Preventing Unwanted Pregnancies:

An Evaluation of Access to Emergency Contraceptives for victims of Sexual Assault in Los Angeles County

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EXECUTIVE SUMMARY

Emergency contraceptives have been approved for use in the United States since 1999, but access to the drug remains somewhat limited. Only nine states allow emergency contraceptives to be distributed over the counter and only 15 states mandate that emergency rooms give information about and dispense emergency contraceptives upon request.[1] Although emergency contraceptives are used to prevent pregnancy from occurring, many right-wing opponents contend that emergency contraception is an abortion pill, a mindset that is used to limit access in many states. Regardless of state laws regarding access, most women and men do not know that emergency contraceptives exist. The majority of physicians and gynecologists do not provide information about emergency contraceptives to patients, and there is little media coverage about the benefits of the drug. This lack of information and access to emergency contraceptives places women in fear of unwanted pregnancies at a disadvantage, especially if they do not have the resources or mental capacity to have an abortion.

For women who are sexually assaulted, emergency contraceptives offer victims a chance to prevent a pregnancy that is an unwanted outcome of the assault. Many of these women have difficulty coping with becoming pregnant from their assailant, and are forced to bear a double burden of facing choices about pregnancy and dealing with the assault itself. Some states have expanded access to emergency contraceptives for victims of sexual assault, but passing laws that increase access for all women could help victims who do not want to seek help for their assault.

[1] Guttmacher Institute. "State Policies in Brief: Emergency Contraception". 1 April, 2008. pg 1.

California has some of the best laws for promoting access to emergency contraceptives in the United States. In California, emergency contraceptives are available over-the-counter and emergency rooms are required to provide information and dispense emergency contraceptives if requested. However, there are still many ways access could be improved for all women and for female victims of sexual assault.

This study is focused on Los Angeles County to evaluate, even where access to emergency contraceptives is better than in other states, the number of ways to further expand access. Additionally, the evaluation also identifies the ways that Los Angeles County, a county with high racial diversity and income disparities, can improve access along racial and economic lines. The current state of access in Los Angeles County and recommendations for improving access can be tools utilized by other regions and states in developing a system that effectively offers emergency contraceptives for those in need, especially for victims of sexual assault.

The research further examines current federal, state and local policies regarding emergency contraceptives and creates a framework for understanding the state of access to emergency contraceptives in Los Angeles County. Several studies have been conducted that address pharmacy access to emergency contraception, the history of emergency contraception, limitations to distribution, economic benefits of emergency contraception and state policies concerning the drug. However, few studies focus specifically on the importance of providing emergency contraception for victims of sexual assault. Furthermore, this study aims to expand knowledge about the resources available in Los Angeles County to victims of sexual assault immediately after an attack and how these services can be improved in order to become more accessible to victims.

Finally, the study evaluates ways to enhance the organization of the sexual assault support network that can co-facilitate improving access to emergency contraceptives for victims of sexual assault. This includes Sexual Assault Response Teams, pharmacies and rape crisis centers. By gaining an understanding about the current national state of emergency contraceptive accessibility and the resources available for victims in Los Angeles County, we can begin to look at avenues for change that will help all women and victims of sexual assault nationwide.

INTRODUCTION

Access to emergency contraceptives is an important issue in the United States. It is especially crucial for women who are victims of rape, who are forced to deal with the assault and the possibility of a traumatic pregnancy. If access to emergency contraception was improved in pharmacies, hospitals and clinics and there was increased education about the drug, many women, including victims of sexual assault, would have greater chances to access emergency contraceptives and possibly prevent unwanted pregnancies. Evaluating access to emergency contraceptives is crucial step towards enacting change.

This study uses previously conducted research about emergency contraceptives and individual research about access for victims of sexual assault in Los Angeles County to address the following questions. What are some of the national, state, and local barriers for accessing emergency contraceptives? Where can victims of sexual assault obtain emergency contraceptives? How easy is it to access these services? How is the sexual assault resource network structured in Los Angeles County and is it effective in helping victims? Are there racial and economic disparities in access to resources that provide emergency contraceptives in Los Angeles County? What are some recommendations for improving local, state, and national access to emergency contraceptives, especially for victims of sexual assault?

The following sections will set the stage for evaluating the state of access to emergency contraception in the United States and Los Angeles County and providing possible avenues for change. The background will give a comprehensive history of emergency contraceptives and the importance of providing emergency contraceptives to

victims of sexual assault. The section on access details the resources available to victims of sexual assault and the protocols for providing emergency contraceptives to victims. To further the discussion of access, a spatial analysis will follow, in order to determine if race and income play a role in accessibility to emergency contraceptives. Finally a list of recommendations will outline the ideas to improve policies surrounding emergency contraception, possible avenues to improve access and specific recommendations for how to expand access to emergency contraceptives for victims of sexual assault in Los Angeles County.

BACKGROUND

The US has the highest unintended pregnancy rate of any country in the developed world. In the United States, half of the six million pregnancies a year are unintended and 1.3 million end in abortion.[2] Half of these unintended pregnancies occur even when couples are using a contraceptive method. In California, nearly 900,000 of the 7.5 annual million pregnancies are unintended and 26 percent end in abortion.[3] Low income women, who may not have access to contraceptive services, are more likely to develop unwanted pregnancies. And in California, only half of the women in need of contraceptive services receive them due to income level or lack of accessibility.[4] Research shows that emergency contraception lowers the chance of unwanted pregnancies by 75 percent if used correctly.[5] The federal government, which has established a national public heath goal to reduce unintended pregnancies by 40 percent by 2010, could reach this goal if access to contraceptives, especially emergency contraceptives were expanded.[6]

What is Emergency Contraception?

