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EC FOR RAPE SURVIVORS

A Human Rights and Public Health Imperative

According to new estimates from the World Health Organization (WHO), one-third of women worldwide will experience violence in their lifetimes; an estimated 7.2% of women will be sexually assaulted by a stranger and many more (23-36%, depending on region) will experience unwanted sex from an intimate partner.¹ To add to the physical and psychological trauma of rape, victims of sexual violence also risk unwanted pregnancy and exposure to sexually transmitted infections (STIs), including HIV/AIDS.

Sexually assaulted women (and men) require a range of emotional, psychological, and medical care. Medical services for post-rape care should include prophylaxis against STIs, including HIV, and emergency contraception (EC) to reduce the risk of pregnancy. While HIV prophylaxis is often provided, EC is not so frequently offered, despite the fact that the risk of pregnancy is higher than the risk of HIV.^{2,3} Emergency contraception must be readily available in emergency care facilities as both a human rights and public health imperative.

About emergency contraception

Emergency contraceptive pills (ECPs), sometimes called the “morning after pill,” can be used to prevent pregnancy for up to 120 hours (five days) after unprotected sex, as often occurs during forced or coerced sex. ECPs should be taken as soon as possible after unprotected intercourse because they are ineffective once a woman is close to ovulation; therefore, prompt access is critical. Levonorgestrel ECPs, the most commonly-available form, primarily work by preventing ovulation;^{4,5} they cannot terminate or interfere with an established pregnancy. ECPs reduce the risk of pregnancy by up to half and possibly by as much as 80-90% for one act of unprotected sex. If a dedicated EC product is not available, higher dosages of combined oral contraceptives, a regimen known as the “Yuzpe method,” can be used as emergency contraception instead. (For more information on the Yuzpe regimen, please visit www.not-2-late.com.)

Although some governments and providers impose age restrictions on ECP access, ECPs are safe and effective for females of all ages. Therefore, all female survivors of rape, no matter their age, can and should be offered emergency contraception, if they have reached puberty or are otherwise believed to be at risk of pregnancy.

Some countries require a pregnancy test before ECPs can be administered as part of post-rape care. However, guidance from the WHO and others does not support pregnancy testing; ECPs will not work if a woman is already pregnant and will not harm an existing pregnancy.^{6,7}

In addition to ECPs, the Copper Intrauterine Device (IUD) can also be used as emergency contraception, including in post-rape care. The Copper IUD is the most effective method of emergency contraception, at close to 100% effectiveness, and it is safe for women of any age or parity, including those who have never had children. Although many providers and health care settings do not offer the IUD for post-rape care, IUDs can be offered as an EC option to survivors of sexual assault with simultaneous STI testing and prophylactic treatment, as long as informed consent protocols are carefully followed and collection of forensic evidence is not compromised.⁸ In settings in which providers are trained on IUD insertion, they can offer an IUD as one emergency contraceptive option, in addition to the option of EC pills, and allow women to choose their preferred method.

Global guidance and norms for EC after rape

The International Federation of Obstetrics and Gynecology supports rape survivors' right to EC access.⁹ The WHO released new global guidance on sexual violence in 2013, including clear recommendations for the provision of EC as part of prompt and comprehensive women-centered care.⁸

The United Nations Committee against Torture, the treaty monitoring body for the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), has also written that failure to legalize the distribution of oral EC to female rape survivors constitutes a violation of CAT.¹⁰ Additionally, in 2013, the 57th Session of the United Nations Commission on the Status of Women, a global policy-making body, concluded that all Member States must require first responders to include EC provision in post-rape care.¹¹

Access to EC as part of post-rape care is often low

Dedicated ECP products are available in most countries, but not all public sector health systems (where many women seek post-rape care) carry ECPs.¹² Moreover, a few national governments (including those in Costa Rica, Honduras, and the Philippines) still do not allow women to access a dedicated ECP product at all, including outside the public health system.

