Journal of Women's Health Care

OPEN ACCESS Freely available online

Case Report

Management of the Medium-To-Long Term Post-Rape Medical Care of the Adult Female Survivor in South Africa

NB Bougard*

Department of Criminology and Security Science, University of South Africa, South Africa

ABSTRACT

Background: This research formed part of principal project which investigated the lived experiences of 28 service providers and 17 adult female rape survivors regarding the quality of post-rape services rendered within South African criminal justice system.

Methods: A total of nine medical post-rape service providers were recruited at three medico-legal facilities in the Gauteng province. With the aid of a semi-structured interview schedule the researcher collected information in relation to the management of medium-long term post rape medical care rendered to the adult female survivor in South Africa.

Results: Medical service providers shared their experiences regarding the clinical management and main challenges they continuously contend with in rendering post-rape medium-long term medical care to the adult female survivor in South Africa.

Conclusion: Post-rape medical services for the adult female survivor should be incorporated with the Global Health Strategy (2022-2023) and Ministry of Health Referral Policy for South African Health Services and Referral Implementation Guidelines (2020), accompanied by regional and local policies and directives. Moreover, an emphasis should be placed on capacity building, improvement in medical quality-of-service rendering, awareness about treatment availability and adherence, prioritising referral mechanisms being medico-legal, mental health and forensic psychiatric services.

Keywords: Post-rape, Mental health, Public health, Clinical management, Service delivery, Quality

INTRODUCTION

The widespread prevalence of rape in South Africa (SA) is alarming when considering its probable impact on the survivor's health. In sub-Saharan Africa Human Immunodeficiency Virus (HIV) is a considerable public health challenge, with a projected 20.6 million People living with HIV/AIDS (PLWHA) in the region [1, 2]. Besides the physical and reproductive health consequences of rape, survivors of sexual violence are at higher risk of developing mental health problems in contrast to individuals who had never been a victim of rape [3, 4]. Rape is interrelated with HIV acquisition among women in SA. Of importance, the risk of contracting HIV through rape is likely due to genital trauma. Furthermore, the high number of additional seroconversions among rape survivors exceeding the 3-month window period is a reason of concern, suggestive that other pathways of HIV transmission might be contributory to an increase in HIV infection over a period of time [5, 6].

Female rape survivors desire a need for quality medium- long term mental health care, inclusive of additional services in mitigating their risk of contracting HIV with access to Pre-Exposure Prophylaxis (PREP). This risk is further aggravated by personal and communal factors (i.e., low levels of education, exposure to trauma and excessive substance abuse). Long-term health necessitates attending to the acute-medium-long-term physical and psychological needs of the survivor. Long-term physical consequences might include but not limited to chronic pain, persistent headaches or migraines, gastrointestinal disorders, manifold gynaecological complaints, hepatitis B infection and cervical cancer [7, 8]. Psychological implications of rape are but not limited to depression, anxiety disorders, impaired libido, a lack of self-esteem and suicidal tendencies [9-11].

***Correspondence to:** NB Bougard, Department of Criminology and Security Science, University of South Africa, South Africa, E-mail: bradelybougan@gmail.com

Received: 07-Jul-2024, Manuscript No. JWH-24-32700; **Editor assigned:** 10-Jul-2024, PreQC No. JWH-24-32700 (PQ); **Reviewed:** 19-Ju1-2024, QC No. JWH-24-32700; **Revised:** 25-Jul-2024, Manuscript No. JWH-24-32700 (R); **Published:** 29-Jul-2024, DOI: 10.35248/2167-0420.24.13. 735

Citation: Bougard NB (2024). Management of the Medium-To-Long Term Post-Rape Medical Care of the Adult Female Survivor in South Africa. J Women's Health Care. 13(7):735.

OBJECTIVES

The objective of the study was to explore and describe the management of the medium-to-long term medical care of the adult female rape survivor in SA.

