ORIGINAL ARTICLE

Barriers to accessing emergency contraception by victims of sexual assault in Addis Ababa, Ethiopia

Munir Kassa[1], Yirgu G/Hiwot[2], Ahmed Abdella[3]

Abstract

Background: *Medical support including rape management to victims of sexual assault are not well organized and readily available to those who require this service in Addis Ababa.*

Objective: *This survey aimed at examining the potential barriers to accessing emergency contraception (EC) among sexual assault survivors in Addis Ababa, Ethiopia.*

Methods: *This is a quantitative and qualitative study conducted in July of 2006 in Addis Ababa, Ethiopia. The quantitative component was a survey of all hospitals in the city using a standardized questionnaire to evaluate the provision of EC for sexual assault victims. Since sexual assault victims often report to the police, the study included an in-depth interview with police women who were dealing with such cases.*

Results: *Five public hospitals and one model clinic of the Family Guidance Association of Ethiopia (FGAE) give treatment to victims of sexual assault in Addis Ababa. No private hospital provides treatment for such cases as the police do not refer such cases. Though there are five public hospitals, one of them has got a model rape clinic. In the survey, most victims of sexual assault were seen in the FGAE model clinic. This is because the police perceive that the service given by government hospitals is of poor quality. All public hospitals provide EC, a dedicated product called 'Postinor 2' free of charge. The interviewed police women had very little knowledge about EC, though they have worked for a long time with sexual assault victims. According to police women who worked for more than six years, most victims did not come within 3-5 days after the assault. And when victims do come, they often first visit police stations not hospitals. It was also found out that it is the police who determine as to where these victims should get treatment.*

Conclusion: *Public hospitals should improve the quality of service they provide to victims of sexual assault. It is crucial to provide health education on EC to community members and the police working with victims of sexual assault in order to ensure that patients seek care early to prevent unwanted pregnancy and receive timely and appropriate medical certificates to legal bodies. Furthermore, ways should be sought to increase the involvement of private hospitals in the management of victims of sexual assault in Addis Ababa.*

Keywords: *Emergency contraception; legal bodies; sexual assault; gender*

[1]Hawassa University, [2,3] Department of Obstetrics & Gynecology, Faculty of Medicine, Addis Ababa University

Introduction

Emergency contraception (EC) refers to contraceptive methods that are used to prevent pregnancy following unprotected sexual intercourse. At present there are many contraceptive modalities utilized for EC. These include pills containing either estrogen with progesterone or progesterone only; and intra uterine contraceptive devices (IUD). The effectiveness of these methods in preventing pregnancy ranges from 55 to 94%, with an average of 74% (1, 2). While not as effective as the ongoing use of any regular method of contraception, EC use substantially reduces the risk of pregnancy after unprotected sexual intercourse, method failure, misused pills or sexual assault. No woman needs EC as desperately as a woman who has survived sexual assault. A woman who has been raped should be able to protect herself from a conception following the assault. EC is not only safe and effective in preventing unwanted pregnancy, but also empowers sexually assaulted women (SAW) with a sense of control and helps them cope with the trauma of sexual assault.

In the USA, about 12% of all women experience sexual assault in their life time and 4.7% of these assaults are complicated by pregnancy (3). There are more than 32,000 pregnancies that occur as a result of sexual assault each year in the USA. If EC had been used, around 28,000 of these pregnancies could be prevented (4). Immediate insertion of an IUD after a sexual assault is not generally recommended since there is the possibility of introducing infection into the uterus.

Many hospitals simply refer sexual assault patients to another hospital, or provide the victim a prescription to obtain EC in a pharmacy. Women who survive rape, are already in crisis and should not have to face the additional burden of tracking down EC after undergoing a clinical exam in an emergency room. In the USA, only 32% of all general hospitals provide EC for victims of sexual abuse (5) and only 21% of all sexual assault victims received EC (6).

There are few studies done on EC or sexual assault in Ethiopia. The limited information available indicates that sexual assault survivors seek medical care very late. A study conducted at two teaching hospitals in Addis Ababa, revealed that 6.5% of all alleged sexually abused women were pregnant at the time of medical care (7). There was also a significant delay in reporting to the police and for medical care, with a mean delay of 15.6 and 18.6 days, respectively.

This survey explored the extent of service provision and potential barriers to accessing EC among victims of sexual assault in health facilities of Addis Ababa. It assessed the number and percentage of public and privately owned hospitals that give EC for sexual assault victims 24 hours a day and seven days a week, on site and free of charge.

