Providing Emergency Contraception to Sexual Assault Survivors

Emergency contraception (EC) is a time-sensitive Federal Drug Administration (FDA)-approved form of contraception that prevents pregnancy. Timely access to EC is particularly important for survivors of sexual assault. Providing EC to survivors is an integral component of a comprehensive medical response to sexual assault—patients deserve autonomy over their own bodies and failure to provide EC denies patients this right and could force them to confront an unwanted pregnancy. Unfortunately, there are hospital emergency rooms—Catholic hospitals in particular—that do not provide information about or access to EC to survivors of sexual assault.

Fortunately, states are ensuring that EC information and provision aligns with medical experts’ consensus on appropriate care for patients. Twenty-two states and the District of Columbia have laws or regulations that require hospital emergency rooms to provide information about or access to EC to sexual assault survivors. These laws are known as “EC in the ER” laws. Below is context for why EC in the ER laws are especially critical now and elements of a successful EC in the ER law.

While true commitment to reproductive freedom and bodily autonomy means access to all forms of birth control and abortion, it is also important to understand that EC does not cause abortions. EC is a birth control option that prevents pregnancy after unprotected sex. There are currently three types of birth control methods that can be used as EC: levonorgestrel (Plan B), ulipristal acetate (ella), and the copper IUD (ParaGard). Importantly, EC is not an abortifacient and does not end a pregnancy.
Emergency Contraception in a Post-Roe World

Even before the Supreme Court overturned Roe v. Wade and allowed states to ban abortion, birth control access was already at risk, especially for EC. Legislators across the country purposely conflate abortion and certain methods of birth control, including EC, to undermine birth control access.\(^5\) That kind of intentional misinformation about birth control has only become more widespread, and birth control access is now being targeted in new ways. For example, some state abortion bans are worded in such a way that they may be used to block EC access, leading to confusion or decisions to not provide EC.\(^6,7\) At the same time, access to EC is even more critical for those who need it. EC in the ER bills can help alleviate some of these access concerns.

Elements of a Successful EC in the ER State Law

**Information About and Provision of EC.** Hospitals should provide information about EC and EC itself to all sexual assault survivors who want either or both. Providing EC to survivors during their hospital visit ensures timely access to time-sensitive medication. It also saves survivors burdensome additional trips to health care providers and pharmacies at a moment of crisis.

**All Emergency Facilities Must Be Included.** All emergency health care facilities must be included in EC in the ER laws.\(^8\) A patient’s health should always come first. Nearly all EC in the ER laws ensure all hospitals comply with the law’s requirements, allowing timely access to health care for survivors.\(^9\)

- Excluding Catholic hospitals could have dire consequences for many survivors of sexual assault. This is especially important given the increasing predominance of Catholic health systems across the US.\(^10\) One in seven patients in the U.S. is cared for in a Catholic hospital.\(^11\) In one year, Catholic hospitals had more than 20 million emergency room visits.\(^12\)
- Offering EC to survivors is consistent with Catholic hospitals’ statement of identity, which includes work to “foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable.”\(^13\)
- Requiring Catholic hospitals to provide EC does not conflict with the Ethical and Religious Directives for Catholic Health Care Service, which govern Catholic health facilities. Directive 36 states that “compassionate and understanding care should be given to a person who is the victim of sexual assault.” The Directive goes on to specify, “If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.”\(^14\) Some Catholic hospitals interpret this directive in an extreme manner in order to deny EC to sexual assault survivors when they most need it.\(^15\) However, in 2010 the senior director of ethics for the Catholic Health Association made it clear that providing emergency contraception to rape survivors does not violate the directive.\(^16\)

**Enforcement**

An enforcement mechanism provides a way to ensure that health care facilities are complying with the law in the state, as well as a method for taking action when a hospital is not in compliance. Complaint-based enforcement mechanisms empower survivors denied EC to report violations of the law and direct the state Departments of Health to investigate violations. Proactive enforcement mechanisms—such as monitoring, site visits, and reports—recognize that the burden should not rest solely on the survivor, who may be reluctant to come forward and file a complaint. Both complaint-based and proactive enforcement mechanisms are critical to ensuring compliance with the law.

**Complaint-based enforcement.** Eight states—Hawaii, Minnesota, New Jersey, New Mexico, Oregon, Utah, Washington, and Wisconsin—have complaint-based enforcement mechanisms.\(^17\) If the state department of health receives a complaint that a hospital is not complying with the law, the department must investigate the complaint and take appropriate action, including penalties such as fines or license suspension or revocation.

