yet, possess protocols.

The issues are numerous and require further clarification. Service providers are concerned as to the type of information they need to convey to survivors, in addition to the
most appropriate time to do so. The issues of testing, compensation and use of prophylaxis are indeed complex.

The guiding principle around these issues however, should be the belief that survivors have the right of access to appropriate and correct information so that they can make the choices with regard to available medical, counselling and legal options.

The discussion of HIV/AIDS is no longer bound by the concept of 'epidemological grouping'; rather, it has become far more diverse, and the inclusion of sexual assault and HIV/AIDS should be acknowledged as such.

References


Williams, M 1990, 'AIDS and sexual assault', Health Sharing, Summer.