Emergency contraceptive pills are hormonal contraceptives that are used to protect women from getting pregnant after unprotected or ineffectively protected sex. Although commonly referred to as "morning after pills", the term emergency contraception was coined to portray to consumers that it should not be used as a long-

[2] Guttmacher Institute. "State Center: Contraception Counts: California". Online. Internet: http://www.guttmacher.org/pubs/state_data/state/california.html. pg 1
[3] Guttmacher Institute. "State Center: Contraception Counts: California". 1
[4] Guttmacher Institute. "State Center: Contraception Counts: California" 2.
[5] Boonstra, Heather. "Emergency Contraception: The Need to Increase Public Awareness". The Guttmacher Report on Public Policy. October 2002. pg 1
[6] Guttmacher Institute. "State Center: Contraception Counts: California". 1

term contraceptive method.[7] Additionally, the morning after pill implies that women should wait until the morning after to seek treatment when in fact emergency contraception is most effective when taken immediately.[8] Most emergency contraceptives are effective up to 72 hours after unprotected sex and have no long-term side effects.

Emergency contraception was first developed in the 1960s and 1970s and is now available in over 100 countries around the world.[9] The first documented case of emergency contraception was recorded in the mid-1960s when a Dutch physician administered high doses of estrogen to a 13-year-old rape victim, a practice previously used on animals.[10] Since then several forms of emergency contraceptives have been developed. The most common types are levonorgestrel-only regimens (called Plan B in the US) which can be given in one or two doses and combined estrogen-progestin (Yupze) regimens which are given in two doses taken 12 hours apart.

History of Emergency Contraception in the US

In 1998, the FDA first approved emergency contraception usage in the United States even though many other countries had been administering it regularly for more than 30 years. This product could be administered through prescription or "off-label" by a physician. In 1999, Plan B, a second type of emergency contraception was approved for use and it has been the only approved method in the US ever since.[11] On August 24,

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[7] The International Consortium for Emergency Contraception. "Emergency Contraceptive Pills: Medical and Service Delivery Guidelines". Second Edition. 2004. pg. 7.
[8] Ellertson, Charlotte. "History and Efficacy of Emergency Contraception: Beyond Coca-Cola". International Family Planning Perspectives. 22.2: 52-56, 1996. pg 52.
[9] Plan B (Levonorgestrel). "What is Emergency Contraception?" Online. Internet: http://www.go2planb.com/ForCustomers/AboutPlanB/AboutEmergencyContraception.aspx
[10] Ellertson,52.
[11] Hevesi, Alan and Kim Fine. "Emergency Contraception: Fewer Unintended Pregnancies and Lower Health Care Costs". State of New York Comptroller. December 2005. pg. 9

2006 the FDA approved Plan B as an over-the-counter drug for women 17 and over after finding significant data that proved Plan B was safe without a prescription.[12] However, allowing Plan B to be available to teens over the counter is still being debated. In response to this decision, the Government Accountability Office (GAO) issued a statement that deemed over-the-counter emergency contraceptive use as 'unusual' and cited several concerns about this recommendation including the fact that high level FDA management was more involved in the approval process and that the rationale for approval did not follow traditional guidelines for evaluating over-the-counter drug distribution.[13] Despite these concerns, several states have taken action to make contraceptives available over the counter. However, only nine states, including California, allow pharmacies to distribute emergency contraceptives to women without a prescription and only seven states allow collaborative-practice agreements, which allow doctors to call in prescriptions to speed up the treatment process.[14]

California is the leading state in legislation about emergency contraception. The Guttmacher Institute, a public interest organization that uses public policy analysis, public education and social science research to help advance sexual and reproductive issues worldwide, ranked California first overall for its contraceptive legislation.[15] This evaluation was based on rankings of service availability, laws and policies and public

[12] Guttmacher Institute. "State Policies in Brief: Emergency Contraception". 8 November, 2007. pg. 1.
[13] Hevesi 8-9.
[14] Guttmacher Institute. "State Policies in Brief: Emergency Contraception" 1. States that provide emergency contraceptives over-the-counter in pharmacies: Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Washington and Vermont.
For a breakdown of state policies regarding emergency contraceptives see Appendix 3, pg 68.
[15] Guttmacher Institute. "Our Work: Learn More About Our Work". Online. Internet: http://www.guttmacher.org/programs/index.php

funding.[16] California legislation provides easier access to emergency contraceptives. The state requires emergency rooms to provide information about emergency contraception and dispense it on request; mandates that pharmacists must dispense emergency contraception without a prescription under a collaborative practice agreement or state-approved protocol; and requires that pharmacies must fill valid prescriptions for emergency contraceptives.[17] California is a leading example of progressive policies regarding emergency contraceptive availability and distribution.

