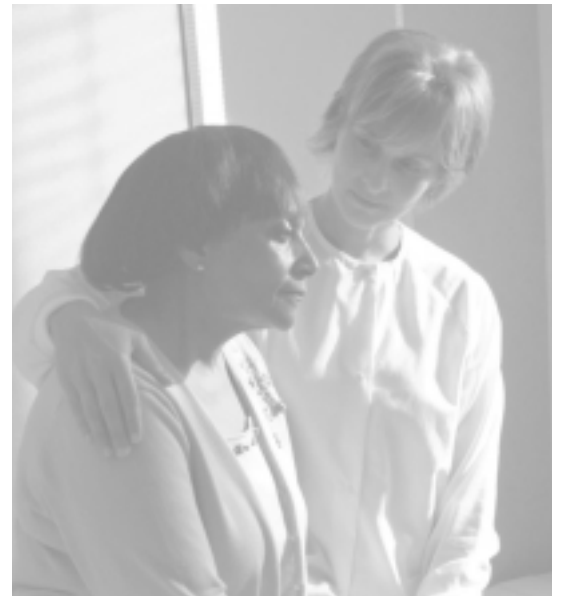
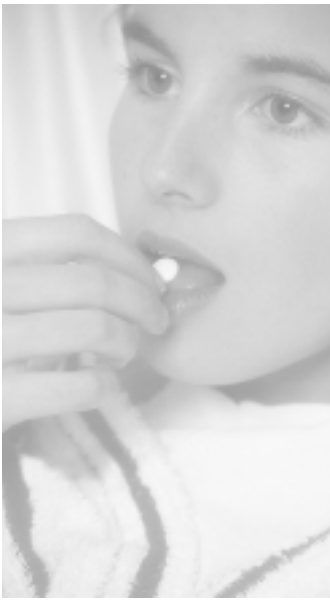


Assessing the Need



Assessing the Need in Your State

Is there a problem?

Are rape victims being offered emergency contraception (EC) when they seek treatment at hospitals in your state? Do policies on EC vary from hospital to hospital, leaving rape victims with “Russian roulette” health care that is excellent if they happen to go to one hospital and substandard if they end up at another facility?

Before attempting to pursue one of the strategies to improve access to EC described in this toolkit, organizations are encouraged to find out whether there is a problem in local hospitals and, if so, what kind of problem it is.

What kind of problem is it?

Here are some examples of the types of problems that could exist (with hospital provision of EC):

- Hospital staff are unaware of EC or have misconceptions about what it is.
- No hospital staff person is designated to inform rape victims about EC and offer it to them.
- The hospital pharmacy does not stock EC because “there is too little demand for it.” Or, the pharmacy frequently runs out of the medication.
- Hospital staff write EC prescriptions for rape victims and send them out to pharmacies to obtain the medication.
- ER staff are allowed to refuse to provide EC if they object to it for moral or religious reasons, and the hospital has no policy to ensure that other staff step in to serve the needs of rape victims.
- The hospital has a policy against offering EC for religious reasons.
- There are few or no trained Sexual Assault Nurse Examiners (SANE)/Sexual Assault Forensic Examiners (SAFE) on the ER staff.
- Sexual assault advocates/counselors are not called by hospital staff when treating a rape victim.

The type of problem that exists could well determine the best approach to take in improving access to EC. For example, if hospital staff are not familiar with EC or are erroneously confusing it with RU-486, also known as the “abortion pill,” the first step may be to undertake a campaign to educate hospital staff. If the problem is that rape victims are being sent out to pharmacies with prescriptions for EC, instead of receiving it immediately in the ER, the best approach may be to demonstrate that some of these pharmacies are not open 24 hours a day, do not stock EC regularly or are inaccessible for rape victims without automobiles.

How widespread is the problem?

A survey of hospitals asking about their policy on EC for rape victims will allow you to determine whether a problem exists, and if so, its scope. If the problem is limited to a handful of hospitals in a state, then the best approach may be to visit hospitals and address the issue on a case-by-case basis. Or, it may be that the problem is at a specific subset of hospitals, such as small facilities in rural areas. In that case, advocacy approaches might be tailored to the specific needs of those hospitals.