- New Jersey law also requires an annual report to the public, summarizing the complaints and actions taken.\(^18\)

**Proactive enforcement.** Complaint-based enforcement should be accompanied by proactive enforcement, which puts the onus on either the state to ensure compliance or on
the hospitals to demonstrate compliance.

- In Illinois, hospitals are required to submit protocol for providing sexual assault survivors with information on EC to the Department of Public Health for approval.\(^9\)
  In May 2005, the Illinois Department of Public Health initiated investigations into hospitals over concerns about unsatisfactory protocols.\(^{20}\)

- Massachusetts law requires hospitals to report annually to the Department of Public Health the number of times EC is administered to sexual assault survivors.\(^{21}\)

- The New Jersey Commissioner of Health must determine, at least annually, whether a health care facility is complying with the law.\(^{22}\)

In Minnesota and Wisconsin, the Department of Health—in addition to accepting and investigating complaints—must also periodically review hospital procedures to determine whether hospitals are in compliance.\(^{23}\)

**Lack of Enforcement Mechanisms.** A lack of enforcement mechanisms in state EC in the ER laws has been linked to low compliance and has frustrated advocates in those states.

**Sufficient and Understandable Informational Materials about EC**

Information about EC presented to survivors of sexual assault must be medically accurate and culturally competent.

- New York law specifies that materials must be clear, concise, readily comprehensible, and in languages other than English.\(^{24}\)

- Oregon law specifies that materials must be “clearly written and easily understood in a culturally competent manner,” meaning that materials must be “sensitive to the patient’s faith, race, ethnicity and national origin.”\(^{25}\)

Health care facilities must receive an adequate supply of informational materials.

- Washington law mandates that the Secretary of Health must develop and produce materials relating to EC for distribution and use in all emergency rooms in the state, and mandates that these materials be available in sufficient quantities.\(^{26}\)
  Oregon law requires the

  Department of Human Services to distribute materials about EC to all hospital emergency departments in the state, “in quantities sufficient to comply with the requirements of this [law].”\(^{27}\)

**Training and Information about EC for All Hospital Personnel**

Training and information about EC for all hospital personnel who interact with survivors of sexual assault is essential. This includes administrative personnel, particularly those who staff the phone and front desk and may be the first person with whom a survivor has contact. Especially since the Supreme Court overturned *Roe v. Wade* and states began making abortion illegal, training and information about EC for hospital personnel is crucial to combat misinformation about EC.

- Studies have shown that many hospital staff may be unaware of or misinformed about EC, even in states with EC in the ER laws. In one study, staff confused emergency contraception with medication abortion and incorrectly said that it is not available in the US or in the state.\(^{28}\)

- New Jersey and the District of Columbia require all personnel who provide care or information to sexual assault survivors to receive training.\(^{29}\)

- Training for those who interact with sexual assault survivors should include sensitivity training. One study reported unsupportive and judgmental comments from those answering the phone at Catholic hospitals, such as “Go look in the Yellow Pages under abortion” and “We frown upon that.”\(^{30}\)

- One study found that among religiously affiliated hospitals surveyed, none reported any time spent during teaching afternoons or grand rounds on the topic of emergency contraception. The same survey showed that emergency contraception policies in a hospital setting were not clearly communicated in religious and non-religious settings, which caused confusion among providers about their hospital’s rules for providing EC to patients.\(^{31}\)

**Involvement of All Stakeholders**

For a successful EC in the ER law, working in collaboration with a wide variety of stakeholders in all stages of the process, including developing, implementing, and
monitoring the law is essential. Sexual assault programs and advocacy organizations in particular can provide valuable insights in the development of a robust law, as well as effective processes for implementation and compliance.

- Washington law requires the formation of a task force, comprising representatives from community sexual assault programs, advocacy groups, medical agencies, and hospital associations to provide input on the development of educational materials and rules to implement the law. The Washington State Catholic Conference participated in the task force.

- New Jersey law codifies involvement of the state sexual assault coalition and the Sexual Assault Nurse Examiner (SANE) program in material development. It also requires that SANE be notified of complaints against non-compliant hospitals.

- Oregon law specifies that the Department of Human Services must produce materials “in collaboration with victim advocates, other interested parties and nonprofit organizations that provide intervention and support services to victims of sexual assault and their families.”

**Conclusion**

EC in the ER laws ensure provision of EC on-site in sexual assault survivors’ initial visit to emergency care facilities, thereby guaranteeing timely access to care and preventing additional burdens to survivors. EC in the ER laws should be passed in all states so that survivors of sexual assault receive the compassionate and comprehensive medical care they deserve. This care is critical at all times, but especially now in an unprecedented crisis in access to reproductive health care.