The only FDA approved form of emergency contraception in the United States is Plan B, a levonorgestrel method that works to protect women from getting pregnant after having unprotected sex. Plan B prevents the ovaries from releasing eggs or thwarts fertilization of the egg by sperm by releasing a higher dose of levonorgestrel than a regular birth control pill. If taken within 72 hours after having unprotected sex, Plan B can decrease the chance of pregnancy by up to 89 percent and is more effective if taken earlier.[18] Plan B does not affect already fertilized eggs. Side effects of Plan B include nausea, abdominal pain, fatigue, headache, menstrual changes, and vomiting.[19] Although some side effect are serious, there have been no long-term health problems or deaths associated with Plan B usage.[20] Although studies have not been conducted about the safety of emergency contraceptives if used over a long period of time, studies of similar drugs indicate that the risk of serious harm from moderate usage is low.[21]

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[16] Guttmacher Institute. "State Center: Contraception Counts: California".
[17] Guttmacher Institute "State Policies in Brief: Emergency Contraception" 2.
[18] Plan B (Levonorgestrel). "What is Plan B?" Online. Internet: http://www.go2planb.com/ForConsumers/AboutPlanB/WhatisPlanB.aspx
[19] Plan B (Levonorgestrel). "What is Plan B?" 1
[20] The International Consortium for Emergency Contraception 9.
[21] Trussel, James, and Elizabeth Raymond. "Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy". Princeton University. January 2008. pg. 5

Despite FDA approval, emergency contraceptives continue to have limited availability and most physicians do not readily supply patients with information about the drug. A lack of commercial advertising and marketing also prevents emergency contraceptives from being widely distributed, prescribed or consumed.[22] In response to this lack of education about emergency contraceptives, the Association of Reproductive Health Professionals in Washington D.C. and the Office of Population Research at Princeton University teamed up to sponsor a free Emergency Contraception Hotline (1-888-NOT-2-LATE) and the Emergency Contraception Website (www.not-2-late.com) which provides general information about emergency contraceptives and how to get it. The hotline and website are in English and Spanish and have received increasing interest since they began in 1996.[23] Some cities, including Seattle and Philadelphia, have developed successful public media campaigns to raise awareness about emergency contraception. [24]

Emergency Contraception in Other Developed Countries

In the Netherlands and United Kingdom, emergency contraception is an accepted component of family planning services. In the United Kingdom, all contraceptives are free. Most women get emergency contraceptives from general practitioners, but emergency contraception is available at National Health Services family planning clinics where it has been free since 1972.[25] Emergency contraception usage has increased dramatically since the PC4 regimen was approved in 1984. In fact, one Edinburgh clinic reported that the use of emergency contraceptives doubled in the five years following this

[22] Trussel 7
[23] Trussel 8
[24] Trussel 8
[25] Glasier, Anna et. al. "Case Studies in Emergency Contraception from Six Countries". International Family Planning Perspectives. 22.2: 57-61, 1996. pg.58.

decision.[26] In the United Kingdom, the use of emergency contraceptives has also saved the government money by preventing unwanted pregnancies. A study indicates that providing one packet of emergency contraception saves the government health service between $727 and $806.[27]

In the Netherlands, emergency contraceptives have been used since 1964, and are widely accepted. Unlike in other countries, emergency contraceptives are not considered abortifacient and are acceptable for teenage use. Most women get emergency contraceptives from general practitioners or low cost healthcare centers and costs range from $7-$41 depending on the method and insurance coverage. These methods are accessible and widely utilized. Due to high contraceptive use in the Netherlands, unwanted pregnancies and abortion rates are low.[28]

Arguments in Support of Emergency Contraception in the U.S.

Emergency contraceptives have the potential to lower the number of unwanted pregnancies, decrease abortion rates and lower health care costs. A study by K. Jones et. al. indicates that approximately 51,000 abortions were prevented in 2000[29] and Planned Parenthood estimates that approximately 300,000 abortions nationally are averted each year due to emergency contraceptive use.[30] By increasing awareness and access to emergency contraceptives, abortion rates could continue to drop. Emergency contraception is also a much cheaper option than abortion, which would lower health

[26] Glasier et. al. 58.
[27] Glasier et. al. 58.
[28] Glasier et. al. 58.
[29] American Civil Liberties Union. "ACLU Letter Urging President George W. Bush to Support the Food and Drug Administration's Petition to Allow the Emergency Contraceptive 'Plan B' to Be Sold Over-The-Counter". 20 January, 2004. Online. Internet: http://www.aclu.org/reproductiverights/contraception/16483leg20040120.html
[30] Planned Parenthood Federation of America and Planned Parenthood Action Fund, Inc. "Planned Parenthood by the Numbers". 2007.

costs for both consumers and insurance companies if used properly. At Planned Parenthood, abortions cost between $350 and $700[31] in the first trimester whereas emergency contraceptives usually cost no more than $20-50.[32] In California, Medicaid often covers abortion costs in Planned Parenthood clinics for low income women, but covering the costs of emergency contraception would be a much more affordable option. In fact, a study by the New York State Comptroller in 2005 predicted that if emergency contraception was more widely accessible, the State's Medicaid system could save $261.6 million annually, $12.8 million from abortion alone.[33] Increased availability of emergency contraceptives would also result in social cost savings by preventing the psychological costs of unintended pregnancies.[34] Not only is emergency contraception a critical tool for reducing unwanted pregnancies, but it is a cost-effective family planning method.

Emergency contraceptives can improve that lives of women who are faced with unwanted pregnancies. Women who cannot support their children, are physically or mentally not well, or feel they are too young to have children, can use emergency contraceptives to stop pregnancy, a benefit to society and to themselves. Additionally, children who are the result of unintended pregnancies are more likely to face a number of physical, mental, emotional and financial hardships including abuse, neglect, depression and low-birth weight.[35] Emergency contraceptives allow women to make choices about

[31] Planned Parenthood. "Procedures". Online. Internet: http://www.plannedparenthood.org/birth-control-pregnancy/abortion/procedures.htm.
[32] Pharmacy Access Partnership. "Emergency Contraception: Getting EC". Online. Internet: http://www.ec-help.org/GettingEC.htm
[33] Hevesi 20
[34] Trussel 11
[35] Hevesi 7

when to have children before they are faced with the possibility of actual pregnancy or abortion.