But if the problem is widespread, existing at dozens of hospitals across the state, then a more comprehensive policy approach – such as legislation or regulation – may be the most effective method to pursue.

Who can help assess the problem and potential solutions in your state?

Early legislative efforts to improve access to emergency contraception for rape victims were led by reproductive health advocacy organizations with years of experience in promoting policies concerning contraception. In some cases, these efforts neglected to include those groups with the most personal and comprehensive knowledge about the needs of rape victims. Rape crisis centers and anti-sexual assault coalitions had been working with the staff of hospitals on a voluntary basis to ensure that victims of sexual assault would receive EC.

Reproductive health advocacy organizations should be commended for their early efforts. However, success was impeded in some cases because EC in the ER was depicted as a choice issue rather than a victims' rights issue. The situation improved when the pro-choice and anti-sexual assault advocacy groups were able to form a united front in addressing EC in the ER as a victims' rights issue, recognizing that each group viewed the problem differently, but shared a common goal.

Recent efforts in at least three states - Pennsylvania, Washington and New York - have demonstrated the effectiveness of forming a coalition of anti-sexual assault advocates and reproductive health advocates to work together on assessing the need for improving hospital EC policies and then promoting the necessary policy changes. That is why we have included a special section focusing on the importance of building a coalition that includes both reproductive health groups and anti-sexual assault coalitions.

Building Coalitions of Reproductive Health and Sexual Assault Victim Organizations

Why it's important for groups to collaborate

In states where advocates have been able to achieve improvements in EC in the ER policies, strong networks between anti-sexual assault groups and pro-choice advocates usually have been the foundation of that success. We cannot emphasize enough how much these ties will enhance your potential.

One of the underlying goals of this toolkit is to help state-based advocates from both anti-sexual assault and pro-choice organizations develop lasting, working relationships to sustain us through whatever the political landscape and social climate sends our way. We need all the allies we can get. By reaching out beyond our usual boundaries, we can offer each other new perspectives and sources of expertise, new avenues for disseminating information about our respective causes and new insights into the obstacles women face every day.

We want to emphasize that in some states, these collaborations began and continue to work smoothly, while in other states early efforts were met with resistance. In some states, anti-sexual assault organizations felt they were not involved in the discussion. In these states, it took significant work for the groups to find areas of common interest and complementary working styles. We believe the collective wisdom of the partners in this effort can offer others insight to help avoid some of the pitfalls we have experienced. We are committed to your success.

“ That was an important issue of trust for us – hearing that the pro-choice community was willing to work with us. ”

- *Suzanne Brown,*
Washington Coalition of
Sexual Assault Programs

WASHINGTON: Pro-choice and sexual assault victim organizations worked together to enact in 2002 the nation's first law mandating the provision of information about EC and the offering of medication on site in the state's hospital emergency departments. The conversation between the groups started after a 2000 NARAL survey showed there was no standard availability of EC for sexual assault victims in hospitals.

At first, because of funding and other legislative priorities, the sexual assault community was not ready to push for the bill. The pro-choice community agreed to delay the bill's introduction until the timing was right for the sexual assault community, creating a strong, trusting partnership. “That was an important issue of trust for us – hearing that the pro-choice community was willing to work with us,” explained Suzanne Brown of the Washington Coalition of Sexual Assault Programs.

By 2002, the timing was right. The coalition framed the legislation as a bill for crime victims who deserve excellent medical standards of care, instead of as a pro-choice issue. This framing of the issue allowed a broader group of legislators to step forward in support of the measure. Sponsors of the bill were selected for their records as crime victims' advocates and advocates for quality medical care. Sexual assault advocates were out front on the bill, while pro-choice groups worked legislative contacts behind the scenes. The bill passed that same session.

A more detailed summary of how this partnership worked is available from the MergerWatch Project of the Education Fund of Family Planning Advocates of NYS at info@mergerwatch.org. Contacts in the state of Washington include: Pamela Crone at the Northwest Women's Law Center, pcrone@nwwlc.org, and Suzanne Brown of the Washington Coalition of Sexual Assault Programs, Suzanne@wcsap.org, as well as NARAL of Washington and Planned Parenthood of Western Washington.

