

improvement in one area of care must come at the expense of another. Patients value both good health outcomes and continuing relationships. The new contract has the promise of a substantial increase in funding for primary care, not merely redirecting payments from one area to another. It is up to general practitioners to respond to this proposal in a way that improves the technical aspects of quality while maintaining the values that have characterised general practice in Britain for generations.

Paul Shekelle *professor of medicine, University of California Los Angeles*

Greater Los Angeles Veterans Affairs Healthcare System, 11731 Wilshire Boulevard, Los Angeles, CA 90073 USA (shekelle@rand.org)

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Management of people who have been raped

Needs special expertise, and more of it

Rape is common but under-reported, with an estimated lifetime risk of up to one in four for women.¹ Definitions vary between countries; in England and Wales the term refers to non-consensual vaginal or anal penetration by a penis, of a woman or a man. Serious sequelae include psychological problems, infection, and unwanted pregnancy. People who have been raped may present, immediately or later, to general practitioners or other clinicians, not all of whom may be familiar with such situations. Here we outline the care of people who present after sexual assault; we use the relatively neutral term clients, as suggested elsewhere.²

Optimal management depends on the client's wishes and needs, time since assault, and whether involvement of the police is requested. Meticulous medical notes are essential even if involvement of the police is declined initially, as reports may be required later for legal processes or compensation. Immediate considerations include safety, management of injuries, forensic examination, and emergency contraception. In situations of domestic violence or perpetrator's physical proximity a client might need alternative accommodation. Although genital injuries have been found in 16-58% of clients examined and non-genital injuries in 31-82%,^{1,3,4} few are sufficiently serious to require hospital referral for suturing or further investigations.³

Forensic examination aims to collect evidence for use in criminal justice processes, including documentation of injuries and samples for DNA and toxicology. It involves a "top to toe" survey as well as genital examination and is ideally undertaken by a doctor or nurse with special training, such as a sexual offences examiner, whose sex is acceptable to the client.⁵ Retrieval of DNA is maximised by conducting the examination as soon as feasible after the assault, and advising the client not to wash, drink, or eat (depending on the orifices involved) until samples have been taken. Police officers can collect urine samples and mouth swabs, thereby minimising the client's discomfort while waiting as well as increasing the chance of detecting drugs excreted in the urine. If more than seven days have elapsed since the assault sampling for DNA is unlikely to be productive,⁶ but documentation of injuries may still be relevant.

In some areas the examination and other treatment can take place in dedicated sexual assault referral centres,^{4,7} otherwise police can organise an examiner. Sexual assault referral centres provide supportive and forensically secure environments; clients who have not directly involved the police can also access them to receive treatment as well as possibly providing anonymous intelligence and evidence. Availability of specialist services, and hence quality of care, varies widely.⁸

Pregnancy following rape occurs in about 5% of women of reproductive age, and adolescents are most vulnerable.² Risk of pregnancy and views on contraception must therefore be explored. Progesterone only emergency contraception (Levonelle) can be taken up to 72 hours after the event; we believe that it should not be withheld after rape even if the woman had unprotected intercourse earlier in that cycle. An intra-uterine device containing copper can be inserted up to five days after the earliest expected date of ovulation, or up to five days after assault in the absence of previous unprotected intercourse in that cycle.

The risk of sexually transmitted infections following rape is 4-56%⁷; infections found reflect those that are prevalent locally. Referral for assessment of sexually transmitted infections two weeks after the assault allows for incubation periods of gonorrhoea and chlamydial infection. A single genital screen misses up to 12% of infections,⁹ but repeated—or even initial—examinations may compound the invasion of the assault. Clients at high risk of sexually transmitted infections but unwilling to be examined further should therefore be offered prophylactic antibiotics² to prevent serious long term sequelae, such as pelvic inflammatory disease.

Acquisition of HIV infection following rape is rare in low prevalence areas such as the United Kingdom; risks are increased if assailants come from high prevalence areas, if there is trauma (including defloration), or if the rape victim is male. Postexposure prophylaxis with antiretrovirals given within hours of occupational exposure significantly reduces HIV acquisition,¹⁰ and is increasingly used after sexual exposure despite the lack of specific evidence.¹¹ The decision to start postexposure prophylaxis should be based on assessment of the individual risk and views of the client—local HIV services can advise further.

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Psychological sequelae of rape are many including anxiety, depression, suicidal ideation, and problems related to relationships and sex.¹² The immediate risk of suicide must be assessed and referral arranged as appropriate. Advice on support and counselling services should be provided and a follow up appointment offered.

Sensitive and coordinated care for people who have been raped is crucial in promoting recovery and preventing later problems. It may also enable clients to participate in criminal justice procedures and thereby help reverse falling conviction rates.⁸ Optimal management recognises a client's multiple needs as well as the allegation of a crime, and is best provided by specialist services resulting from constructive collaboration between health services and police. Wider access to such services is badly needed.

Janthe Wilken *general practitioner and sexual offences examiner*

Jan Welch *consultant*

The Haven, Department of Sexual Health, King's College Hospital, London SE5 9RS (jan.welch@kingsch.nhs.uk)

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Arms sales, health, and security

A call for US leadership

Since the end of the cold war, it has become clear that the main threat to global peace and security is instability in the international system. As the world's only superpower, the United States must take the lead in preserving stability. But the United States exerts its leadership not only with its hard power—its economic and military might—but also with its soft power—the values it preaches and practices.

The sources of instability in the contemporary international system range from terrorists and tyrants who seek to obtain weapons of mass destruction to failing states that can become a haven for these terrorists and tyrants. For example, when the world abandoned Afghanistan after the Soviet Union withdrew, chaos ensued as the warlords struggled for control. The Taliban eventually stepped in, imposed a fundamentalist totalitarian regime, and provided a haven for Osama bin Laden and his al-Qaeda group. Afghanistan became a training ground for the terrorists who attacked not only the World Trade Center and the Pentagon on 11 September 2001 but also the American embassies in east Africa in 1998 and the USS Cole in 2000. To remedy this situation, the United States had to lead a coalition to remove the Taliban and install an interim government. But the cost was high. Not only were thousands of lives lost on "9/11" but the United States alone has spent over \$30bn (£19bn; €28bn) to date on its military operations.

Even if a failed state does not become a haven for terrorists it can create problems for the world community in a number of other ways—for example, in the health area. If a government cannot control disease

among its population in this era of globalisation, the diseases are likely to spread. In addition, a population ravaged by disease retards economic development substantially, making it very difficult for the government to preserve domestic tranquillity.

This is why the article by Southall and O'Hare was so timely.¹ They argue that health problems in poor countries in Asia and Africa are exacerbated by arms sales. They note correctly that even if the arms trade were curbed, the health problems in these countries would persist because many of these nations are also burdened with massive debt and corrupt bureaucracies and have suffered natural disasters. But there is no doubt that exporting arms, particularly small arms, into these poor countries has fuelled the conflicts and that these countries have massive health problems.

The question of why developed countries do not curb this arms trafficking naturally arises. After all, it is in their interest to prevent these conflicts and to stop them from getting out of hand. The answer is that the developed nations place their short term interests before the long term interest of the international community. In particular, why does the United States not take the lead in curbing this arms trade? After all, it was the United States that had to spend its blood and treasure in Afghanistan and Somalia.

The first reason is greed. Exporting arms is big business. The United States exports more military hardware than the rest of the world combined—about \$20bn a year. It not only generates profits for the defence industry but also helps the US balance of trade and reduces the cost of weapons to the Pentagon. Recently the United States sold Poland \$3.6bn worth