CHAPTER 19
Implications of HIV/AIDS for Sexual Assault Survivors

LEARNING OBJECTIVES:
♦ Understand issues of HIV and sexual assault within the sociopolitical context.
♦ Understand the compounding impact of the risk of HIV on sexual assault survivors.
♦ Identify the possible routes of transmission of HIV as well as treatment options.
♦ Understand issues regarding HIV testing for survivors.
♦ Describe aftercare plans relative to HIV for survivors following testing.
♦ Explain points of view on HIV testing of convicted perpetrators.

A significant concern for many sexual assault survivors is the possibility of contracting an infection, especially HIV, as a result of the assault. Survivors who are HIV-positive prior to the assault may have questions of the assault’s potential impact on their current health and treatment. Rape crisis counselors should have an understanding of the significant emotional and physical impacts that the fear of or actual contraction of HIV or HIV-related complications from the sexual assault may have. Counselors should have a basic understanding of the medical aspects of HIV/AIDS to guide and support clients who have concerns about these medical conditions. While rape crisis counselors do not provide medical services or advice, it is important to know of appropriate medical referrals. In particular, the counselor’s knowledge about the indications and testing protocol for HIV are imperative to gaining the survivor’s confidence and to assisting the survivor in making informed decisions. It is important to know that current treatment regimens for HIV have been shown to prevent or delay the onset of symptoms if there is early detection of HIV status and early treatment. There are guidelines for risk assessment and post exposure prevention treatment when indicated.

The Social Constructs of HIV and Sexual Assault

The threat of being infected with HIV contributes to the already enormous burden of trauma carried by survivors of sexual assault. However, the first decade of the HIV/AIDS epidemic produced a remarkably small amount of information on its implications for sexual assault survivors. Only recently have some insights and answers come to light. The lack of attention to this issue is in part explained by the stigmas attached to HIV, AIDS and sexual assault in particular and to sexually transmitted infection (STI) in general.

It is also important to remember that an HIV-positive person can also be the victim of sexual assault. Therefore, rape crisis counselor/advocates should also be prepared to work with survivors who are HIV-positive and to address their many needs including identifying appropriate medical and support services.
Many people in our society still hold negative judgements and promote damaging, victim-blaming myths about sexual assault that result in stigmatizing sexual assault survivors. Sexual assault sometimes is inaccurately viewed as the result of illicit sexual behavior, lack of restraint, or punishment. Some people still view a sexual assault as self-inflicted or provoked by the victim. At times, the criteria used for determining the crime of rape has focused moral assessment on the victim rather than on the accused.¹

Many people in our society also hold negative judgements and promote damaging myths about sexually transmitted infections and assign stigmas to those who contract them. Powerful cultural and social forces have shaped meanings attached to having a sexually transmitted infection. These infections were originally viewed as the result of illicit sexual behavior, a failure of individual restraint, and/or punishment for sin. The effect was that sexually transmitted infections were considered by many to be self-inflicted or deserved. Those infected with sexually transmitted infections often attempt to hide or deny their illness for fear of discrimination and segregation. Some social responses to HIV/AIDS are modern-day versions of these views.²

A sexual assault survivor not only needs to heal physically and emotionally from the assault, but also is confronted with societal judgements about having been sexually assaulted and possibly contracting a sexually transmitted infection from the assault. This compounded impact on survivors of the risk of sexually transmitted infection can make recovery from the assault even more difficult. Access to services designed for these issues, especially support and counseling, is also a need and concern for survivors.

Rape crisis centers attempt to address many of the problems associated with access to services. The rape crisis counselor should be prepared to discuss the fears and unknowns associated with recovering from a sexual assault and the possibility of contracting an STI, including HIV, as well as additional concerns for a survivor who was HIV positive prior to the assault. Some of the concerns of a survivor may include:

- What is my actual risk of getting an STI?
- What is my risk of contracting HIV?
- Is there anything I can do now to lower my risk of developing HIV from the assault?
- If I was already HIV-positive before the assault, what do I need to know and what do I do now?
- Should I be scared that I may become infected and feel sick?
- Where can I get more counseling on HIV issues?
- Telling my partner that I was sexually assaulted is difficult enough, how am I going to talk about the HIV risk?
- Where can I get tested for HIV antibodies?

Over time, there has been progress in negating societal judgements and defeating victim-blaming myths. There is increasing awareness of the actual risk of HIV transmission through sexual assault. Sexual assault is now recognized as a means of transmission in
medical organizations ranging from local departments of public health to the World Health Organization.