NEW YORK: Family Planning Advocates of NYS (FPA) worked together with the New York State Coalition Against Sexual Assault (NYSCASA) to win passage of an EC in the ER bill in that state in June of 2003. The bill was first introduced in the 1999-2000 legislative session following a hospital telephone survey conducted by NARAL New York, which found that 54 percent of hospitals did not provide EC on site. The bill had been languishing in the legislature since 2000, passing the Democratically-

controlled Assembly each year but failing to gain any momentum in the Republican-controlled State Senate. NYSCASA had been lukewarm in support of the bill, placing it behind other issues on the organization's priority list.

Staff of the two organizations, FPA and NYSCASA, got to know each other by having lunch together, talking informally about their concerns and attending each other's statewide conferences in Albany, the state capitol. They also worked together behind the scenes to influence the provisions of an administrative manual, the *Protocol for Treatment of the Adult Sexual Assault Patient*, issued by the NYS Department of Health (NYS DOH) in May of 2002. The Protocol strongly recommended, but did not absolutely require, that hospital emergency departments dispense EC on site to rape victims.

“At last, rape victims treated at hospitals can count on having emergency contraception available on-site, without needless delays.”

-JoAnn Smith, President and CEO of Family Planning Advocates of NYS

In the summer of 2002, the two organizations decided to work together to survey the state's 210 hospital emergency departments to determine how they were implementing the NYS DOH protocol. They sent a joint letter and survey form to the hospitals in September and worked together to follow up and achieve a nearly 100 percent response rate. They announced the results at a press conference in January 2003, pointing out that while an impressive 85 percent of hospital emergency departments had adopted policies requiring that EC be dispensed, as many as 1,000 rape victims a year were still being sent away from hospitals without having received the medication.

The two groups lobbied together and featured the legislation at both their statewide lobby days. The bill passed the State Assembly once again and began to gain momentum in the State Senate, as additional sponsors and supporters were found. Following the successful model in the state of Washington, the New York coalition worked to frame the bill as a crime victims' measure. After a last-minute push in the closing days of the legislative session, the bill passed the State Senate and was signed into law by Republican Governor George Pataki in September 2003.

“When a rape survivor walks through the door of any hospital, immediate, adequate and appropriate comprehensive care should be the response.”

-Anne Liske, Executive Director of the New York State Coalition Against Sexual Assault

“New York’s legislators have recognized the necessity of providing comprehensive and compassionate care to victims of rape. At last, rape victims treated at hospitals can count on having emergency contraception available on-site, without needless delays.”

-JoAnn Smith, President and CEO of Family Planning Advocates of NYS

PENNSYLVANIA: When Rebecca Simons, MD, approached Carol Petraitis of the Duvall Project in 1999 about collaborating on Simons’ master’s thesis, neither could have foreseen where the project would lead them. Petraitis had already begun exploring the issue of emergency contraception services for rape victims in Pennsylvania hospitals, and Simons elected to expand on this initial work with a statewide survey of emergency rooms. From her perspective as a public health physician, Simons recognized the intersection of pro-choice and sexual assault issues in her study. She felt that contact with sexual assault advocates would be valuable. This decision was a turning point in the Duvall Project’s advocacy work.

Prior to conducting the survey, Simons and Petraitis contacted the local and state sexual assault coalitions for feedback. They first met with Barbara Sheaffer of the Pennsylvania Coalition Against Rape (PCAR) in Harrisburg in early 2000. “We didn’t even know about SAFE nurses or their statewide training programs,” Petraitis recalls. “We were lucky that Barbara was knowledgeable about emergency contraception. She was already on board.” Sheaffer was able to confirm that a statewide survey had not yet been conducted, and with PCAR’s support, Simons went forward with the project.

Nearly six months later, Petraitis and Simons returned to Harrisburg to share the survey results with PCAR and to plan the next steps. Both groups had additional collaboration in mind: “We asked ourselves how we could use this information to fulfill our goals,” Petraitis explains, “but we also wanted to use it to combine efforts with PCAR.” The disappointing survey results were a call to action

“Over the course of time, both organizations recognized how much they learned, and continue to learn, from one another.”

*-Barbara Sheaffer,
Medical Advocacy
Coordinator, PCAR*

for both groups. As Sheaffer observes, “We knew EC provision in the ER was a problem, but we hadn’t gauged how bad the situation was.”