It also describes the process sexual assault victims pass through police stations and assesses the knowledge of police men and women about the use of EC by sexual assault victims. The findings generated are expected to be instrumental in formulating policies, regulation and programs related to EC provision for survivors of sexual assault. The results strengthen advocacy work and implementation of evidence based programs regarding EC in general and specifically for SAW.

The objectives of the study were to determine the proportion of hospitals that provide treatment for SAW; determine the proportion of hospitals in Addis Ababa that provide EC after sexual assault; determine the proportion of health facilities in Addis Ababa providing referral, information about EC for victims of sexual assault. The study also identifies potential service delivery barriers in Addis Ababa in accessing EC after sexual assault and assess the knowledge of police men and women in Addis Ababa about EC use after sexual assault.

Subjects and Methods

Both quantitative and qualitative methods were used in a cross sectional survey of all health facilities in Addis Ababa to assess EC provision after sexual assault. An in-depth interview was also conducted with key informants at police stations. The study was conducted in Addis Ababa, the capital city of Ethiopia. Addis Ababa is one of the eleven regional administrations in Ethiopia with an estimated four million residents. There are about 520 high, medium and low level private clinics, 24 hospitals (17 private and 7 public), 23 health centers and 9 government owned clinics. For the in-depth interviews, four police stations were selected randomly using lottery method out of the ten police stations in the city. These were Lideta, Gulele, Kirkos and Kolfe Keranyo sub city police stations.

Data was collected from July 16 to 30, 2006. A pre-tested questionnaire having three parts was used for the health facility surveys. The first and second part studied the identifiers of the facility and the provider, respectively. The last part assesses the service provision of EC for sexual assault victims. The physicians who were identified by the medical directors as the ones managing SAW were interviewed. If no service to SAW was provided by the facility, no further inquiry was made. Before conducting in-depth interviews at the police stations, permission was secured from the chief of the stations after the research objectives were explained, and the ethical approval letter from the Department of Obstetrics and Gynecology, Addis Ababa University was presented. With the assistance of each police station head, the key informant was identified based on the experience of the informant with sexual assault victims presenting to the police station.

All the key informants who were working in the crime investigation unit of each of the four police stations were police women. After informed verbal consent from each key informant, interviews were held privately in their offices. Interviews were recorded by a tape recorder and later noted down. Open ended questions followed by directed questions were asked as a follow up to the responses.

For the quantitative study, all medical directors of health facilities were briefed about the research and approval ascertained. Data entry, cleaning and analysis were done manually. Frequency, percentage and means were used to present the findings. For the qualitative study, the data collected was transcribed according to predetermined themes as well as newly emerging themes on the same day of data collection.

Results

A. Quantitative study

Among the 576 health facilities in Addis Ababa, 6 (1.04%) were found to provide services to SAW. While all the 24 (7 governmental and 17 private) hospitals had various medical emergency services, only five (20.8%) of the public hospitals were managing SAW (Table 1). The single and non-hospital facility providing treatment to SAW was the FGAE sexual violence model clinic.

The five hospitals providing treatment to sexually assaulted women had 24 hours a day and seven days a week service provision; while the FGAE model clinic service was limited to 8 a.m. to 5 p.m. from Monday to Friday and 8:00 a.m. to mid-day on Saturdays. The load of cases were estimated by the key informants to vary between one to five SAW per week at each hospital while at the FGAE clinic, it was stated to be thirty SAW per week.

The five hospitals and the FGAE clinic were providing screening and treatment for STIs; and always provide counseling and provide EC to SAW. The public hospitals always provided a dedicated EC (i.e. '*Postinor 2*' containing two 0.75 mg *levonorgestrel*), on site and free of charge. On the other hand, FGAE clinic provided prescriptions that enabled the SAW to buy the EC at the pharmacy of the clinic for five Birr (0.5 USD). If the SAW could not afford the prescription, the EC was provided free of charge. In all the public hospitals, general practitioners, obstetrics and gynecologic residents and senior physicians provided care to SAW.

Table 1: Health facilities providing services to sexually assaulted women in Addis Ababa, Ethiopia, 2006

Type of health facility	Health facilities in Addis Ababa*	Facilities providing Services to SAW N (%)
Government hospitals	7	5 (%)
Private hospitals	17	0 (0.0 %)
Private, NGO clinics (lower, medium, higher)	520	1 (0.2%)
Government Health centers	23	0 (0.0 %)
Government clinics	9	0 (0.0 %)
Total	576	6 (1.04%)

**Source: Addis Ababa Bureau of health*

At FGAE clinic, the service was provided by a general practitioner who was specifically assigned for this purpose. On the other hand, the service provided at the Gandhi Memorial Hospital (GMH) model rape clinic is by a nurse but the treatment is also given by physicians and residents working at the hospital. Almost all SAW presented to the health facilities with a police letter for certification of amount of injury sustained. Any SAW presenting to these facilities without a police letter could get the service but would not be able to get the certificate until she produced such a letter.

