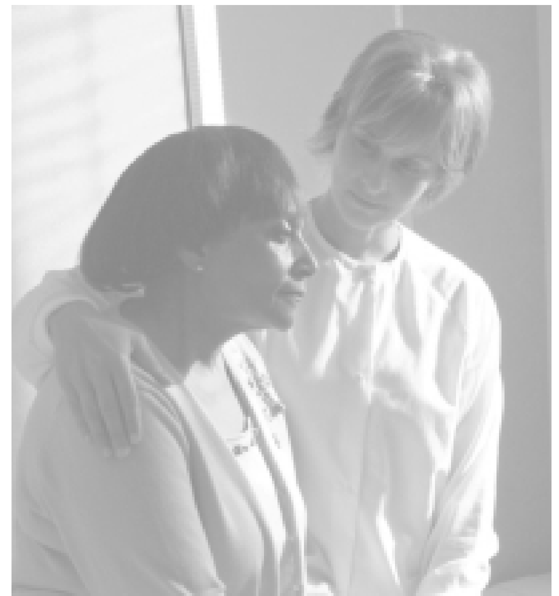
Preventing Pregnancy from Sexual Assault

Four Action Strategies to Improve Hospital Policies on Provision of Emergency Contraception



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We dedicate our work to the thousands of rape victims whose lives we hope to improve by ensuring that they have the opportunity to prevent the additional trauma of unintended pregnancy.

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Introduction

Each year, an estimated 25,000 American women become pregnant following an act of sexual violence. As many as 22,000 of those pregnancies could be prevented through the prompt use of emergency contraception (often referred to as "the morning after pill"). Emergency contraception (EC) is a high dosage of regular birth control pills. It is a safe and effective FDA-approved method of preventing pregnancy after unprotected sex.

Yet only 20 percent of rape victims receiving treatment at hospital emergency departments actually received EC over a seven-year period in the 1990s, according to a national study. Surveys in several states have identified wide variations in hospital policies on providing EC to rape victims. In New York, a hospital survey found that as many as 1,000 rape victims a year were being sent away from emergency rooms without having received EC on site.

Leading national medical organizations recognize EC as part of standard rape treatment in hospital emergency departments. Yet, clearly, it is not. How can this essential aspect of emergency care for sexual assault victims be improved?

Three organizations have come together to produce this toolkit explaining how your organization can work to ensure that every sexual assault victim is offered the means to prevent pregnancy when she receives treatment at a hospital. The National Sexual Violence Resource Center (www.nsvrc.org) has approached this issue from the perspective of providing expertise in development and distribution of resources that will ensure sexual assault victims' right to quality health care. The Education Fund of Family Planning Advocates of New York State (www.fpaofnys.org) and the Clara Bell Duvall Project of the ACLU of Pennsylvania (www.aclupa.org/duvall) have brought to the partnership their expertise in women's reproductive health care and policies that ensure women's access to emergency contraception.

This toolkit describes four different options for organizations interested in working to improve the provision of EC at hospitals:

1. Legislation mandating that all hospitals offer EC to rape victims.
2. State administrative action or the issuance of regulations by state agencies that oversee hospitals.
3. Litigation on behalf of rape victims who are denied EC.
4. Voluntary action such as approaching hospitals and asking them to voluntarily improve their policies, providing training to service providers and increasing public awareness.

For each of these four approaches, the toolkit offers helpful practical tips and real-life examples of what community organizations have done. The appendices provide useful resources and references where more information can be found.

This toolkit offers basic information on rape, pregnancy and the use of emergency contraception to prevent pregnancy. It provides advice on how community-based organizations can conduct surveys to determine what the policies are at their local hospitals concerning the offering of EC to rape victims. The Duvall Project and the ACLU Reproductive Freedom Project have published a separate detailed manual, "E.C. in the E.R.: A manual for improving services to women who have been sexually assaulted," on hospital survey techniques. That manual and this policy toolkit are intended as companion pieces. For a copy of the manual, please contact either the ACLU Reproductive Freedom Project at rfp@aclu.org, or Carol Petraitis at Duvall@aclupa.org or 215-629-0111.