METHODS

A qualitative research approach steered the research process, as the subjective experiences of medical service providers rendering post-rape services to adult female rape survivors within the Criminal Justice System (CJS) was explored. The data was collected at three medico-legal research sites, known as Thuthuzela Care Centres (TCCs) in the Gauteng province. Nine medical professionals participated in the study, which formed part of strata of 28 post-rape service providers. In light of the principal project, stratified sampling was utilised to document service providers' perspectives (being medical, medico-legal, psychosocial, and legal) in rendering post-rape services to adult female rape survivors. The type of research was applied since the researcher proposed recommendations on improving the medium-long-term medical post-rape management in SA. Face-to-face interviews were analysed by using Braun and Clarke's thematic analysis. Ethical clearance to conduct the research was provided by the Faculty of Humanities' Ethics Committee, University of Pretoria (GW20180844HS). Furthermore, permission to conduct the research was approved by key governmental stakeholders being the National Prosecuting Authority (NPA), Department of Health (DoH) and South African Police Service (SAPS).

Participants

In total 9 interviews were conducted with 3 medical doctors and 6 forensic nurses. The majority of the participants were female with most being representative of research site (RS) 3. The number of years' experience were quite varied with participant 6 (forensic nurse) being the most qualified (37 years) and participant 4 having one year experience. The mean years of experience of the sample of 9 participants were 18. Most of the participants had work experience of between 10-20 years (participants 1-2 and 7-9), which is adequate in rendering post-rape medical services Table 1.

RESULTS AND DISCUSSION

The perspectives of 9 medical service providers were explored in relation to the management of the medium-long term post-rape medical care of adult female survivors. From their experiences, the researcher highlighted the clinical management and main challenges encountered rendering post-rape medium-long term medical care to the adult female survivor in SA. The Table 2 below provides an overview of the themes and sub-themes.

THEME 1: CLINICAL MANAGEMENT OF POST-RAPE CARE FOR ADULT FEMALES

Sub-theme 1.1: Secrecy regarding HIV-seropositive status

Service provider 17 (Forensic nurse) shared that the secrecy of some rape survivors regarding their HIV status is a challenge in rendering medium-long term medical post-rape care.

Some of our patients are already on antiretroviral medication. When we test them, they are negative due to the viral load being undetectable, virally suppressed, and then they don't tell us and take our medication. We take blood to the laboratory, and it comes back HIV-positive. But they say nothing to us. They are very secretive.

A myriad of factors comes into consideration when a person decides to disclose their HIV status [12, 13]. Specialists are of the opinion that disclosure is plausible in curbing stigma, which is a crucial step forward in improving the quality of post-rape medical services and prioritise the well-being of PLWHA. Persons' who opt to conceal their HIV-status do so potentially due to underlying substance abuse, marginalisation, stigma and feelings of guilt, shame or regret. Importantly, non-disclosure of an HIV-status to a healthcare practitioner poses the risk of HIV transmission to intimate partners and mother-to-child transmission [14-16].

Table 1: Overview of medical service providers.

MEDICAL SERVICE PROVIDERS				
Participant	**Gender**	**Professional status**	**Years of experience**	**Research site**
1	Female	Forensic nurse	12	RS 1
2	Female	Forensic nurse	19	RS 2
3	Female	Forensic nurse	6	RS 3
4	Female	Forensic nurse	1	RS 3
5	Female	Forensic nurse	33	RS 3
6	Female	Forensic nurse	37	RS 3
7	Male	Medical doctor	12	RS 1
8	Female	Medical doctor	20	RS 2
9	Male	Medical doctor	20	RS 3

Table 2: Overview of referral mechanisms within the DoH.

Theme 1: Clinical management of post-rape care for adult females
Sub-theme 1.1: Secrecy regarding HIV-seropositive status.
Sub-theme 1.2: Side-effects of medication.
Sub-theme 1.3: Referral for specialist post-rape care.
Sub-theme 1.4: Clinical and psychosocial monitoring of the patient.
Theme 2: Challenges in implementing protocols and processes in rendering medical post-rape care to adult female survivors
Sub-theme 2.1: Patient comprehensiond with regards to medication and adherence to follow-up appointments.

Sub-theme 1.2: Side-effects of medication

Service provider 19 (forensic nurse) voiced concern over the side-effects of Post-Exposure Prophylaxis (PEP). Some medication makes them nauseas, and some will just not finish, particularly PEP.