Within a few months, Duvall drafted letters to hospitals informing them how they had fared in the survey and included local sexual assault coalitions’ contact information. In a round of follow-up letters to the hospitals the following year, Duvall included information PCAR had provided about an increase in funds for victims’ compensation. “Carol was really expanding her work on EC to improve the situation for victims,” Sheaffer notes.

Built on mutual trust and respect, the relationship between Duvall and PCAR has grown steadily since this initial project. Each group provides valuable information and support for the other. As Sheaffer explains, “The great thing about working with Carol is that Duvall is able to do things we don’t have the time or resources for, like the survey and hospital letters.” Likewise, PCAR is able to provide information about sexual assault treatment the Duvall Project lacks. Perhaps most significant, both organizations have incorporated the other’s cause into its work. “Sexual assault is part of my work now, and that wasn’t the case a few years ago,” Petraitis says. “This remarkable change indicates how profound our collaboration is.”

Conducting an EC in the ER Survey

Before you do any type of advocacy on EC in the ER, you should first try to gain a comprehensive understanding of what policies are already in place at the hospitals in your state. You may want to conduct a survey of emergency department policies on EC in the ER, if another group has not already done one, or if an existing survey is out of date.

The ACLU Reproductive Freedom Project and the Clara Bell Duvall Reproductive Freedom Project of the ACLU of Pennsylvania have collaborated to produce a manual containing step-by-step guidance for conducting a telephone survey of hospitals to determine if hospitals routinely provide EC in the ER. For detailed information and advice about doing a survey in your state using the Duvall/ACLU model or for a copy of the manual, please contact either the ACLU Reproductive Freedom Project at rfp@aclu.org, or 212-549-8579 or Carol Petraitis at duvall@aclupa.org, or 215-629-0111.

This EC in the ER policy toolkit is intended to be a companion to the ACLU survey manual, *EC in the ER: A Manual for Improving Services for Women Who Have Been Sexually Assaulted* and therefore does not duplicate the survey instructions included in that manual. However, we want to note that in some instances, advocates may want to consider an alternative survey method. The type of survey you choose to do will depend on many things, including how you plan to use the findings (such as whether you intend to use it to support a legislative proposal), the number and level of expertise of the staff members and/or volunteers you have available, and your knowledge of hospital policies going into the study. To discuss which survey method is best for your state, contact duvall@aclupa.org or info@mergerwatch.org. Below are the two types of surveys that our organizations used.

The Telephone Survey

The ACLU survey has the great advantage of being methodologically sound and thus not likely to be challenged by hospitals, legislators or the public. Moreover, because it is being used in several states, your results will be comparable to other states that have used the same method, contributing to a national picture of EC policies for sexual assault victims.

The disadvantages are that the work involved is fairly extensive and you may require some help with analyzing the results. If you choose to survey only a sample, or a “cross-section” of hospitals in your state, you will not have information about every hospital, which can be a disadvantage when preparing for grassroots work and for working with politicians.

The Duvall Project first surveyed a cross-section of hospitals. Later it used a second telephone survey (with fewer questions) to reach out to hospitals that were not in the original sample. This follow-up survey allowed Duvall to “fill in the gaps” and to collect information useful for grassroots efforts.

Written and Mailed Survey

One of the key advantages of sending a written survey form out to hospitals is that ER managers fill out the information and return it to you, leaving you with a permanent and indisputable record from the hospital. If hospital officials later contest the survey findings when speaking to news reporters or legislators, you can simply produce the form filled out by the hospital. There is never a case in which a hospital president can insist that a telephone surveyor misunderstood or misrepresented the

hospital's policy. This is extremely important for the credibility of advocacy organizations when using survey results to demonstrate the need for policy change, such as through legislation.

Mailing a written survey also can be easier than trying to reach busy hospital ER staff on the phone to conduct a survey. Therefore, you may be able to contact all the hospitals in your state and have a more complete record, which will be useful in trying to influence statewide policy change. New York advocates found that state lawmakers became more interested in the issue when they were able to view the policies at hospitals in their own districts. See Appendix 1 for a sample cover letter and written survey.

The disadvantage of the written method is that your survey results will show what hospital officials say their policies are, not what the hospitals may actually be doing in practice. Care must be taken to draft survey questions that get at the nuances of hospital policies, and some follow-up phone calls may be necessary to clarify the responses you receive.