**What is HIV Disease and AIDS?**

*HIV* is an acronym for Human Immunodeficiency Virus, the virus that causes AIDS. “Human” because this virus can only infect human beings. “Immuno-deficiency” because the effect of the virus is to create a deficiency, a failure to work properly, within the body’s immune system. “Virus” because the organism is a virus. Without treatment, in its early phases, the virus rapidly replicates and is stored in cells of the body. Eventually, it results in severe impairment of the immune system and development of AIDS. There currently is no cure for HIV. However, especially with treatment, people often live with HIV disease for many years before developing AIDS. New treatments have proven effective in slowing the progression of HIV disease in many cases. In addition, studies on pregnant women have shown certain treatments to be extremely effective in decreasing the rate of mother-to-child transmission (see below for transmission information).

*AIDS* is an acronym for Acquired Immune Deficiency Syndrome. “Acquired” because it is a condition one must acquire or get infected with, not something transmitted through the genes. “Immune” because it affects the body’s immune system, the part of the body which usually works to fight off germs such as bacteria and viruses. “Deficiency” because HIV makes the immune system deficient or unable to work properly. “Syndrome” because someone with AIDS may experience a wide range of different diseases and opportunistic infections.

**HIV Transmission and Sexual Assault**

HIV is transmitted when an infected body fluid that carries a significant concentration of the virus (blood, semen, pre-ejaculatory fluid, vaginal secretions, menstrual blood, and/or breast milk) enters the blood stream of another individual through an open cut in the skin, or the mucous membranes that line the mouth, vagina, or anus, or from mother to fetus in utero or from mother to child through breast milk. Blood has the highest concentration of HIV so that a small amount of blood may be enough to infect someone, while much larger amounts of other body fluids would be needed for HIV transmission. Healthy, unbroken skin does not allow HIV to get into the body.

If a sexual assault perpetrator is HIV-infected, a number of conditions influence the probability of transmission of HIV to the survivor from the assault, including:

- **The type of sexual assault.** Higher infection rates have been found for receptive anal intercourse than for receptive vaginal intercourse. Oral sex generally poses a lower risk. Due to the smaller, tighter anal opening, forced insertion is more likely to produce tears or cuts in the tissue that provide easier/direct entry into the blood
stream. Ejaculation in any of these cases increases the risk of transmission significantly.

- **The type and amount of body fluid transmitted by the perpetrator.**
- **The number of assaults and/or assailants at one time, or over a period of time.**
- **Other forms of violence associated with the assault that expose the survivor to blood or sexual secretions.**
- **The presence of other preexisting sexually transmitted infection in the survivor.** There is particularly greater risk of transmission with those STIs that produce open sores. These sores provide a point of entry for the virus.
- **The stage of HIV infection, or the viral load of the perpetrator at the time of the assault.** If not getting treatment, the most infectious individuals are those that are newly infected, and those in the late stages of AIDS.

**Individual** risk, however, depends on many factors. For example, sexual contact with an infected person or exposure to many infected persons’ bodily fluids (for example, a “gang rape”) is statistically more likely to result in HIV transmission than a single potential exposure. Overall, it is also statistically unlikely that a perpetrator is HIV-positive. Additionally, overall rates of sexual transmission of HIV vary depending on the type of exposure. Individual situations and risks vary and because of the traumatic nature of sexual assault, the fear of being infected or experiencing HIV-related complications is very likely to be a concern for many survivors.

Sometimes a survivor may be concerned about the assumption that sex offenders, due to probable multiple exposures, may be at higher risk for HIV infection and therefore are more likely to infect those that they assault. No concrete data exist to suggest that sex offenders have a different HIV infection rate than that of the general population. It is important to remember that the survivor will usually not know the HIV status of the perpetrator. Risk of transmission from the perpetrator to the victim during sexual assault depends upon a number of factors. The first factor is the HIV status and viral load (amount of virus in the blood) of the perpetrator. If the perpetrator is not infected at the time of the assault, there is no risk of HIV transmission to the survivor from that assault. If the perpetrator is infected, the probability of transmission of HIV to the survivor from that assault varies depending on the conditions described previously.