A small number of studies have identified the PEP adherence and completion rate among SA rape survivors, which found that while some patients may lack to fully comprehend the importance of follow-up visits, communicate side-effects with the clinician, and possibility of seroconversion. Other reasons for non-adherence to PEP are but not confined to partial understanding of taking PEP; the alleged rapist is known to the survivor; patient presented late for treatment; self-refusal; effects of the trauma after rape; inadequate psychosocial support and not adopting a systemic and interdisciplinary approach in rendering post-rape services to the adult female survivor [17].

Sub-theme 1.3: Referral for specialist post-rape care

Service providers 21 (Forensic nurse) and 25 (Medical doctor) are of the opinion that adult female survivors are in urgent need of post-rape specialist referral services.

Forensic nurse: Some come back, and we refer them to a psychologist or a psychiatrist.

Medical doctor: With medical care, we have follow-ups and assess the patient, if the need arises; we refer for the appropriate services such as referral to the psychologist, psychiatrist, or gynaecologist.

The National Development Plan (NDP) (2030) outlines directives for the Department of Health (DoH) in rendering quality healthcare services to all, irrespective whether if it might be private or public, and in line with standards. The Referral Policy for South African Health Services, as well as the supporting Referral Implementation Guidelines, has been expanded to address the gaps recognised as being beneficial in enabling timeous referral within the medical domain of post-rape service rendering. This policy envisions restoring the dignity of the impoverished and marginalised patients within the SA healthcare system [18]. Below follows a table outlining the modes of referral mechanisms applicable to adult female rape survivors and their alleged rapist(s) Table 3.

Sub-theme 1.4: Clinical and psychosocial monitoring of the patient

Service provider 22 (Forensic nurse) specified the timeframe of assisting the patient with medical care.

Firstly, the patient arrives here, she goes for counselling. We examine the patient and give her medication. Then we give seven days date, to come for counselling again. Then we give another date to come after six weeks. We check whether the medication was taken properly. We check constantly whether the medication was fine for the patient, if she does not experience any nausea or vomiting. Then we give three months appointment to check the patient again. We do the pregnancy test, and the psychological well-being of the patient, and to give another dose of hepatitis injection, it's for the prevention of STI. Then we give six months appointment again, to come to review everything. When a person is HIV-positive at arrival, we give the medication, antiretrovirals, and then we make monthly appointments to make sure that she is fine. We check the blood for viral load after three months and then after six months.

A holistic clinical plan of a patient presenting STI-associated symptoms should comprise of a comprehensive medical examination (i.e., medication history, vaccination, and allergies if any), and for women, gynaecological history (i.e., contraception and pregnancy) [19, 20]. The clinical examination of the survivor consists of the ano-genital area, oral cavity, and testing for HIV and syphilis. Women should be evaluated for symptoms and signs indicative of pelvic inflammatory disease (PID). Screening for STI's is crucial to curb infection, morbidity, and corresponding health challenges within the specific geographical area. As part of an all-inclusive post-rape health assessment, testing for hepatitis B virus (HBV), hepatitis C (HCV), syphilis, cervical cancer (human papillomavirus [HPV]), should be performed in accordance with national and international guidelines and directives, dependent on resource availability [21, 22].

There is seems to exist limited information in relation to the indicators on the mode and quality of post-rape psychosocial services in SA. The significantly high occurrence of mental health challenges among SA female survivors call forth for an improved response with a focus on post-rape specialised mental health services [23]. Female survivors are of the opinion that mental

Table 3: Overview of referral mechanisms within the DoH.

Medico-legal services	Mental health services	Forensic psychiatric services
A formal and legitimate request substantiated with the specified documentation is a prerequisite for all medio-legal investigations (i.e., rape, Gender-Based Violence (GBV), assault).	On provincial level, all health facilities are mandated to provide information on available mental health and support services.	Courts may need an assessment of the alleged perpetrator and survivor of rape. A referral is advisable in instances whereby numerous competencies are required to determine the ability of the alleged rapist or survivor to testify, consent to sex, which would guide investigative and procedural processes.
Informed consent is essential from the client/patient prior to any investigations (i.e., blood alcohol levels).	Free and readily available acute-medium- long term community, forensic and tertiary mental health services.	High-risk observation patients (inclusive of state patients) should be transferred to tertiary level forensic services.
Referral to the suitable unit (internal or external) for rape is necessitated for medico-legal requests not within the capacity of the health facility.	Referral mechanisms according to a clinical pathway for the various clinical condition(s) as reserved within the Mental Health Care Act.	Low-risk and 'minor offences' should preferably be referred to general psychiatrists and other mental healthcare practitioners.
A copy of the medico-legal report must be kept in the patient's clinical record.	Medication should be dispensed in accordance with the formulary of the specific healthcare facility.	Offenders may be referred to district or regional hospitals where a specific required medico-legal service is provided.