Lastly, unless you get a very high response rate (like the 96 percent New York State advocates achieved through persistent follow-up), there could be bias in the results, because the hospitals that don't return the surveys may be exactly the ones with problematic policies.

"Mystery shopper" surveys

Some groups have used a "mystery shopper" method to survey hospitals on their provision of EC. This method involves calling a hospital posing as someone who needs EC and asking for the emergency room. The caller then asks whether the hospital would provide EC. This type of survey can be done more quickly than the written survey method or the more involved ACLU method. Some groups also feel this method produces a snapshot of what would actually happen to a woman seeking EC at each hospital. The main disadvantage of this method is that the results may not reflect actual policy. If the person who happens to answer the telephone in a busy ER is not actually knowledgeable about EC or treatment of rape victims, the answer could be inaccurate and subject to challenge by hospital administrators when survey results are released. Moreover, some advocates contend that the "Mystery Shopper" method is not an accurate account of what a rape victim would do. In general, women do not call an ER inquiring about the availability of EC after they have been sexually assaulted.

Related Survey of Pharmacies

In some states, hospital surveys have uncovered a high rate of emergency department personnel writing prescriptions for emergency contraception and sending rape victims out to pharmacies. If your hospital survey produces these kinds of results, you may want to follow up by surveying pharmacies. Because some hospitals in Pennsylvania commonly give prescriptions for EC to sexual assault patients (rather than providing EC on site), the Duvall Project surveyed pharmacists to determine how easy it might be to fill a prescription and how much pharmacists knew about EC products. The results were quite alarming with 13% of pharmacists confusing EC with RU-486 and over two-thirds saying a prescription could not be filled that day in their store. More complete information will be posted on Duvall's website: www.aclupa.org/duvall or in the October 2003 issue of the journal *Contraception*.

Survey of Pennsylvania Hospital Emergency Departments

Summary of 2000 Findings

Conducted by Clara Bell Duvall Reproductive Freedom Project

Survey method and response rate

- 125 of 165 Pennsylvania hospital emergency departments, Catholic and non-Catholic, were contacted by telephone over a three-month period in the year 2000. This is 76 percent of general hospitals.
- Telephone interviews were conducted with emergency room personnel familiar with the treatment of rape victims.
- Survey consisted of 15 open-and close-ended questions designed to determine the services that were provided routinely and the EC protocol typically followed in cases of sexual assault.

Findings on providing emergency contraception on site

- 28 percent of hospitals surveyed routinely offer and provide EC on-site to victims of sexual assault (categorized as Appropriate Care).
- Six percent of Catholic hospitals were providing appropriate care versus 33 percent of non-Catholic hospitals.
- 51 percent of hospitals relied on the discretion of the physician on duty (categorized as Physician Dependent Care).
- 12 percent of all hospitals did not provide any EC services.
- Nine percent of hospitals have an unclear policy

Findings in rural counties and across Pennsylvania

- Seven counties in Pennsylvania do not have general hospitals, but an additional 34 counties have no hospitals with adequate EC policies. These 41 counties represent 61 percent of Pennsylvania's 67 counties.
- Of the 63 hospitals surveyed in western Pennsylvania, only 13 provide appropriate care, giving a woman a 1 in 5 chance of receiving appropriate services. Of the 62 hospitals surveyed in Eastern Pennsylvania, 23 provide appropriate care, leaving women with a 2 in 5 chance of receiving reliable care for pregnancy prevention.

SAFE/SANE Programs

- 25 hospitals in Pennsylvania currently have SAFE/SANE programs in their emergency departments.
- Among hospitals with a SAFE/SANE program, 56 percent provide appropriate care. Only 21 percent of hospitals with no SAFE/SANE program provide appropriate care.

Survey of New York Hospital Emergency Departments

Summary of 2002-2003 Findings

Conducted by New York State Coalition Against Sexual Assault
& Family Planning Advocates of NYS

Survey method and response rate

- Joint letter and survey form sent to hospitals by FPA and NYSCASA on Sept. 12, 2002
- Surveyed 210 hospital emergency departments; 201 hospitals responded (96 percent response)
- Survey forms sent to four administrators at each hospital: CEO, General Counsel, Emergency Room Director and Nurse Manager.
- Follow-up letters and phone calls made and faxes sent to remaining non-responders.
- All survey findings list the hospitals' own statements about their official policies on dispensing EC in the ER. There was no attempt to independently verify the hospitals' statements, such as by calling hospital ERs pretending to be rape victims.