The two government-hospitals, Ras Desta and Menelik II that were not managing SAW had no obstetric and gynecology service at all. The seventeen private hospitals were well equipped to manage SAW and were providing various medical emergency treatments but were not caring for SAW. In case a victim of sexual assault visited any one of these hospitals, she would be given referral to another government hospital.

B. In-depth interview

All key informants were police women who had long experience in handling SAW at the police stations. They had worked in sexual assault related crimes for six to nine years at different police stations in Addis Ababa. They are engaged in handling adult SAW only; as there were different units for sexually assaulted children. The first issue raised during the in-depth interviews was what happens when a case of sexual assault was reported to the police station. In all the four stations, SAW presenting at working hours would be interviewed by a police woman who was specifically assigned for such crimes. But, those SAW presenting at night or during weekends were interviewed by any of the duty police officers who could be a male or a female.

Victims come at any time of the day and some come soon after the assault, but if they come late they tend to come on working days. All the four police women mentioned that most SAW come very late after the incident seeking help. They observed that victims usually seek help when they are advised by friends or relatives to do so or when they get pregnant. Otherwise, it is rare that victims report within five days after the assault. The number of SAW seen by the four police stations varies from one to three cases per week. The difference was explained to be largely due to the location of the police station, the key informants reasoned out.

SAW seek help first by going to police stations rather than to health facilities. One police woman commented "*I don't remember in my nine years of service, a sexually assault victim who came to a police station after receiving treatment at hospital.*" According to the informants, the reason for reporting first at the police stations was that hospitals would not treat SAW unless they produce a police letter requesting for treatment and certification of evidence of assault. All the police informants suggested that SAW first be seen by the medical personnel at the hospitals as the victims could get timely treatment and collection of evidences. When a woman with sexual assault reports to a police station, she will be asked to describe the incident to the duty officer. She is asked when, where and how the assault occurred; the assailant's identity and about any witnesses that were present during the assault. One of the police woman mentioned that if the sexual assault has occurred just before the victim reports, the police woman visits the site of the assault for more evidences. The police women also inspect the victim's clothing and body for any sign indicating physical abuse like the presence of blood and wounds.

After all the required information is documented, the SAW will be given a referral paper to one of the health service facilities in the city. The average duration that this procedure takes was estimated by the police women to range from 20 to 60 minutes. But it could be longer if the police investigator has to visit the site where sexual assault has taken place to collect more evidence.

When key informants were asked as to which health service facility they refer cases, their answers were all similar. If the woman comes during the working days, she will be sent to the FGAE clinic, but, if she comes at night or during the weekends, she will be referred to one of the five government hospitals as the FGAE model clinic does not provide service at these times.

No police woman interviewed has ever referred cases to private hospitals, even when patients could afford the payment at these facilities. All police women prefer the FGAE clinic better than other hospitals. The reasons for preferring to the FGAE clinic were that it provides cards to SAW free of charge; SAW are seen right away and all investigations with their results are ready in one day; the physician's report of the case is ready in about three days; and the medical report is detailed and of good quality.

Hence, the police can present the medical reports with all the other evidences to the court within a short period of time.

In government hospitals, the informants explained that the SAW has to pay up to 10 Birr for the card; investigations take many days and, hence, the SAW and the attending police women have to make visits to these health facilities to finalize the investigations. One police woman commented that the final report of the physician may not be as detailed as it had to be. But the most important problem the police face at government hospitals is the time it takes to get the medical evidence and submit it to the court.

According to one of the police woman, "*The process may take 2-3 months to get a certificate from a government hospital.*"
As a result, the process of police investigation is delayed considerably and this leads to prolonged detention of the suspected perpetrator.