Each state is different. The best approach for one state may not work in another. Several factors are necessary to consider before initiating any of these proposed strategies. Please refer to the section titled: "Four Strategies to Increase Access to EC" in this toolkit. If you need help deciding on the best approach for your state, please contact The MergerWatch Project of the Education Fund of Family Planning Advocates of NYS at info@mergerwatch.org or 518-436-8408, ext. 214, or the National Sexual Violence Resource Center at www.nsvrc.org or 877-739-3895, ext. 104.

Stories of Victims of Sexual Assault

The following two stories are powerful testimonies about victims of sexual assault. The first story is written by a direct services provider who supervised a case of a 14-year-old girl, while the second story is provided by a brave sexual assault victim. Each story illustrates the importance of receiving EC during emergency department treatment; one by showing the harm of not receiving EC, the other by showing the positive impact receiving EC had on the victim. (The following stories are presented in the authors' own words.)

Failure to Receive EC

I am a Direct Services Supervisor for a sexual assault services center in southeastern Pennsylvania. In the summer of 2002, I supervised a case involving a 14-year-old girl who was sexually assaulted by an acquaintance. The teen's mother took her to the local emergency room where a physician in the children's medical department interviewed and examined her. At the conclusion of the examination, the doctor wrote a prescription for emergency contraception and instructed the mother to have it filled right away. The mother was Hispanic and spoke very little English, but she understood that she needed to have the prescription filled immediately.

Approximately 10 days later, the teen came in for a follow-up appointment with the doctor. It was at that time that we learned about their difficulties in getting the prescription filled. The girl said that after leaving the hospital between 3 and 4 a.m., both went to a 24-hour CVS pharmacy. It was the 14-year-old who had to do most of the talking and translating for her mother. When the mother presented the prescription, the pharmacist refused to fill the prescription because it was "too strong for her age." The pharmacist did not offer to help them by calling the physician or referring them elsewhere. The first thing in the morning, the mother and daughter went to a privately-owned pharmacy. Again, the pharmacist there would not fill the prescription or offer any help. In the end, they were not able to obtain any emergency contraception.

This Hispanic mother did not have a lot of money, so even if she had found someone to fill the prescription, it would have been a financial burden. One of the saddest things about this whole situation was putting the 14-year-old girl through the added trauma of being the one to ask the pharmacists for the emergency contraception and being denied their help.

In my view, we need to have a system that is more compassionate to young victims of sexual assault. If she had received emergency contraception in the hospital, she would have been spared a lot of unnecessary trauma.

Direct Services Supervisor
Pennsylvania

Successful Provision of EC

After midnight on July 8, 2002, while asleep in bed next to my 4-year-old son, I was accosted by an unknown man who handcuffed, blindfolded and kidnapped me from my home at gunpoint, threatening to kill me if I did not cooperate. I was driven to an unknown location, raped and - miraculously - returned to my front porch unharmed within a few hours' time. I was warned not to call the police or the man would return to kill both me and my son.

Because I was more afraid of not calling the police and having the stranger return to assault me again, I called the police department immediately. They arrived at my home shortly, and after a few brief questions, I was instructed to allow the paramedics who had accompanied the police to take me to the Sexual Assault Nurse Examiners (SANE) unit located at St. Joseph's Hospital in Albuquerque, so that they could examine and treat me for any harm that may have been inflicted during the assault.

At the SANE unit, I was provided emotional counseling, was physically examined, and questioned by the detective in charge of my case. I was given various antibiotics and preventive treatments for the possibility that I may have contracted a sexually transmitted disease during the assault. I was also given Plan B - an emergency contraception that, as I understand it, is 89% effective if taken within 72 hours after having unprotected sex.*

I feel very fortunate to have been taken to a place like the SANE unit after going through what was easily the most terrifying experience of my life. And I feel equally fortunate to have received the anti-STD treatments and emergency contraception that were provided. Knowing the emotional difficulties that I have had to surmount since the attack, I cannot imagine how much worse it could have been if I had to deal with an unwanted pregnancy.

