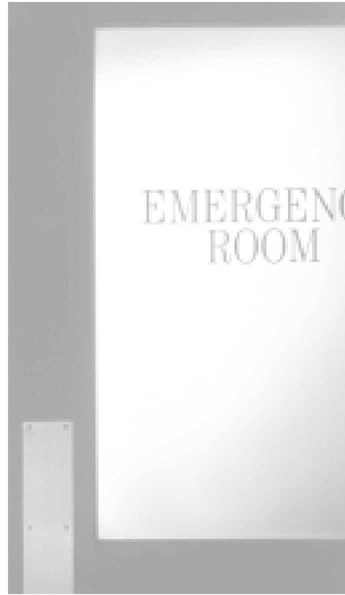
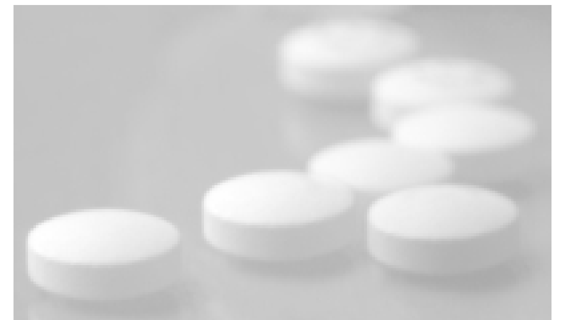
Strategy 4: Voluntary Change





Introduction

Encouraging voluntary change in hospital policies can be the easiest way for state advocacy coalitions to begin improving rape victims' access to emergency contraception in emergency rooms. This method allows advocacy groups to avoid the publicity and/or politics that generally accompany legislative action. Voluntary approaches also can work more quickly than administrative or litigation strategies. In some states, anticipated opposition to legislative action makes the voluntary approach the only logical option—at least initially. For the most effective change on the voluntary level, these actions should be carried out collaboratively between the sexual assault and pro-choice coalitions.

Advantages:

- Efforts can be made on a small scale and have immediate and beneficial results.
- Voluntary tactics serve to educate, generally creating a cooperative environment.
- Voluntary action can take place behind closed doors, avoiding public controversy.

Disadvantages:

- Voluntary action cannot be enforced.
- Hospital policies are subject to change, for any number of reasons, including when administrators change.
- Because hospitals often must be approached one-by-one or in small groups, the effort to create widespread change can be time-consuming.
- Large-scale trainings, mailings or outreach campaigns are expensive and time-consuming.

Methods that can be used to promote voluntary change include training those professionals who provide direct services to victims of sexual assault about including EC in rape treatment; encouraging hospital administrators to include EC in rape treatment protocol; and establishing public awareness campaigns about EC and sexual assault that can lead to patient requests for EC at local hospitals and/or hospitals voluntarily adopting policies to offer EC.

Training of Professionals Serving Rape Victims:

For comprehensive coverage, EC training should be given to all direct service providers that may come in contact with a rape victim seeking treatment.

Some communities have a Sexual Assault Response Team (SART). Typically, such a team includes sexual assault forensic examiners (SAFEs) or sexual assault nurse examiners (SANEs) – who are nurses specifically trained in forensic evidence collection and rape treatment – as well as sexual assault advocates/counselors, law enforcement representatives and prosecutors. The team determines how best to coordinate services to serve rape victims. SART coordination generally includes a protocol of response guidelines developed with additional input from organizations such as the state department of health, the state anti-sexual assault coalition, victim service providers, hospital administration, the state attorney general's office and others. Most SARTs also do regular trainings to keep up to date on

providing the best care for victims of sexual assault. As part of their training curriculum, SAFE/SANEs receive training on emergency contraception. With a few exceptions, SAFE programs (that may be part of a SART) provide information about EC to victims and give EC to victims if they want it.

Advocates might want to check with SAFE programs to see what the policy is on EC and to make sure they are giving the best and most current treatment. For example, an emergency department might still be providing combination EC pills when they could make things easier for the victim by providing Plan B®. They might also not know that both doses of Plan B® can be given at the same time. Because medicine constantly evolves, advocates will have to stay up to date on EC and make sure the SAFE/SANEs are up to date also.

Many communities, however, do not have a SART and protocol, and in those communities, many hospitals do not have SAFE/SANEs. The result is that rape exams may be performed by an emergency department nurse, doctor or resident who is most likely not trained in sexual assault forensic evidence collection or rape treatment protocol. Advocates should review what the exam and medication procedures are and find out who conducts the exams. Training should be provided to every staff person who provides sexual assault exams or forensic exams. It may also involve setting up a structure to improve EC access. For example, if nurses conduct most of the exam, a physician could write standing orders for those nurses to provide EC to victims. Other staff, such as residents should receive training on EC also.