One key informant commented that GMH is improving these days and the report could be available in one week time. All police women have never referred SAW to private medical institutions. Various reasons were given for this. According to one key informant, "*Reports by physicians from private hospitals are not seriously taken by the district attorney compared to the ones that come from government hospitals*." Another one suggested by saying, "*Private hospitals may give false results especially for rich people who some time assault their house maids.*"

Three of the four police women were unaware of EC at all except one who stated that she had once seen a SAW having certain pills though she does not know much about these pills. When the police women were given explanations about the EC, they were excited and wanted to know more. After the information about EC provided by the interviewer, they suggested that the EC be widely available not only for SAW, but also to other women who may need it. They emphasized that it should be available easily in the nearby health facilities, especially at the health centers. One key informant also suggested that the EC be available at the police stations so that victims could get the drug right away. The police women also commented that police women who are usually dealing with sexual assault victims should be given health education about EC. From the discussion, all the police women were eager to help SAW to prevent unwanted pregnancy as a result of sexual assault. They said that if police women had good knowledge about EC, they can hasten referral to hospitals so that SAW get treatment on time.

Discussion

Compared to other parts of Ethiopia, Addis Ababa has a relatively higher number of health facilities and qualified health personnel. The city has more than 500 health service facilities including 24 hospitals with emergency rooms. These relatively higher numbers of facilities and personnel than rural areas may indicate relatively lesser barriers in accessing EC services. Nevertheless, this study has identified a number of barriers faced by SAW in accessing EC services in Addis Ababa.

One of the important barriers identified is the late presentation of SAW to either health facilities or the police stations. This delay was also noted in health facilities by a previous study in Addis Ababa that documented a mean delay of 18.6 days after the assault (7). In this study, the consequence of such delays was demonstrated by the rate of 6.5% of pregnancy among the SAW at presentation for medical care following the assault. Among the reasons for not seeking care at health facilities by SAW is low level of knowledge about EC in the society, which was identified as one of the serious programmatic problem (5). These women do not seek help till confronted by subsequent pregnancies at which time they may turn to unsafe abortion or carry on with the unplanned and unwanted pregnancies.

Another barrier for accessing services by victims of sexual assault is when staffs of health facilities send away victims to bring papers from the police before providing them with any of the services. Although the police believe that victims need to be examined first in hospitals, this practice is one of the deterring factors for getting timely medical help by SAM. There is no regulation that says victims have to be seen first by police; and then by the health facilities. It is obvious that if victims are asked to go to a police station first and report the sexual assault, and then come back to the health facility, this would inevitably delay not only the provision of EC but also the timely recording of the important evidence for the police.

SAW presenting without police letter to health facilities should be provided with all the necessary medical care and advised to report to the police immediately. The other barrier to accessing EC in the city is the presence of only few hospitals that provide treatment for SAW. There are only six health facilities that were providing services to SAW in Addis Ababa. However, there are seventeen private hospitals; which are well equipped and staffed by either a gynecologist or general practitioner and serving for twenty four hours a day and seven days a week, but unfortunately not providing services to SAW. FGAE model clinic takes the lion's share in providing care to SAW when compared to other health facilities. However the model rape clinic at GMH has not seen more than 150 patients in a year (most of whom were children), and this underutilization of services has to be taken up with the police to improve the situation.

From the in-depth interview it was possible to see that the police have negative attitudes towards the treatment given in government hospitals.In Addis Ababa, the government hospitals that could provide the necessary services are underutilized. According to the police, the main reason for this is the long time that hospitals take to give the medical certificate to the courts. Some hospitals would take up to three months to report while the model clinic at FGAE would do so in about three days. As a result, they frequently refer cases to the FGAE model clinic and to government hospitals only if cases come on weekends or at night.

The police also have a negative attitude towards the treatment given in the private hospitals and so they don't refer cases to the private clinics. The reasons why police women are not sending SAW to the private hospitals are not justified and supported by evidence.

To improve the situation, discussion should be initiated among health officials, private sector, the police and the judiciary about the role of these health institutions in the provision of care to such patients.

The other potential barrier is the fact that the police women who are dealing daily with SAW had very little knowledge about EC. In a study in Nairobi, Kenya, among clients of family planning users, EC was scarcely known or used (8).

In order to improve the care of SAW and increase their EC utilization, health education should be given using mass media and other outlets to inform the general population.

Government and private hospitals/clinics should have clear protocols on how to handle SAW. Victims should also be encouraged to go to hospitals first to seek help.

Health education should also be given to police women who are dealing with SAW about EC. Government and private health facilities should work on improving the quality of service given to victims of sexual assault, including the provision of EC. Standardizing formats during the registration of data about SAW should be considered by all sectors.

An efficient system has to be established where medical help and certification of findings are given to the police as soon as possible. Organizing a training program for health care providers on the management of sexual assault victims is an urgent task. Making EC widely available in health facilities so that it can be accessed at any time by SAW is an essential step that has to be taken by all stakeholders. Further research is recommended to assess the quality of services given by health facilities to SAW in Addis Ababa.

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