Opposition to Emergency Contraception in the US

In the United States there is heated controversy about emergency contraception. Pro-life and anti-contraception activists oppose emergency contraception because they believe it terminates a pregnancy. Portraying emergency contraception as a drug that kills a fetus allows pro-life groups to personalize the issue. Definitions of when pregnancy begins vary from state to state, giving the religious right an opportunity to sabotage emergency contraception use. The federal government accepts the American College of Obstetricians and Gynecologists (ACOG) definition of pregnancy, which indicates that "the establishment of a pregnancy takes several days and is not complete until a fertilized egg is implanted in the lining of the woman's uterus".[36] However, many states have adopted provisions that define pregnancy differently. As of 2005, eighteen states adopted provisions that outline pregnancy as beginning at fertilization and conception.[37] Under this definition, emergency contraception terminates pregnancies, feeding the fuel for anti-abortion campaigns. Although these definitions of pregnancies are not scientifically based, they are confusing to female consumers who may mistake emergency contraception for abortion pills.

There are other reasons why opponents are concerned about emergency contraception. Some of the most potent opposition comes from advocates who are worried about teen use of the drug. Many people believe that educating teenagers about emergency contraceptives will increase promiscuity, but there are no studies that indicate

[36] Gold, Rachel Benson. "The Implications of Defining When a Woman is Pregnant". The Guttmacher Report on Public Policy. May 2005. pg 7.
[37] Gold 8.

that these claims are valid. Other opposition comes from people who worry that women may use emergency contraception as a long-term contraceptive method. However, studies show that women do not substitute emergency contraception for more reliable, healthier methods.[38] Additionally, research illustrates that women who regularly use ongoing contraceptive methods are the group most likely to seek out emergency contraceptives if needed.[39]

Many laws also seek to limit emergency contraceptive availability by allowing pharmacies or health providers to refuse to distribute the drug. These measures, commonly referred to as consciousness clauses, give pharmacists the right to deny access to contraceptives for moral or religious reasons. In 1998, the American Pharmacists Association adopted a policy that recognizes a pharmacist's right to decline service and "supports the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal".[40] The growing right wing movement that attempts to classify emergency contraception as an abortion pill has fueled a movement in states to pass laws allowing pharmacists not to fill prescriptions about which they are morally opposed. However, a New York Times poll in 2004 showed that "8 out of 10 Americans believed that pharmacists should be required to fill prescriptions for birth control, even when they have religious objections".[41] Although many states are spearheading legislation that demand pharmacists fill emergency contraception prescriptions conscientious clauses are a significant threat to the

[38] Boonstra, Heather. "Emergency Contraception: Steps Being Taken to Improve Access". The Guttmacher Report on Public Policy. December 2002. pg. 13.
[39] Trussel 8
[40] Dailard, Cynthia. "Beyond the Issue of Pharmacist Refusals: Pharmacies The Won't Sell Emergency Contraception". The Guttmacher Report on Public Policy. August 2005. pg. 10.
[41] Sonfield, Adam. "Rights vs. Responsibilities: Professional Standards and Provider Refusals". The Guttmacher Report on Public Policy. August 2005. pg. 9.

distribution of emergency contraception. As a result, pharmacist's individual and moral viewpoints have a significant impact on emergency contraceptive distribution, despite the substantial interest of the general public and other government policies in its availability.

Pharmacies also exercise their ability to refuse to stock emergency contraception. Public policy, which focuses primarily on the pharmacist's role in emergency contraception distribution, often overlook when pharmacies refuse to stock the drug. Until recently, Wal-Mart, the country's third largest pharmacy chain, refused to carry emergency contraceptives.[42] Effective March 20, 2006, Wal-Mart changed its policies by agreeing to stock Plan B due to an impending lawsuit in Massachusetts.[43] Wal-Mart claimed that it changed its policy because it could not "justify being the country's only major pharmacy chain not to carry the morning-after pill".[44] However, independent chains, which comprise 42 percent of the pharmacies nationwide, are also a threat to distribution.[45] Women who rely on these chains as their primary drug dispenser are at a disadvantage if they do not supply emergency contraceptives.

Similarly, medical professionals also have the right to decline to discuss or provide emergency contraceptives to patients. The World Medical Association states that the varying opinions of human life can cause differences regarding how medical professionals relate to patients. Creating an environment where providers have the right to ethically refuse service, undercuts the core values that the medical field is expected to uphold. Instead professional standards often endorse a provider's right to "withdraw"

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[42] Dailard 11.
[43] The Associated Press. "Wal-Mart to stock emergency contraception pill". USA Today. 3 March 2006. Online. Internet: http://www.usatoday.com/money/industries/retail/2006-03-03-walmart-contraception-pills_x.htm.
[44] The Associated Press.
[45] Dailard 12.

from offering health care services that they do not support for ethical or religious reasons.[46] Legislation also supports exemption of services for moral reasons. The Church Amendment, passed in 1973, allows healthcare providers to opt out of abortion or sterilization procedures that are against their beliefs.[47] Most states also have legislation that gives medical providers the right to choose when not to provide services.