Other direct service providers who should be included in trainings on EC for rape victims are rape crisis line/hotline operators, sexual assault counselors, hospital social workers, and staff of child advocacy and victim assistance centers. Training for direct service providers should review general information about EC and its importance in sexual assault treatment.

Training should cover the following topics:

- **The prevalence of pregnancy in victims of sexual assault:** About 5 percent of rapes result in pregnancy. Recent studies have estimated 25,000 to 32,000 women in the US become pregnant as a result of sexual assault each year.
- **How EC works:** Like birth control pills, EC prevents ovulation, fertilization or implantation of a fertilized egg, with implantation being the least likely mechanism of action, according to recent studies.
- **Why EC does not cause an abortion:** the medical definition of pregnancy is that it begins at the moment of successful implantation of a fertilized egg on the wall of the uterus. EC works before implantation, and thus prevents pregnancy. EC is not the same thing as RU-486, the "abortion pill."
- **The effectiveness of EC:** EC pills are 75 to 89 percent effective in preventing pregnancies that would otherwise have occurred, depending on which product is taken and how soon it is taken after unprotected sex.
- **Why EC should be part of the standard protocol of care for victims of sexual assault:** Victims should not be re-victimized by having to deal with a pregnancy resulting from rape, and the sooner EC is taken, the greater the effectiveness of preventing pregnancy.

Training should also review the procedure for offering of EC as part of proper sexual assault treatment:

- The patient should receive accurate and complete verbal and written information about EC in order to make an educated decision whether to take the medication.
- Before she takes EC, the patient should receive information about the likelihood of pregnancy. Some factors to consider are whether the patient is of childbearing age, if she uses regular hormonal contraceptives, if she has had a copper IUD inserted, if she has had a tubal ligation and if she knows she is already pregnant. (A pregnancy test often is part of rape treatment, but is not a prerequisite for EC because EC has no effect on an established pregnancy.)
- The emergency department should be encouraged to stock the type of EC that is most effective, has fewer side effects and has a lower medical risk, currently Plan B® and Preven."
- The emergency department staff should be trained on the latest research on EC and resources on staying up-to-date with new research as it is released, such as the 2002 studies showing the effectiveness window of EC to extend to 120-hours from the previous 72 hours and research showing that a single 1.5 mg dose of Plan B® is as effectives as two .75 mg doses taken 12 hours apart (meaning the complete regimen of EC can be administered in the emergency department).

Handouts should include:

- An EC fact sheet (refer to fact sheet at the beginning of this toolkit for a model)
- A list of birth control pills and regimens that will be effective as EC (a list is available at not-2-late.com, under EC Pill Brands Worldwide for the United States)
- List of policy statements from medical societies (available at www.aclupa.org/duvall/pubs/ecguidelines.html)
- Sample hospital protocol (See Appendix 3 for sample protocol)

Encouraging Hospitals to Voluntarily Improve Policies:

It is important to encourage hospital administrators to include the offering of EC as part of standard protocol for rape treatment in the emergency department. If a state has no law ensuring EC is routinely offered to victims of rape at all hospital emergency departments, policies may vary from hospital to hospital. At some facilities, it is up to the individual staff to administer EC, which may not happen because of the religious beliefs of a physician or nurse, misconceptions about EC or a general lack of knowledge about EC as part of rape treatment. This situation leads to inconsistency of care and leaves to chance the probability that a rape victim will be offered the means to prevent pregnancy. In theory, inconsistent care can be worse than a policy of not providing EC because the local rape crisis center would then know to make alternative arrangements to ensure access to EC.

Writing letters to hospital administrators is a great way to begin this process (see the sample letters in Appendix 3). An introductory letter should introduce your organization, tell the recipient about EC and explain why it should be a part of standard rape treatment. If your organization has surveyed hospital EC policies (which we recommend in this toolkit), you can include in the letter the results for each hospital and compare them with the statewide findings. When hospital administrators discover they are out-of-step with other hospitals, they may be more inclined to consider adding EC to their emergency protocol for treatment of rape victims.

The mailing might also include an EC fact sheet, medical society policy statements and language alerting hospitals to potential liability if a rape victim is not given proper treatment (see litigation section of this toolkit). A copy of state sexual assault treatment protocol/SART guidelines/SANE guidelines could be included as well. (Contact your state sexual assault coalition for a copy of the guidelines. A list of coalitions can be found in Appendix 4 of this toolkit.)

Special considerations for Catholic Hospitals: Catholic hospitals require a specialized approach because of religious and ethical restrictions. (See the separate sample letter in Appendix 3 of this toolkit.)

To all hospitals, packet/letters should be addressed to a number of people on the hospital staff, including:

- The hospital president/CEO
- Emergency department doctors
- Emergency department nurse manager

After sending your packet/letter, scheduling a follow up meeting may be a good idea, if you have the time and resources. The following pages discuss site visits advocates in NY made to hospitals to discuss EC for rape victims.