Even where ECPs are available in countries' health systems, they are often not provided on-site to women who seek post-rape care. For instance, in South Africa, one study found that only 14% of girls between 12 and 17 received EC as part of post-rape care.¹³ Similarly, a survey of multi-sectoral response services ("one-stop centers") for sexual assault survivors in Kenya and Zambia found that three out of five did not offer ECPs to survivors.¹⁴ In the US, surveys indicate that half of hospitals do not administer EC to sexual assault survivors on-site, and less than one-fifth provide comprehensive services to sexual assault patients.¹⁵ Another sampling of US emergency departments found no improvement in EC provision between 2004 and 2009.¹⁶

In areas where access to safe abortion is restricted, failure by emergency facilities to offer EC exposes a rape survivor to additional harm if she becomes pregnant and turns to unsafe abortion to end her pregnancy.

Increasing access to EC in post-rape care: policies, front-line health care, and enforcement

Ensuring EC for post-rape care in national and local laws and policies

Country-level policies and guidance on providing EC in post-rape care vary significantly. Some national governments, such as those in Kenya,¹⁷ Ecuador,¹⁸ South Africa,¹⁹ Brazil,²⁰ and the United States,²¹ have published management guidelines for sexual assault survivors which recommend EC use. However, many governments do not have national guidelines for post-rape care, or have guidelines that do not specifically include EC. Ensuring that EC is explicitly included in national guidelines on post-rape care can help to standardize EC as an essential component of treatment.

Front-line provision of EC as part of post-rape care

Health care practitioners are often the first point of contact for rape survivors and, as a result, play a significant role in preventing unwanted pregnancy and protecting women's human rights. They should be trained in EC provision and their facilities should stock EC so that providers can offer EC on-site as quickly as possible, rather than refer rape survivors to pharmacies. They should also be able to offer counseling about EC's effectiveness and mechanism of action.

In many settings, however, police officers, emergency medical technicians, social workers, and other non-health professionals may be the first point of contact after a sexual assault and can thus play a critical role in providing medical care, including ECPs, to survivors. In settings where these professionals are not permitted by pharmaceutical regulations to provide ECPs, referral systems can be put in place.²² In some cases, policy changes to allow non-health providers to offer EC can increase women's access following

sexual assault. A study by Population Council in Zambia's Copperbelt Province, for instance, found that training and equipping police to provide EC after rape (under community-based family planning distribution guidelines) increased access to EC, leading community members to say: "Now we quickly report to the police because we know we will find assistance like EC."²³ Reporting of rape increased by 48% in participating police stations from 2006-2007.

Enforcing laws and policies that protect sexual violence survivors

Even where standing policies require health care practitioners and other front-line responders to dispense EC to rape survivors, efforts must be made to ensure that these policies are enforced. Regular monitoring can help ensure that EC provision is not omitted.

Enforcement of these laws and policies must also address instances in which individuals, institutions, and/or governments have cited "conscientious objection" as the reason for not providing rape survivors with timely access to EC. Governments are responsible for ensuring that all medical facilities provide comprehensive post-rape care and that conscientious objection laws, policies, and/or practices do not obstruct rape survivors' access to EC. Laws that allow public and private health care workers to conscientiously object to providing EC, even in cases of rape, without mandating alternative means to access EC, violate sexual violence survivors' human rights and freedoms. While the Roman Catholic Church has often expressed opposition to EC, some Roman Catholic Church leaders have distinguished rape from other cases of unprotected sex.²⁴ In the US, for example, Directive 36 of the *Ethical and Religious Directives for Catholic Health Care Services* supports the provision of EC in cases of sexual assault where it can be proven that pregnancy has not already occurred (i.e., through a pregnancy test).²⁵

Recommendations

Emergency contraception can prevent pregnancy after rape and is safe in all circumstances and for females of all ages. Therefore:

- Governments must implement and enforce policies that guarantee compassionate and comprehensive post-rape care, including prompt on-site provision of EC by both health and non-health professionals.
- Health care institutions, health care policies, training, and supply systems should support provision of EC.
- Where appropriate, non-health professionals should be authorized to provide ECPs or referrals.
- Conscientious objection must not impede EC provision.

Failure to ensure that rape survivors receive EC may harm women's physical and psychological health, especially in areas where safe abortion is illegal or unavailable, and violates women's human rights.

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