Lack of Medicaid coverage for emergency contraception limits accessibility for those who need it the most. In 2005, 26 state Medicaid programs did not cover emergency contraception compared to 19 states that covered Plan B.[48] Even if emergency contraception is covered by Medicaid, the patient may have to pay out of pocket initially and wait to be reimbursed. Because emergency contraceptives must be taken within 72 hours, there is often not enough time to wait for coverage. This system puts low-income women at a disadvantage because they may not be able to afford to purchase Plan B initially, even if it is covered by Medicaid. Barriers to emergency contraceptive use impact populations at high risk for unintended pregnancies.[49]

In California, Medi-Cal and Family PACT cover emergency contraceptives. However, when a 17-year-old female client was unable to get Medi-Cal coverage for emergency contraceptives, advocates discovered that effective January 2007, Medi-Cal coverage was restricted to women 18 and over.[50] After negotiation between Medi-Cal

[46] Sonfield 7.
[47] Sonfield 9.
[48] Institute for Reproductive Health Access, National Health Law Program, National Latina Institute for Reproductive Health, Ibis Reproductive Health "Emergency Contraception & Medicaid: A State-by-State Analysis and Advocate's Toolkit". November 2005. pg. 9.
[49] Institute for Reproductive Health Access et. al. 4.
[50] Maderas, Nicole Monastersky. "Dear Pharmacy Access Partnership Friends and Colleagues". Pharmacy Access Partnership. 12 March, 2007. pg 1

EDS and the California Department of Health Services, this restriction was removed, allowing women of all age groups to get Medi-Cal to cover Plan B.[51]

Emergency Contraception and Victims of Sexual Assault

The availability of emergency contraceptives is a crucial issue for victims of sexual assault. Approximately 25,000 to 32,000 pregnancies a year are the result of rape or incest and it is estimated that half of these pregnancies end in abortion.[52] If used correctly, emergency contraception could prevent 22,000 of these pregnancies.[53] For victims of sexual assault, emergency contraception would help ease anxiety about pregnancy and prevent abortions.

Pregnancy as a result of rape is often traumatic for rape victims. A study conducted by three psychologists from Columbia in 2001 indicates that pregnancy as a result of rape "extends the damage and psychological fragility of the victims, above all because it occurs at a time of great emotional risk".[54] Additionally, women who deny the assault find it more difficult to admit that they are pregnant, preventing them from terminating the pregnancy in time. For other survivors who fear pregnancy from the moment they are raped, waiting for results is anxiety provoking and upsetting. Many women who get pregnant as a result of rape feel as though the attacker is inside them, a process that leaves them feeling trapped in the assault itself.[55] Of the women who participated in this study, 62.8 percent of women terminated their pregnancies and none

[51] Maderas 1
[52] "Compassionate Assistance for Rape and Emergencies Act of 2007". United States Senate. 26 April, 2007. Online. Internet: http://thomas.loc.gov/cgi-bin/query/D?c11:32:./temp/~mdbsaTd2do::
[53] American Civil Liberties Union 2.
[54] Gil, Ana Milena, Bertha Ortiz and Ana Maria Jaramillo. "Pregnancy Resulting from Rape: Breaking the Silence of Multiple Crises". Women's Health Collection: 109-113. Pg. 112
[55] Gil 110

of these women regretted their decisions.[56] Raising a child that is the result of rape can be a huge emotional burden to a rape victim and can cause harm to the child. The long-term physical and emotional consequences of rape, including higher rates of suicide, depression and sexual dysfunction, are enough of a burden for rape victims themselves, let alone their children.[57]

Easy access to emergency contraception in pharmacies is an important issue for victims of sexual assault. Victims who do not receive emergency contraceptives in the hospital immediately, have to find a doctor to fill a prescription and wait for the prescription to be filled, all the while decreasing the chances of stopping a pregnancy. Because emergency contraceptives are more reliable the sooner they are used, rape victims who are already traumatized from their attack may not have the energy or time to get a prescription within 72 hours. Additionally, victims who do not want to report the crime or seek medical help will not have access to emergency contraception if a prescription is needed.[58] Even if women are able to obtain emergency contraceptives at pharmacies without a prescription, the lack of privacy and fear of talking to a pharmacist may deter women from seeking out this valuable resource.[59]

In response to these concerns, legislators are formulating laws that make emergency contraception more accessible in pharmacies. Currently, seven states allow pharmacists to provide emergency contraceptives under a collaborative practice agreement. Under these laws, doctors are allowed to call in prescriptions in advance or whenever the need arises, eliminating the time used to schedule an appointment. Offering

[56] Gil 112
[57] Gil 111
[58] American Civil Liberties Union 1.
[59] Trussel 10

emergency contraceptives over the counter is one of the most effective ways to distribute emergency contraceptives, but only nine states have provisions allowing over-the-counter distribution.[60] A study conducted by the Guttmacher Institute in 2006 found that of eighty six percent of women in the study who needed emergency contraceptives immediately, women who chose to get it over the counter did so because it was faster and easier than getting a prescription from a doctor.[61] For victims of sexual assault, over-the-counter access is especially important because it is quick and maintains anonymity.

Medical professionals, including the American College of Obstetricians and Gynecologists believe that emergency contraceptives should be provided to female sexual assault victims following an attack as a "standard of care".[62] However, in many areas, over two thirds of emergency rooms do not regularly supply emergency contraceptives to female rape victims.[63] A survey of Pennsylvania hospital emergency rooms between 2000 and 2002 found that 10 percent of hospitals did not even offer emergency contraceptives as an option for sexually assaulted patients.[64] In Wisconsin, only 9 of the 35 Catholic hospitals supply emergency contraceptives to rape victims.[65] Only 16 states require that emergency rooms provide information about emergency contraceptives to victims of sexual assault.[66] Therefore, services in many states are inadequate and leave sexual assault victims vulnerable for traumatic pregnancies and possible abortions.

