EMERGENCY CONTRACEPTION IS A SIMPLE PART OF POST-RAPE CARE: WHY IS IT NOT ROUTINELY PROVIDED?

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Emergency contraception (EC) can reduce the risk of pregnancy after unprotected sex, including in cases of sexual violence. Global guidance is clear that EC should be offered to women and girls within 120 hours of sexual violence to prevent the traumatic consequences of pregnancy resulting from rape.

Yet women and girls who have experienced unprotected sex, including through sexual violence, do not routinely have access to EC. The global aid communities must work together to increase access to EC for sexual violence survivors around the world, including for women and girls who are the most marginalized, like those living in crisis-affected settings. A range of strategies can be implemented to improve access to EC. Further research is also needed to identify, evaluate, and invest in new and innovative solutions.

ABOUT EC

EC pills are very safe, simple to use, and suitable for all women and girls who wish to prevent pregnancy, including adolescents. They can be used after any instance of unprotected sex, including sexual violence. They work mainly by preventing or delaying ovulation, and cannot terminate an established pregnancy. They should be taken as quickly as possible because they are more effective the sooner they are taken after unprotected sex, but can be taken up to 120 hours later. They have no complicated or long-term side effects.

THE NEED FOR EC AMONG SEXUAL VIOLENCE SURVIVORS

Provision of EC for rape survivors is a human rights imperative. Pregnancy resulting from sexual violence can be very traumatic. The World Health Organization’s (WHO) clinical and policy guidelines for sexual violence and companion clinical handbook include recommendations to provide EC pills as part of comprehensive, woman-centered care. The United Nations recognizes EC pills as an essential, life-saving commodity, through its Commission on Life-saving Commodities for Women and Children. Failure to ensure that sexual violence survivors receive EC may harm their physical and psychological health (especially in areas where safe abortion is illegal or unavailable); such failure is a violation of their human rights.

For the millions of women and girls who have been displaced by conflict and natural disasters, access to EC is particularly essential. Forced displacement, exposure to violence, and separation from families and communities expose displaced people to increased risk of sexual violence. At the same time, women in these settings often lack access to regular family planning methods, which protect against the accompanying risk of unwanted pregnancies. EC access is a critical need for these women and girls.
BARRIERS TO EC ACCESS FOR SEXUAL VIOLENCE SURVIVORS

Although EC is a critical, life-saving treatment that is very simple to provide, many barriers to EC access persist; in most settings, EC is neither routinely counselled on nor provided. These barriers are often exacerbated for survivors of sexual violence, and in crisis-affected settings in particular.

Policy, legal, and regulatory barriers. EC access can be facilitated or hindered by a country’s legal and regulatory framework for EC. At least three-fourths of countries have a registered EC product (meaning the pills can be legally sold, purchased, or otherwise made available), representing vast progress over the past few decades. However, some countries remain without a dedicated EC product. Even in countries with a registered product, EC is far from being mainstreamed in many ways:

- EC pills are included in only about half of countries’ national Essential Medicines Lists (see database and fact sheet).
- Many countries require women to obtain a prescription before accessing EC.
- Some countries do not have standardized protocols on care for sexual violence survivors; in other countries, such policies may introduce additional barriers, like requiring survivors to first report to the police before receiving care, or requiring that survivors must first take a pregnancy test before providing EC.

All of these factors limit the likelihood that a woman will obtain EC pills within the short 120-hour timeframe for effectiveness. As such, in national health systems, EC access remains low overall.

Facility protocols and provider biases. Barriers to EC access can also arise at the facility and provider levels. Surveys of health care providers in several countries indicate that significant gaps still exist in knowledge about EC and that biases persist around the provision of EC. When women report sexual violence, they are not systematically provided EC pills on-site, even in countries where EC pills are available in the national health system.

Women’s low of knowledge of EC and delayed care-seeking. In most countries that capture EC knowledge in their most recent Demographic and Health Survey (DHS), too few women have any knowledge or awareness that EC pills exist. In 35 countries, less than a quarter of women have heard of them. When women are not aware of EC, they are extremely unlikely to seek it out. Similarly, when women are unaware of the benefits of seeking care following sexual violence, they are not likely to pursue it. Unfortunately, underreporting (or delayed reporting) is frequent for a wide variety of reasons, and these survivors are then also precluded from timely referrals and treatment.

These barriers are often exacerbated in crisis settings. A 2014 study of reproductive health care in humanitarian contexts found that “systematic, comprehensive clinical management for rape survivors remained limited.” A number of factors make EC access in crisis-affected settings particularly challenging. Many of the countries with no registered EC product are currently or have recently been affected by conflict, such as East Timor, Libya, North Korea, Somalia, and Sudan. Several other countries with no registered product are in the Middle East, which hosts large numbers of displaced people; notably, Jordan, with 2.8 million displaced people, does not have a registered EC pill product. In these settings, off-label use of conventional oral contraceptives for EC (i.e. the Yuzpe regimen) represents an important option, but is less effective and has more side effects than dedicated EC pills.

Fragile settings may also be more likely to lack skilled staff and sufficient supplies. A three-country study in DRC, South Sudan, and Burkina Faso found that “only three out of 63 total facilities met the criteria to adequately provide selected elements of clinical management of rape.” In Jordan, only one of 13 assessed sites "had skilled staff and sufficient supplies to provide clinical care for rape survivors.” Moreover, some humanitarian aid organizations opt out of providing EC for religious reasons, often because they mistakenly conflate EC’s mechanism of action with that of abortion, thereby denying women their right to this essential health treatment.

ADDRESSING THE GAP IN EC PROVISION
A wide range of efforts are needed to increase access to EC, including favorable policy change, donor commitment, secure commodity flow in tandem with responsive programming, provider training, and awareness-raising campaigns among women (see examples here and here). There is also a need to more rigorously evaluate existing approaches to ensuring comprehensive care for sexual violence survivors; literature reviews from 2013 and 2015 found limited research on gender-based violence programming, particularly program evaluations.

Finally, it is urgent that we identify and invest in new and promising approaches to increasing care for sexual violence survivors, with EC included. For EC specifically, distribution by non-health workers like police can yield positive results, whereby women reporting to the authorities can safely and immediately receive EC pills on-site from police officers, along with referrals to health facilities. Novel strategies such as provision of community-based care for sexual violence also merit further research, particularly in settings with limited access to facility-based care.

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