**HIV Antibody Testing**

In Massachusetts, HIV antibodies testing is voluntary. A health care provider must obtain written informed consent before an HIV antibodies test can be done. HIV antibodies testing is a means to determine whether or not a person has the antibodies to the HIV virus in their blood, which would indicate that the person has been infected with the virus. The decision to test is a personal one that should take place only after pretest counseling. Waiting to take a test, waiting for the results, and other test-related issues may provoke heightened feelings of helplessness and anxiety for survivors. Post-test counseling should also be provided prior to the survivor receiving the HIV antibodies test result.
It is important for sexual assault survivors who are interested in HIV testing to discuss timing and scheduling of tests with the test site personnel. The “window” period for seroconversion (the time it takes a person to develop antibodies that may show up on an HIV test from the time of infection) varies from person to person. Some people seroconvert as early as three weeks after exposure, with greater than 80% of the infected individuals testing HIV antibody positive by six weeks (MDPH HIV/AIDS Bureau Clinician’s Guide to HIV Counseling and Testing; May, 2000). Six weeks is generally the time it takes an infected person’s blood to produce the HIV antibodies (“seroconversion”) that can be detected by the HIV test. Therefore, to detect possible infection from an assault, a survivor would get tested at six weeks post-assault when seroconversion is most likely to occur and be detectable. Testing before this time may be too soon to tell a survivor whether s/he was infected from the assault. In Massachusetts, it is therefore recommended that survivors of sexual assault get tested for HIV at six weeks post-assault.

There are three types of HIV tests:

**Conventional HIV tests**

**Serum test**
This is a blood test during which a needle is used to draw blood from the arm into a set of tubes and is sent to the lab. Results are ready in about two weeks.

**Oral mucosal test (or OMT)**
This test gathers fluids and cells, oral mucosal transudate (OMT), taken from the inside of the mouth using a toothbrush-like tool and the sample is sent to the lab. This is a screening test only. If the OMT test result is positive, it may mean the person is HIV positive. A confirmatory blood test should be taken and it takes about two weeks to get this test result.

**Rapid HIV test**
Depending on the technology, this test can use either a small sample of blood from the finger tip or fluid from the mouth. Depending on the facility, the sample may be tested right then and there and results may be ready in about 10-20 minutes. If the test result comes back non-reactive, it means the person is HIV negative and does not need more immediate testing. If the test gets a reaction, it may mean the person is HIV positive. A confirmatory blood test should be taken and it takes about two weeks to get this test result.

A positive or reactive test at any time, while anxiety-provoking, can allow the survivor to begin taking the necessary steps to deal with this new health status.

In MA, HIV testing is done confidentially with some sites assigning a number instead of your name; this is considered anonymous testing. To maintain the highest level of confidentiality, an anonymous test is often recommended for sexual assault survivors. However, some advocates believe that wherever possible, HIV antibody testing should be provided in the context of ongoing care, with discussion of how the
confidentiality of records is maintained. Testing of pregnant survivors is strongly recommended by most health care providers due to the apparent reduction in fetal transmission rates with the administering of combination drug therapy to pregnant women who test positive for HIV.

Additional Testing Considerations for Survivors

The fear of telling others about the assault and fear of HIV infection may deter the survivor from getting tested for HIV antibodies. It is crucial that HIV test providers are trained on the special issues of survivors of sexual assault, so they are prepared for the emotional and legal implications of disclosure.

For several reasons, HIV testing is typically not recommended as part of a sexual assault evidence collection exam in hospital emergency department settings. First, in the hospital emergency department setting it is unlikely that appropriate pre-test and post-test counseling will be part of such a test. Second, the crisis reaction to rape may not afford the survivor the presence of mind to give informed consent to being tested. Third, the test is not anonymous in this setting, and becomes part of the survivor’s medical records that can be subpoenaed into evidence at trial. Introduction of any information regarding HIV status and testing could have a detrimental effect on legal proceedings. Finally, testing immediately following the sexual assault will only indicate whether the survivor had already contracted HIV before the assault. Introduction of any information regarding HIV status and testing could have a detrimental effect on legal proceedings.

Some survivors may request “baseline testing” immediately following an assault (e.g., within a week) to establish whether or not they contracted HIV prior to the sexual assault for other reasons. Some hospitals may also provide on site testing as part of their “PEP” protocol (see section on Post-Exposure Prevention/Prophylaxis on p. 19-8 of this chapter). The decision to be tested, after adequate information is provided for informed consent, is ultimately the patient’s. If HIV testing is done, ED clinicians should ensure that appropriate mechanisms for specific informed consent, protection of HIV testing records and post-testing follow-up are provided.