Adopted: (Referral Policy for South African Health Services and Referral Implementation Guidelines, 2020:20-21)

health disorders (predominantly resultant of the rape), places an immense burden on their daily functioning and quality of life. As such, specialist post-rape mental health services should be readily available [24, 25]. Most importantly, female survivors may be at risk of developing a mental illness within months after the rape [26-28].

THEME 2: CHALLENGES IN IMPLEMENTING PROTOCOLS AND PROCESSES IN RENDERING POST-RAPE MEDICAL TO ADULT FEMALE SURVIVORS

The researcher investigated the challenges of services providers in relation to the implementation of post-rape protocols. Two themes emerged being patient comprehension with regards to the importance of follow-up visits and adherence to taking treatment as prescribed.

Sub-theme 2.1: Patient comprehension with regards to medication and adherence to follow-up appointments

Service providers 21 (Forensic nurse) and 22 (Forensic nurse) articulated concerns with regards to adherence to follow-up appointments and medication adherence.

Forensic nurse: Sometimes, they don't ask, and they come back. Like with the medication for 28 days, they finished it in one week. Its strong medication and they are severely sick. Trauma is something else, because you are here, but you are not here. At that point, they don't actually take in the information that you give them. We also call them to follow-up, some come, and others don't.

Forensic nurse: I don't think we have challenges, especially us health providers. The main problem can be the patient, some of them; they don't take the medication as prescribed. Some of them, they don't come on the days that are given. Some of them, they just disappear.

Post-rape medical services to the adult female survivor is managed through directives and legislation being the National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases (2009); TCC protocol namely the Uniform Protocol For the Management of Victims, Survivors and Witnesses of Domestic Violence and Sexual Offences (2008); The Victim Support Services Bill (2020) within the Ministry of Health Referral Policy for South African Health Services and Referral Implementation Guidelines (2020) [29]. In sub-Saharan Africa, dual epidemics of HIV and rape are an inhibiting factor in relation to the implementation of PEP, which remains an imperative public health response to rape [30, 31].

The discovery of antibiotic-resistant gonorrhoea and subsequently limited therapeutic approaches, which are scarce, prompted a health public health concern, affecting STI management and intervention initiatives [32, 33]. During the period of December 2018 and May 2019, Ayieko and fellow researchers conducted a pilot study of PEP service rendering to high-risk HIV exposures in five rural communities in Kenya and Uganda. This study evaluated challenges in accessing PEP with the aid of focus groups with healthcare service providers and members of the community, with the intention of informing PEP implementation strategies. The research identified the following:

- A scant of awareness about PEP as a preventative first line of action and accessibility to these services.
- Inadequate of health systems resource and logistical challenges (i.e., PEP medication and HIV test kits to compliment PEP further on than occupational exposure).
- Inconsistencies in the availability of PEP services across medical facilities (i.e., being open 24/7).
- Uncertainty among post-rape service providers in administering; and
- Other concerns relate to confidentiality, side-effects of medication and training of services providers rendering PEP [34].

RECOMMENDATIONS

Within their proposed vision and mission in curbing STI infection rate universally, the World Health Organization (WHO) Global Health Strategy (2022-2023) propose action(s) to be endorsed in curbing the incidence and prevalence rate of STI's worldwide. Empowering STI case management is one key aspect of this strategy. Effectual person-centred STI case management is context-dependent and complemented by availability of resources. Circumstances in which there are limited resources, syndromic (being cognisant of symptoms of the patient) case management with the aid of a schematic representation of a detailed plan is preferred [35, 36].