Policies on providing emergency contraception on site

- 171 hospitals (85 percent of the 201 responding hospitals) said it is their standard policy to dispense emergency contraception immediately, on site, to all rape victims who choose it after having been counseled.
- 24 hospitals (12 percent) said they do not have a standard policy of dispensing emergency contraception to rape victims.
- Six hospitals (three percent) were determined to have inconsistent policies on providing rape victims with emergency contraception.

Impact on rape victims

- As many as 1,000 rape victims a year may be sent away from hospital emergency departments without receiving emergency contraception. This number is based on the number of rape victims treated each year by hospitals without standard policies of dispensing emergency contraception.
- 16 New York counties have hospitals that do not have a standard policy of providing emergency contraception to rape victims. Women who are sexually assaulted in these 16 counties may not be able to obtain emergency contraception in a timely manner.

Responses from Catholic hospitals

- Of the 210 emergency departments surveyed, 38 were located in Catholic hospitals.
- 36 responded, and two failed to respond.
- 27 (or 75 percent of the responding Catholic emergency departments) said it is their standard policy to provide emergency contraception to rape victims. Some stated they require a pregnancy test before the medication is dispensed.
- Nine (or 25 percent) of the respondents said they do not dispense emergency contraception to rape victims.

Choosing a Strategy to Increase Access to EC in Your State

What is the best way to ensure that hospital emergency departments have policies of consistently offering emergency contraception to rape victims? The answer depends on the particular situation in your state.

Some factors to consider include:

- The policies and practices in your state's hospital emergency departments (based on the findings of your survey of EC in the ER), including the percent of hospitals not offering EC to rape victims and the policies of those hospitals (rural, urban, religious).
- The resources (personnel, time and money), skills (such as medical, legal or political) and missions of the groups in your coalition.
- The political climate in your state (such as liberal, conservative, anti-choice) and how powerful the opposition might be to your efforts to promote consistent statewide policy on EC in the ER.

Use this assessment of your situation in deciding which of the following approaches would work best for you:

- **Legislation:** Supporting state legislation that would mandate that EC be offered to rape victims at all hospital emergency rooms.
- **Administrative action:** Approaching the executive branch agency in your state that is responsible for regulating hospitals (usually a state Department of Health) and asking for promulgation of a protocol or regulation requiring that EC be offered in the ER. It could also involve the enforcement of existing regulations or laws.
- **Litigation:** Bringing a lawsuit against a hospital or physician on behalf of a rape victim or victims who were not informed about or offered EC to prevent pregnancy.
- **Voluntary change:** Approaching individual hospitals or a hospital association and asking for voluntary adoption of policies, pursuing public awareness campaigns and addressing EC with the range of professions that work with victims of sexual assault.

In the sections that follow, we explain each approach and give tips for deciding which one (or sequence of approaches) will most likely succeed in your state. Please realize that you may begin with one approach and then decide that you are ready for the next step.

For instance, in New York State, early attempts at enacting an EC in the ER bill (legislative approach) stalled. This lack of progress led to dialogue and the formation of a stronger choice-sexual assault alliance. Together, the groups worked to influence the State Health Department to address the issue of EC in the ER in the department's protocol for hospitals treating sexual assault patients (administrative approach). A survey conducted following issuance of the Protocol found that quite a few hospitals still were not offering EC to rape victims consistently. Release of the survey results gave new momentum to the EC in the ER legislation. The bill passed both houses of the legislature in June 2003 and was signed by the Governor in September 2003.

Likewise in Pennsylvania, several years of voluntary measures - informing hospital emergency departments about their rankings in the EC in the ER survey, developing a web page advertising this information, developing guidelines for SARTs (sexual assault response teams), editorials, press conferences, and so on - led to an increase in the percentage of hospitals providing appropriate care for EC in the ER (from 28 percent up to 46 percent). Now the state has elected a pro-choice governor and advocates recognize that a legislative or administrative approach may be more feasible than it has been for many years.