Successful criminal or civil prosecution related to HIV transmission would need to show that the survivor became HIV positive as a result of the rape and not from other risk behaviors before or after the rape. Survivors should be informed that this type of action could open their entire medical and sexual histories to scrutiny, and could eliminate all protections granted by the rape shield law. If a survivor wishes to pursue baseline testing outside of the ED, s/he can access state-funded HIV anonymous testing and counseling sites through 1-800-235-2331 or ask if the hospital has an Infectious Disease of HIV follow-up system.

HIV Antibody Test Counseling

Pre-test counseling by an HIV testing counselor will include:
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- HIV transmission and risk opportunities
- Benefits of early diagnosis and treatment
- Prior history of HIV testing, reasons for testing and expectations
  - Technical aspects of testing options
- Testing options
- Natural history and clinical manifestations of HIV/AIDS
- Potential role of post-exposure prevention (prophylaxis) in selected cases
- Screening and/or referral for STIs and other coinfections (hepatitis A, B, C)

Discussion of testing, however, should not be limited to the pretest session. A survivor may choose or need to have an ongoing discussion about testing issues with a counselor/advocate in preparation for the actual test.

- Why is the survivor being tested?
- What information does the testing give the survivor?
- What support system is in place to help the survivor during the waiting period?
- Does the survivor have a plan of action based on a specific result?
- What will the result mean to the survivor, and is that meaning accurate and likely to help or hinder the healing process?
- What services will be available if the result is positive?
- Has fear of HIV become a mask for other issues?

In answering these questions, the survivor may decide to test, postpone testing, or not test at all. The decision must be the survivor’s own. The counselor/advocate should keep in mind her/his role, as distinct from a pre-test counselor’s role, and remain non-directive. She or he should focus on the survivor’s concerns and feelings rather than dwell on time periods of disease progression.

Testing of Perpetrators

Some survivors may want to know the perpetrator’s HIV status. There is no state law that provides for mandatory testing of perpetrators at this time, though for many years in Massachusetts bills have been introduced that would require this after conviction.

Victim advocates, such as Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence, and its member programs oppose mandatory HIV testing of sexual offenders and are convinced that such a law is of no value and is potentially harmful to victims of sexual abuse. The major points of their opposition are:

- That such a measure could mislead survivors about their risk for contracting HIV as a result of sexual abuse and their options for discovering their HIV status. It usually takes up to 2 years for a court case completion and conviction. If survivors want to be tested, they are encouraged to do so long before the results of a criminal prosecution.
That the healing process will be jeopardized by falsely suggesting to survivors that they are reliant on their perpetrator to provide them with information. This would unnecessarily delay or endanger the healing process if the perpetrator is not convicted or if the survivor did not, cannot, or does not report the assault and participate in the prosecution of the case.

That offender testing will ultimately violate survivor confidentiality. By involving the courts in the HIV testing and reporting process, at least several people become aware of the survivor’s specific potential exposure to the virus. Additionally, legislative efforts often include permission for a survivor’s immediate family members to request that the perpetrator be tested for HIV – without the survivor’s consent and regardless of the survivor’s age. The fact that others would have this information could cause the survivor further anguish and expose her or him to potential discrimination in areas such as employment and insurance.

Victim advocates who are proponents of mandatory testing have as their rationale that the exposure to HIV starts with a wrong, and that the perpetrator has a duty to limit the harm caused by the wrong. They believe that fear of HIV infection is a harm that can be limited by testing. They identify three possible objectives of testing the perpetrator, all of which hinge on testing at the earliest possible time, in most cases at arrest or indictment:

- The survivor would have a psychological benefit, despite the possibility of false positive and negative results. Having information on the offender’s HIV status would possibly relieve some anxiety caused by the fear of contracting HIV.

- Increased knowledge about their HIV risk may prompt healthier behaviors in survivors who resume sexual activity soon after the assault, if they are pregnant or are trying to become pregnant.

- The survivor may receive clinical benefits, such as combination drug therapy. However, this would depend on the survivor’s HIV test and not the perpetrator.