Considering the mental health burden on female survivors of rape, inclusive of service providers, an urgency for long-term care and accessibility thereof is plausible with an emphasis on specialised mental health service providers [37, 38]. The quality of post-rape psychosocial service remains widely fragmented at the time of writing, considering already struggling Non-Governmental Organisations (NGOs) and Non-Profit Organisations (NPOs) rendering these vital services in practice. There exists a need from service providers for specialised in-house mental health support services [39-41]. Various cognitive behavioural therapy CBT-based interventions might enhance the mental health of rape survivors during the acute phase of seeking post-rape psychosocial care. Henceforth, the needs and wishes of the adult female rape survivor must be imperative when considering therapeutic interventions. Additionally, CBT-based interventions afford the survivor to regain her autonomy and avoid negativity emanating from the traumatic ordeal she had suffered [42-44].

It is advisable that areas affected with high-risk HIV exposures be endorsed with a patient-centred PEP programme that is sustainable, feasible and with prospects of advancing current PEP initiatives in the near future and beyond [45, 46]. To improve the quality of HIV care in the public sector, a proactive response is warranted by improving infrastructure and establish functional and effectual internal initiatives aimed at constant monitoring and evaluation of these services envisioned improving the quality of post-rape medical care [47].

CONCLUSION

The management of post-rape medium-long-term care should place prominence on the overall well-being of the adult female survivor being physical and psychosocial. It is further advisable that PEP programmes cater for the needs of patients, aligned with local, regional and international guidelines and directives.

LIMITATIONS OF THE STUDY

The research findings cannot be generalised since the study was conducted at three medico-legal researches and comprised of nine medical service providers.

ACKNOWLEDGEMENTS

This study formed part of a doctoral study funded by the University of South Africa, Academic Qualifications Improvement Programme. The research was conducted through the University of Pretoria. Opinions expressed and conclusions reached are those of the author and are not necessarily to be attributed to the University of South Africa and University of Pretoria.

CONSENT FOR PUBLICATION

Written informed consent was obtained from medical service providers as indicated in the informed consent form.

ETHICAL APPROVAL

Faculty of Humanities Ethics Committee, University of Pretoria, GW20180844HS.