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[60] Guttmacher Institute. "State Policies in Brief: Emergency Contraceptives". 1.
[61] Foster, Diana Greene et. al. 2006. "Pharmacy Access to Emergency Contraception in California". Perspectives on Sexual and Reproductive Health. 38.1: 46-52. pg 1.
[62] "Compassionate Assistance for Rape and Emergencies Act of 2007".
[63] American Civil Liberties Union 2.
[64] Boonstra 10.
[65] Howard, Jane. "State legislators introduce 'Rape Victims Act'". The Badger Herald. 10 March, 2005. Online. Internet: http://badgerherald.com/news/2005/03/10/state_legislators_in.php
[66] Guttmacher Institute "State Policies in Brief: Emergency Contraception" 1.

Lack of education about emergency contraceptives is also an issue for victims of sexual assault. Many women do not know that there is a drug that can prevent pregnancy and as a result may not ask medical providers to supply it. In areas where emergency contraception is not widely discussed or distributed, victims without knowledge of the method are at a particular disadvantage. The Emergency Contraception Education Act, introduced on August 24, 2007 by Congressmember Slaughter (D, New York), would fund public health efforts and campaigns to education women about the benefits and availability of emergency contraception.[67] Increasing the number of gynecologists and general practitioners who inform patients about emergency contraceptives and developing public media campaigns would help increase education about the drug. Educating women emergency contraception is especially important for victims of sexual assault.

During Bush's presidency, access to contraceptive services has declined significantly. In September 2004, the Department of Justice (DOJ) released guidelines about medical protocol surrounding victims of sexual assault that did not include the mention of emergency contraceptives.[68] The 130 page report, entitled *National Protocol for Sexual Assault Medical Forensic Examinations*, sets the standards for medical protocol around the nation and therefore has the potential to hinder access to emergency contraceptives for thousands of women.[69] This exclusion represented a shift towards more conservative policies surrounding contraception especially because dispensing

[67] NARAL, Pro-Choice America. "Pro-Choice Americans Issue State of the Union Challenge to President Bush". NARAL Press Releases. 18 January, 2007. Online. Internet: http://www.prochoiceamerica.org/news/press-releases/2007/pr01182007_bushsotu.html
[68] Planned Parenthood. "'Best Help for Rape Victims Act' Giant Step Forward for Survivors of Sexual Assault". 14 March, 2005. Online. Internet: http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/victims-act.html
[69] Trussel 8

information about emergency contraception was encouraged in previous handbooks. The DOJ manual gives medical professionals no advice as to how to discuss or distribute emergency contraception to victims. Similarly, the Department of Defense Pharmacy and Therapeutics Committee removed emergency contraceptives from the list of medications every Medical Treatment Facility should stock. As a result, women in the military are unable to obtain the drug, a particular concern for women soldiers who are raped.[70] The Pentagon records indicate that sexual assaults in the military increased by 24 percent in 2006 for a total number of 3000 reported assaults in 2006.[71] Military women, who are at increasing risk for sexual assault, do not even have access to this important drug.

There is widespread support for increasing access to emergency contraceptives for victims of sexual assault and federal and state legislation is underway in support of this issue. A recent poll found that 80 percent of American women believe that all hospitals, regardless of religious affiliation, should provide emergency contraception to victims of sexual assault.[72] Widespread constituency support encourages legislators to demand rights for rape victims by pushing for legislation on a state and federal level. Currently, 16 states require hospital emergency rooms to give emergency contraceptive-related services to sexual assault patients; 15 states require that emergency rooms discuss emergency contraceptives with patients and 11 states require emergency rooms to provide emergency contraceptives to victims if it is requested.[73] Even though steps are

[70] Trussel 8
[71] Press Office of Hilary Clinton. "Senator Clinton Introduces Bill to Give Servicewomen Access to Emergency Contraception". 17 July, 2007.
[72] NARAL, Pro-Choice America.
[73] Guttmacher Institute "State Policies in Brief: Emergency Contraceptives" 1.
For a list of emergency contraceptives by state see Appendix 3, pg. 68

being made in the right direction, more work needs to be done to ensure that victims of sexual assault are given emergency contraception in hospital emergency rooms.

The "Compassionate Assistance for Rape Emergencies Act of 2007" was introduced into the US Senate by Senator Clinton on August 26, 2007. This act seeks to deny federal Medicare or Medicaid funds to hospitals that do not provide emergency contraceptives to victims of sexual assault.[74] This policy has generated support among pro-choice activists and organizations around the country including NARAL and Planned Parenthood. A similar bill entitled "Best Help for Rape Victims Act" was introduced into the House in 2005.[75]

Sexual Assault and Rape

Sexual assault and rape is a huge problem in the United States. Although the number of sexual assaults is declining, high levels of sexual assault persist. One out of six American women are victims of sexual assault and every two and a half minutes someone is sexually assaulted in America.[76] Of the percentage of rape victims, 44 percent are under the age of 18. Young females are four times more likely to be sexually assaulted that any other group. Most sexual assaults and rapes are committed by someone who knows the victim. In fact, 73 percent of sexual assaults in 2005 were carried out by non-strangers.[77] In 2006 there were 656 reported incidences of forcible rape reported to

[74] "Compassionate Assistance for Rape and Emergencies Act of 2007".
[75] Planned Parenthood. "'Best Help for Rape Victims Act' Giant Step Forward for Survivors of Sexual Assault".
[76] Rape, Abuse & Incest National Network (RAINN). "Statistics: Key Facts". Online. Internet: http://rainn.org/statistics/index.html. pg 1
[77] Rape, Abuse & Incest National Network (RAINN). "Statistics: Key Facts". 3

police in Los Angeles County, but the total number of rapes or attempted rapes is much higher.[78]

Sexual assault is legally defined as any genital, oral, or anal penetration by a part of the accused's body or by an object, using force or without the victim's consent. Sexual assault has been used to expand the definition of rape to be gender-neutral. Rape, on the other hand, is defined similarly, and is often divided into the categories of date rape, acquaintance rape, rape, statutory rape, sexual child abuse and incest.[79] In California, rape is defined as an act of intercourse with a person who cannot give legal consent, by force or violence, with a person who is unconscious, or says no.[80] Children, defined as anyone under the age of 18 in California, are unable to consent to sexual relations with an adult even if it is consensual. Sex with a minor is called statutory rape or sexual child abuse.