I can say from personal experience that dealing with an unplanned pregnancy is difficult enough, much less in a situation where sexual assault is involved. One thing that has made my recovery from the attack much easier is that I have not had to deal with any residual effects - in other words, I have not had to deal with the trauma of recovering from serious injury, contracting a disease, or pregnancy.

Based on my experience, I urge legislators at any level to support emergency contraception legislation, making this crucial birth control available to all women who survive sexual assault.

Sexual Assault Victim
New Mexico

** Recent studies show the EC can be taken up to 120 hours after unprotected intercourse.*

Facts About Emergency Contraception for Rape Victims

Rape and Pregnancy

- An estimated 25,000 U.S. women become pregnant as a result of sexual assault each year. EC could be used to prevent as many as 22,000 of these pregnancies.[1]
- 12% of all women experience sexual assault in a lifetime and 4.7% of those assaults result in pregnancy.[2]
- An estimated 3 million unintended pregnancies occur in the U.S. each year. EC could prevent as many as 1.5 million, including as many as 800,000 pregnancies that result in abortion.[3]

Safe and Effective Pregnancy Prevention

- Emergency contraception is a safe and effective, FDA-approved method of preventing pregnancy after unprotected intercourse.[4]
- EC is time-sensitive. The sooner it is given, the better it works.[5]
- EC pills can be given in different ways. One approach requires giving a first dose within 72 to 120 hours of unprotected intercourse and a second dose 12 hours later. The second approach, which applies uniquely to progestin-only medications, entails giving the entire course of medication at one time within 72 to 120 hours after unprotected intercourse.[6]
- The side effects of EC are temporary and may include nausea, vomiting and breast tenderness. Plan B® appears to be associated with the fewest side effects.[7]
- According to the World Health Organization, EC will have no effect on an established pregnancy.[8] It is not the same thing as RU-486, the "abortion pill."

EC in the ER: Care for Rape Survivors

- The American Medical Association, the American College of Emergency Physicians and the American College of Obstetricians and Gynecologists all recognize EC as part of standard rape treatment.
- Yet only 20% of rape victims receiving treatment at hospital ERs actually received EC over a seven-year time period in the 1990s, according to a national study.[9]
- Surveys in several states have found wide variation in hospital policies on provision of EC to rape survivors.
- As of this printing, four states – Washington, California, New Mexico, and New York – have enacted laws requiring hospitals to offer emergency contraception to rape victims. Illinois' law requires counseling of rape victims about EC, but not on site provision of the medication.

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[1] Stewart, F. and Trussell, J. "Prevention of Pregnancy Resulting from Rape," *American Journal of Preventive Medicine.* 2000. (19):228-229. An earlier estimate by Holmes (1996) is 32,000 pregnancies result from sexual assault.

[2] Holmes, M.M., Resnick, H.S., Kilpatrick, D.G., and Best, C.L. "Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women," *American Journal of Obstetrics and Gynecology.* 1996. 175:320-325.

[3] Trussell, J., et al. "Emergency Contraception Pills: A Simple Proposal to Reduce Unintended Pregnancies," *Family Planning Perspectives.* 1992. 14:269-273.

[4] Food and Drug Administration approval announcement. "Prescription Drug Products: Certain combined oral contraceptives for use as postcoital emergency contraception," *Federal Register*. Vol. 62, No. 37. February 25, 1997.

[5] Ellertson, C., Evans, M., Ferden, S., Leadbetter, C., Spears, A., Johnstone, K., et al. "Extending the time limit for starting the Yuzpe Regimen of emergency contraception to 120 hours," *Obstetrics and Gynecology.* 2003. 101(6):1168-71.

[6] von Hertzen, H. "Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial," *The Lancet*. 2002. 360:1803-09.

[7] American College of Obstetricians and Gynecologists. "Emergency oral contraception," *ACOG Practice Bulletin*. 2001. Washington, D.C.: ACOG.

[8] World Health Organization. Emergency Contraception: A guide to the provision of services," *Reproductive Health and Research*. 1998.

[9] Amey, A. and Bishai, D. "Measuring the Quality of Medical Care for Women Who Experience Sexual Assault with Data from the National Hospital Ambulatory Medical Care Survey," *Annals of Emergency Medicine*. June 2002. 39:6.