COMPETING INTERESTS

None

REFERENCES

1. Global HIV/AIDS overview. 2020.
2. Tessema BT, Bune GT, Mamo ZB. Non-Disclosure of HIV-Positive Serostatus: Unmatched Case–Control Study in People Living with HIV in Public Health Facilities of Gedeo Zone, Southern Ethiopia. HIV/AIDS-Research and Palliative Care. 2023:313-24.
3. Menon S, Rossi R, Zdraveska N, Kariisa M, Acharya SD, Broeck DV, Callens S. Associations between highly active antiretroviral therapy and the presence of HPV, premalignant and malignant cervical lesions in sub-Saharan Africa, a systematic review: current evidence and directions for future research. BMJ Open. 2017;7(8):e015123.
4. Dworkin ER. Risk for mental disorders associated with sexual assault: A meta-analysis. Trauma Violence Abuse. 2020;21(5):1011-28.
5. Peeters L, Vandenberghe A, Hendriks B, Gilles C, Roelens K, Keygnaert I. Current care for victims of sexual violence and future sexual assault care centres in Belgium: the perspective of victims. BMC Int Health Hum Rights. 2019;19:1-2.
6. Abrahams N, Mhlongo S, Chirwa E, Lombard C, Dunkle K, Seedat S, et al. Rape survivors in South Africa: analysis of the baseline socio-demographic and health characteristics of a rape cohort. Glob Health Action. 2020;13(1):1834769.
7. Center for Disease Control and Prevention (2015). Sexual violence: Consequences, CDC Injury Prevention &Control, Division of Violence Control, Center for Disease Control & Prevention.
8. Malan Z, Debley OA. Improving the quality of care for female rape survivors at Scottish Livingstone Hospital, Molepolole, Botswana: A quality improvement cycle. Afr J Prm Health Care Fam Med. 2020;12(1):1-1.
9. Oshodi Y, Macharia M, Lachman A, Seedat S. Immediate and long-term mental health outcomes in adolescent female rape survivors. J Interpers Violence. 2020;35(1-2):252-67.
10. Holton G, Joyner K, Mash R. Sexual assault survivors' perspectives on clinical follow-up in the Eden District, South Africa: A qualitative study. Afr J Prm Health Care Fam Med. 2018;10(1):1-7.
11. O'Doherty L, Whelan M, Carter GJ, Brown K, Tarzia L, Hegarty K, Feder G, et al. Psychosocial interventions for survivors of rape and sexual assault experienced during adulthood. Cochrane database of systematic reviews. 2023;(10).
12. Ngonzi J, Mugyenyi G, Kivunike M, Mugisha J, Salongo W, Masembe S, Mayanja R, et al. Frequency of HIV status disclosure, associated factors and outcomes among HIV positive pregnant women at Mbarara Regional Referral Hospital, southwestern Uganda. Pan Afr Med J. 2019;32(1).
13. Tessema BT, Bune GT, Mamo ZB. Non-Disclosure of HIV-Positive Serostatus: Unmatched Case–Control Study in People Living with HIV in Public Health Facilities of Gedeo Zone, Southern Ethiopia. HIV/AIDS-Research and Palliative Care. 2023:313-24.
14. Living Positively with HIV: Healthy Mind and Healthy Body. (2013).
15. Mavhunga AD. Ramifications of Status Non-Disclosure by People Living With HIV/AIDS in Alice, Eastern Cape (Doctoral dissertation, University of Fort Hare).
16. Fatoki B. Understanding the causes and effects of stigma and discrimination in the lives of HIV people living with HIV/AIDS: qualitative study. J AIDS Clin Res. 2016;7(635):2.
17. Scannell M, MacDonald AE, Berger A, Boyer N. The priority of administering HIV postexposure prophylaxis in cases of sexual assault in an emergency department. J Emerg Nurs. 2018;44(2):117-22.
18. Inciarte A, Leal L, Masfarre L, Gonzalez E, Diaz-Brito V, Lucero C, et al. Post-exposure prophylaxis for HIV infection in sexual assault victims. HIV Med. 2020;21(1):43-52.
19. National Department of Health. Referral policy for South African Health services and referral implementation guidelines. 2020.
20. Eogan M, McHugh A, Holohan M. The role of the sexual assault centre. Best Pract Res Clin Obstet Gynaecol. 2013;27(1):47-58.
21. Skjælaaen K, Nesvold H, Brekke M, Sare M, Landaas ET, Mdala I, Olsen AO, et al. Sexually transmitted infections among patients attending a sexual assault centre: a cohort study from Oslo, Norway. BMJ Open. 2022;12(12):e064934..
22. Bekker LG, Brown B, Joseph-Davey D, Gill K, Moorhouse M, Delany-Moretlwe S, et al. Corrigendum: Southern African guidelines on the safe, easy and effective use of pre-exposure prophylaxis: 2020. South Afr J HIV Med. 2020;21(1).
23. Kane D, Holmes A, Eogan M. Post-exposure prophylaxis, STI testing and factors associated with follow-up attendance: a review of 4159 cases of acute post-sexual assault medical care. Sex Transm Infect. 2024;100(1):39-44.
24. Baert S, Fomenko E, Machiels A, Bicanic I, Van Belle S, Gemmel P, et al. Mental health of sexual assault victims and predictors of their use of support from in-house psychologists at Belgian sexual assault care centres. Eur J Psychotraumatol. 2023;14(2):2263312.
25. Manning D, Majeed-Ariss R, Mattison M, White C. The high prevalence of pre-existing mental health complaints in clients attending Saint Mary's Sexual Assault Referral Centre: Implications for initial management and engagement with the Independent Sexual Violence Advisor service at the centre. J Forensic Leg Med. 2019;61:102-7.
26. Vik BF, Nöttestad JA, Schei B, Rasmussen K, Hagemann CT. Psychosocial vulnerability among patients contacting a Norwegian sexual assault center. J Interpers Violence. 2019;34(10):2138-57.
27. Brooker C, Tocque K, Paul S. Assessment of the mental health status of a one year cohort attending a two Sexual Assault Referral Centres in England. Journal of Forensic and Legal Medicine. 2018;54:44-9.
28. Clarke V, Goddard A, Wellings K, Hirve R, Casanovas M, Bewley S, et al. Medium-term health and social outcomes in adolescents following sexual assault: a prospective mixed-methods cohort study. Soc Psychiatry Psychiatr Epidemiol. 2023;58(12):1777-93.
29. Bougard NB. Service delivery within the criminal justice system: The experiences of adult female survivors and service providers. Unpublished doctoral thesis, University of Pretoria, South Africa. 2023.