Sexual assault is one of the most underreported crimes in America. A study by the U.S. Department of Justice in 2002 indicates that 63 percent of completed rapes, 65 percent of attempted rapes and 74 percent of completed and attempted sexual assaults against women were not reported to police.[81] Sexual assault, rape and attempted sexual assault often goes unreported for a number of reasons including fear of reprisal, to protect the offender, and fear of police. Sexual assault and rape may also go unreported if the victim and the offender know each other. Studies have shown that the closer the

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[78] Los Angeles County Sheriffs Department. "Crime and Arrest Statistics 2006". Online. Internet: http://www.lasd.org/sites/yir9600/yir2006/contents.htm

[79] Medem: Connecting Physicians and Patients. "American College of Obstetricians and Gynecologists: Definitions of Sexual Assault". Online. Internet: http://www.medem.com/medlb/article_detaillb.cfm?article_ID=ZZZMR97EKEC&sub_cat=6

[80] Rape, Abuse & Incest Network (RAINN). Online. Internet: http://www.rainn.org/what-should-i-do/criminal-statutes-of-limitation/index.html#CA

[81] Rennison, Callie Marie. "Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2002". Department of Justice: Bureau of Justice Statistics Selected Findings. August 2002. pg. 2

relationship between the perpetrator and the female victim, the less likely the victim will report the crime to the police.[82] Because most rapes are committed by acquaintances, relatives or intimate partners, this could significantly lower reporting rates.

The sensitive nature of rape and sexual assault also prevents many victims from receiving medical help. The Department of Justice found that most women who are sexually assaulted or raped do not seek medical help. Only 32 percent of completed rape victims, 32 percent of injured attempted rape victims and 27 percent of injured sexual assault victims received medical treatment. Of these women who sought medical help, 48 percent were treated at the scene or at home, but not admitted to a hospital.[83] Due to the trauma of sexual assault or rape it is even more imperative that more women and men receive medical assistance for their injuries.

There are significant psychological impacts of sexual assault. After experiencing sexual assault, many victims suffer from Rape-Related Post Traumatic Stress Disorder, also known as Rape Trauma Syndrome, which results in persistent flashbacks or nightmares of the assault, social withdrawal and lack of feelings, avoidance of behaviors and actions that relate to the rape, and increased physiological arousal characteristics that can affect sleep and lead to exaggerated reactions to normal daily situations.[84] Due to the frightening nature of the event, victims often experience shock, feelings of shame and self-blame, intense emotions, anxiety, depression, fears about safety, avoidance of sex,

[82] Rennison 3
[83] Rennison 2
[84] Rape, Abuse & Incest Network (RAINN). "Effects of Rape". Online. Internet: http://www.rainn.org/statistics/effects-of-rape.html pg. 1

and physical symptoms like headaches.[85] Some or all of these symptoms may appear suddenly after the rape or be significantly delayed.

[85] Rape Treatment Center, Santa Monica UCLA Med Center. “Impact of Rape: Common Reactions”. Online. Internet: http://66.216.123.69/RTC/Impact+of+Rape/Common+Reactions/

ACCESS FOR VICTIMS OF SEXUAL ASSAULT

If a woman is sexually assaulted, there are several scenarios that can follow. A woman may choose to report the incident to the police, who would then escort the victim to the nearest emergency facility that has a Sexual Assault Response Team (SART) Center so the woman can receive a forensic examination and crucial medical services. Or an assault victim may go directly to the hospital by herself or with supporters following an attack. If the hospital does not have a SART center, the patient is referred to the nearest hospital which provides these services. If the victim lives in a state which mandates that emergency rooms give information and dispense emergency contraception, she may have access to the drug. If not, she may not even know that she has that option. A forensic nurse examiner may refer the victim to a councilor, usually stationed at a nearby rape crisis center. Or, a victim of sexual assault may choose not to report to the police or receive medical attention. If she knows about emergency contraceptives she may go to the nearest pharmacy in search of this resource, or she may have a trusted loved one go for her. If she does not live close enough to a pharmacy that stocks emergency contraceptives over-the-counter she may not be able to prevent a possible pregnancy.

This is why access to services that provide emergency contraception to victims of sexual assault is important. The sooner emergency contraceptives are provided for victims of sexual assault, the less likely these women will develop unwanted, even traumatizing pregnancies. Examining the system of support for victims following an assault is a crucial part of evaluating the level of access to emergency contraceptives.

The following section provides a brief background of pharmacy access and protocol, SART history and SART teams and hospitals in Los Angeles, and the resources rape crisis centers in Los Angeles provide for victims of sexual assault. Data was gathered from communicating with non-profit organizations, Sexual Assault Response Team organizers and Rape Crisis centers in Los Angeles County and analyzing existing studies and information about these services.