Post-Exposure Prevention (Prophylaxis)

Post-exposure prevention, known as prophylaxis or PEP involves medication which may reduce (but not eliminate) the possibility of HIV infections. Its effectiveness has been studied through health care providers exposed in the work place. These workers had a 70% reduction in the rate of seroconversion to become HIV-positive when they were started on treatment shortly after exposure. Because of reported successes, many health care facilities administer PEP to workers who are stuck with potentially infected needles. PEP is usually a four-week program of two or three antiretroviral medications several times a day. The medications have serious side effects that can make it difficult to finish the program. The sooner PEP is administered, within 72 hours of possible HIV exposure, the more effective it is.
It is imperative that the medical provider conduct risk assessment for PEP as soon as possible within the first 72 hours after the assault. This assessment should include the following:

- The HIV status of the survivor (if known),
- The HIV status of the perpetrator (if known),
- Specifics of the risk behavior (unprotected receptive anal or vaginal intercourse, receptive oral sex with ejaculation, and/or other exposure to blood or semen, including eyes).
- Factors that would increase the risk include vaginal or anal ulceration, bleeding, presence of lacerations, multiple sexual assailants and injection drug use needle exposure.
- If the individual is pregnant, treatment recommendations should occur with obstetric consultation.
- The individual’s willingness and ability to complete the regimen and participate in follow-up care.

A sexual assault survivor considering using PEP should first receive HIV counseling that will enable her or him to determine individual risk as accurately as possible. The survivor should also receive full information and support to make difficult treatment decisions. Other considerations are:

- The potential side effects of the recommended combination drug therapy.
- The individual’s ability to complete the required 30 days of treatment, the complexity of the treatment regimen, and the importance of adherence to the treatment regimen.
- The high cost of the combination therapy drugs (although assistance may be available as described below).
- Availability of medications and follow-up care.

Depending on the hospital, when survivors are started on PEP, the provider will recommend an HIV testing sequence. The survivor will likely be given a starter pack of PEP and requested to have testing done as soon as possible within three days of PEP initiation. This will cover important blood testing to include pre-existing/baseline HIV status. If the baseline test indicates the survivor was already HIV positive, he/she would be referred for appropriate HIV assessment/treatment services. If the baseline test is negative, the survivor will be on a schedule of PEP for 30 days and will be asked to return for testing in three months and six months to monitor their HIV status. This process should all be coordinated in the patient’s follow-up discharge planning (Form 6) of the Massachusetts Sexual Assault Evidence Collection Kit form.

It is the role of the counselor/advocate to support the survivor during the decision-making process. If PEP treatment is begun, it is necessary that survivors receive care from a physician who can monitor and support the survivor throughout the PEP regimen. If PEP is going to be used, it is generally recommended that the medications be started at the emergency department, and that arrangements are made within as soon as possible within 3
days following the sexual assault medical exam for baseline testing and medication monitoring outside of the emergency department. Note that baseline HIV testing within as soon as possible within 3 days for survivors who are starting HIV PEP medication is important because a survivor who was HIV positive prior to the assault but didn’t know it may need different HIV medications and services than PEP. Most hospital emergency departments can administer PEP and there are health care facilities that will offer PEP throughout MA. Medical professionals who are unsure if PEP should be administered should call the National Clinicians’ Post-Exposure Prophylaxis Hotline (PEPline) at 1-888-448-4911 for consultation. Hotline staff will help determine if PEP should be administered, and recommend a treatment regimen specific to the exposure and the exposure history (if available).

HIV Counseling and Prevention Issues for Survivors

While there is not much data about the incidence and prevalence of HIV transmission from a sexual assault or domestic violence incident, we certainly recognize that violence increases the risks for injury which may also increase the risk for transmission of sexually transmitted infections and HIV. This fear and real risk contributes to the grave emotional trauma experienced by survivors and has implications for counseling survivors.

In addition to needing to heal physically and emotionally, an abuse survivor is also confronted with societal judgments about having been abused and possibly contracting a sexually transmitted infection. This compounded impact on survivors can make healing from the abuse even more difficult. Access to services designed with these issues in mind, especially support and counseling, is also a need and concern for survivors.

Suggestions for Counselors when Addressing Issues Related to HIV/AIDS

- Be non-judgmental while giving facts and expressing concerns.
- Deal with your own issues, fears, and prejudices related to HIV/AIDS before working with survivors.
- Become comfortable using vocabulary in sessions to openly discuss issues that are related to HIV and sexual assault.
- Acknowledge how complicated issues related to HIV and sexual assault are for survivors, for example: the issue of a survivor reclaiming positive feelings about sex and the body, while having concerns about the need for safe sex techniques.
- If the survivor is in a long-term relationship, be prepared to address the possibility that the survivor may want to use safe sex practices that may be different from practices previously used, and this may change the relationship and prompt questions from the survivor’s partner.

The rape crisis counselor/advocate can play an integral role in empowering and supporting the survivor through providing education and information on HIV/AIDS and listening and responding compassionately to the survivor’s fears and concerns.
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1 Susan Brownmiller, Against Our Will: Men, Women and Rape (Harmondsworth, 1976).