30. Kharsany AB, McKinnon LR, Lewis L, Cawood C, Khanyile D, Maseko DV, et al. Population prevalence of sexually transmitted infections in a high HIV burden district in KwaZulu-Natal, South Africa: Implications for HIV epidemic control. Int J Infect Dis. 2020;98:130-7.

31. Manjate A, Sergon G, Kenga D, Golparian D, Tyulenev Y, Loquilha O, et al. Prevalence of sexually transmitted infections (STIs), associations with sociodemographic and behavioural factors, and assessment of the syndromic management of vaginal discharge in women with urogenital complaints in Mozambique. Front Reprod Health. 2024;6:1323926.

32. Cohen MS, Council OD, Chen JS. Sexually transmitted infections and HIV in the era of antiretroviral treatment and prevention: the biologic basis for epidemiologic synergy. J Int AIDS Soc. 2019;22:e25355.

33. Peters RP, Garret N, Chandiwana N, Kularatne R, Brink AJ, Cohen K, et al. Erratum: Southern African HIV Clinicians Society 2022 guideline for the management of sexually transmitted infections: Moving towards best practice. South Afr J HIV Med. 2022;23(1).

34. Ayieko J, Petersen ML, Kabami J, Mwangwa F, Opel F, Nyabuti M, et al. Uptake and outcomes of a novel community-based HIV post-exposure prophylaxis (PEP) programme in rural Kenya and Uganda. J Int AIDS Soc. 2021;24(6):e25670.

35. World Health Organization. Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. World Health Organization; 2022.

36. World Health Organization. Guidelines for the management of symptomatic sexually transmitted infections. 2021.

37. Vandenberghe A, Hendriks B, Peeters L, Roelens K, Keygnaert I. Establishing Sexual Assault Care Centres in Belgium: health professionals' role in the patient-centred care for victims of sexual violence. BMC Health Serv Res. 2018;18:1-1.

38. Stefanidou T, Hughes E, Kester K, Edmondson A, Majeed-Ariss R, Smith C, et al. The identification and treatment of mental health and substance misuse problems in sexual assault services: A systematic review. PLoS One. 2020;15(4):e0231260.

39. Jordaan S, Slaven F, Louwrens C, Sodo P, van den Broek L, Klapwijk J, et al. Thuthuzela care centres compliance audit and gap analysis. Pretoria: Foundation for Professional Development. 2016.

40. Dworkin ER, Schumacher JA. Preventing posttraumatic stress related to sexual assault through early intervention: A systematic review. Trauma Violence Abuse. 2018;19(4):459-72.

41. Global Fund to Fight AIDS, Tuberculosis and Malaria. 2019.

42. Leichsenring F, Steinert C. Is cognitive behavioral therapy the gold standard for psychotherapy? The need for plurality in treatment and research. JAMA. 2017;318(14):1323-4..

43. Lakin DP, García-Moreno C, Roesch E. Psychological interventions for survivors of intimate partner violence in humanitarian settings: an overview of the evidence and implementation considerations. Int J Environ Res Public Health. 2022;19(5):2916.

44. Best Therapy for Sexual Assault Victims. 2023.

45. Gorli M, Barello S. Patient centredness, values, equity and sustainability: professional, organizational and institutional implications. Sustain. 2021;13(23):13217.

46. Baldini B. Towards sustainable access to healthcare: patient-centred, needs-driven, and evidence-based. European Public Health Alliance. 2022.

47. Mpale R Selman B. Assessing the Quality of HIV Care in Health Care Facilities in Kinshasa, Democratic Republic of Congo: Compliance with National Guidelines. J Women's Health Care. 2024. 13(5):725.