There are other ways to effect change in hospitals. You can promote the hiring and training of SAFE/SANEs. As discussed above, SAFE/SANEs are not the norm in hospital emergency departments, but offer expert care to victims of sexual assault. Since these nurses have been trained to treat sexual assault patients, they are likely to be aware of the need to promote EC as part of complete emergency department care for victims of sexual assault. Also, a hospital emergency department with SAFE/SANEs has committed staff to proper treatment of sexual assault, and thus is more likely to develop a comprehensive treatment protocol for victims that includes EC. The organization of a SART can also lead to awareness of the issue and proper hospital protocol. Consult with your state anti-sexual assault coalition or local rape crisis center to help ensure comprehensive care.

EC public awareness campaigns:

Public awareness/education campaigns are great tools for promoting change in hospital policies. They increase community/public awareness of emergency contraception and thus support for EC in the ER. With this support, you have a greater chance of achieving success through any of the four strategies for action.

A public awareness/education campaign is generally an ongoing effort to bring public attention to the issue. Awareness campaigns on EC in general can also be beneficial because EC is widely unknown or misunderstood by the general public.

Some ideas for beginning a public awareness/educational campaign include:

- **Develop and distribute educational materials/fact sheets on EC and sexual assault**
  Many organizations have publications on EC and EC in the ER available free of charge or for a small fee that you can purchase. (www.pcar.org, www.prch.org, not-2-late.com, and choice organizations such as Planned Parenthood, NARAL, and others.) A quick search on the web will also give you all the information you would need to develop your own fact sheet or pamphlet.

- **Include discussion of EC in organization publications/website**
  If your organization has a newsletter or a website, include a section or article on EC and why it is an important part of treatment for victims of sexual assault.

- **Include EC discussion at public events**
  Give a presentation on EC and sexual assault at conferences, include EC as part of training/workshop sessions when appropriate, add EC as an issue your organization wants to address using any four of the strategies outlined in this toolkit. There are many ways to share EC information with your audience.

Following up on EC in the ER survey results: Site visits to hospital ERs in New York State

Sometimes face-to-face meetings with hospital administrators can produce positive change in emergency department policies on the dispensing of EC. Women's health advocates in New York State found that was the case when they made a series of site visits to hospitals in the spring of 2003.

Members of Save Our Services-Long Island, a coalition working to preserve and expand access to reproductive health services, visited a series of hospitals in New York's downstate region. The hospitals had either failed to respond or had provided inconsistent responses to a statewide written hospital survey on ER policies regarding the offering of emergency contraception to sexual assault victims. The advocates met with either hospital administrators or ER staff, depending on who was available at each hospital.

Approach

A non-confrontational educational approach was used. The advocates began by presenting each hospital representative with a written summary of the EC in the ER statewide survey conducted by Family Planning Advocates of NYS and the New York State Coalition Against Sexual Assault. They highlighted the high percentage – 85 percent – of hospitals that had stated they had standard policies of offering EC to rape victims.

Advocates then discussed the policy of the hospital being visited and compared its policy to the recommended standard of care for rape victims under the New York State Department of Health Protocol for Treatment of the Adult Sexual Assault Patient, as well as to the anticipated mandate under the EC in the ER legislation that was then pending.

The advocates reviewed basic information about how EC works and the time-frame in which it is effective. In at least one visit, hospital medical staff appeared not to be aware that EC is not the same thing as RU-486, the "abortion pill." When requested, the advocates discussed specific EC products, including Preven® and Plan B®. In one case, the visit turned into an "in-service training" for interested hospital staff.

Results

At two hospitals that had failed to return surveys, advocates learned that the ER staff appeared to be actually dispensing EC to rape victims, but did not want to fill out the survey for internal administrative reasons. In two additional cases, the advocates obtained promises that emergency contraception would be added to the treatment regimen for rape victims.

At one hospital, advocates learned that EC was not stocked in the hospital pharmacy. A physician present at the meeting with advocates requested information on brands of EC, which advocates sent to him. He followed up by sending a request to the pharmacy that Plan B® be stocked.

At the second hospital, the advocates found that institutional religious policies had been preventing the dispensing of EC, but that the hospital had just been taken over by a nonsectarian system. The president of the nonsectarian system pledged to introduce EC in the ER at the formerly religious hospital.

While the site visits were time consuming and labor intensive, the advocates concluded that face-to-face meetings with decision-makers proved effective in assessing and improving the status of delivery of EC in the ER. These meetings also provided the opportunity to educate medical staff about the effectiveness of EC and to address any misconceptions about how it works. To find out more, contact SOS-LI coordinator Sarah Miller at Sarah.Miller@ppnc.org

To see sample hospital letters, protocol and training materials, refer to Appendix 3 for voluntary change resources.