Access to Emergency Contraceptives Over-the-Counter in California

Pharmacy Access Partnership, a non-profit devoted to expanding access to contraceptive services in pharmacies, was a valuable resource in determining the state of access to emergency contraceptives in California. In 2005, Pharmacy Access Partnership developed a map of all the pharmacies in California that have one pharmacist trained to distribute emergency contraceptives. However, this map defines access to emergency contraceptives as within 10 miles from one or more pharmacies.[86] This broad definition of access does not take into account transportation limitations or possible disparities by race or income.

Because Pharmacy Access Partnership conducts studies that mostly focus on California as a whole, it was difficult to obtain specific information about Los Angeles County. However, their website, which contains numerous publications and lists pharmacies with trained pharmacists who can distribute over-the-counter emergency contraceptives, was helpful in evaluating access. Currently, there is no complete list of all the pharmacies in California that actually stock emergency contraceptives, but steps are being taken to improve the comprehensive list of pharmacies by state, county, city or zip code. Currently, pharmacies are only on the list if they ask to be. Princeton College

[86] For the Pharmacy Access Partnership map see Appendix 2, pg. 67

has developed a website that provides a comprehensive search by zip code of all the pharmacies in the United States that stock emergency contraceptives and insurance providers who cover Plan B. However, the website does not allow the viewer to search by city or county, making it difficult to obtain a complete list of the pharmacies that stock Plan B regionally.

Pharmacy Protocol for Emergency Contraceptives Distribution in California

In order to distribute emergency contraceptives without a prescription, a pharmacy must have one pharmacist who is trained on how to administer the drug. Training programs for pharmacists have evolved over the years. Initially training programs were 20 hours, but as of 2004 only one hour of training was required by California State law. California Senate Bill 490, which was effective in January 2004, helped simplify the process of providing emergency contraceptives in pharmacies without a prescription by developing a standard protocol that all trained pharmacists can download online. And in June 2004, Pharmacy Access Partnership developed a one hour online training program that meets California training standards.[87] This process makes it easier for pharmacies to stock emergency contraceptives and distribute the drug without a prescription.

There is specific protocol that pharmacists are expected to follow when dispensing emergency contraceptives. Pharmacists often ask a series of questions to determine the need for treatment. These questions can include the date of the patient's last period and when unprotected sex occurred.[88] If the patient is deemed eligible for emergency contraceptives, the pharmacist will provide the patient with a standardized

[87] Pharmacy Access Partnership. "EC story in California". Online. Internet: http://www.pharmacyaccess.org/ECStoryInCA.htm
[88] Pharmacy Access Partnership. "Emergency Contraception: Getting EC".

fact sheet about emergency contraceptives.[89] If the pharmacy does not carry emergency contraceptives, a pharmacist is required to refer the client to another emergency contraceptive provider.[90]

Many pharmacies in California charge an administrative fee in addition to the cost of the drug to pay for the counseling component of providing emergency contraceptives to patients. California Senate Bill 545, enacted in 2004, prohibited pharmacies from charging more than 10 dollars for this consultation fee.[91] This fee is in addition to the price of emergency contraception in pharmacies which ranges from $20-50.[92]

Sexual Assault Response Teams

Sexual Assault Response Teams (SARTs) were first created in the 1970s in response to the need to improve resources available to rape victims. The primary goals of SARTs are to respond to the needs of victims of sexual assault and to provide necessary information, medical care, and services to these victims.[93] Services that SARTs provide vary, but can include: supporting victims through advocacy, counseling and intervention; providing medical and forensic examinations; and offering law enforcement assistance.[94] SARTs are commonly composed of highly trained forensic nurse professionals who specialize in responding to the immediate physical and mental needs of sexual assault victims and gather information to provide to police.

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[89] See a copy of the Fact Sheets given to patients who receive emergency contraceptives from pharmacies in California in Appendix 4, pg. 69

[90] Pharmacy Access Partnership. "Emergency Contraception Drug Therapy Collaborative Agreement Protocol". Emergency Contraceptive Protocol. Online. Internet: http//www.pharmacyaccess.org/ECprotocols.htm

[91] Pharmacy Access Partnership. "EC story in California".

[92] Pharmacy Access Partnership. "Emergency Contraception: Getting EC".

[93] National Sexual Violence Resource Center. "Report on the National Needs Assessment of Sexual Assault Response Teams". 1 March, 2006. pg. 1

[94] National Sexual Violence Resource Center 2

A 2006 study conducted by the National Sexual Violence Resource Center that examines and compares SART programs nationally found that there is a lack of central organization to these groups nationwide. Rarely is there an overall administer for a region, and SART teams are often labeled under victim advocacy agencies, health centers, law enforcement agencies, campuses, or family justice centers.[95] Without this central organization, it is difficult to locate or contact SART teams, leading to disjointed communication between local SARTs themselves. SART teams generally establish agreements informally, relying on verbal communication rather than written agreements. Most SART teams do not receive direct funding, but do sometimes receive federal funding in the form of grants. Training for SARTs take place locally and vary depending on regional protocol.[96] This study shows that SART protocol often includes developing protocol for forensic examinations, medical treatment, dispatchers, advocates and law enforcement.[97]

The survey conducted by National Sexual Violence Resource Center of 258 SART teams indicated the types of services forensic examiners provide for victims of sexual assault.[98] Forensic exams are most likely to take place in a hospital, where a number of services are provided. The results also show that 62 percent of forensic exams include supplying emergency contraceptives or giving victims referrals for emergency contraceptives (23%). Fifty four percent of forensic exams include testing for sexually

[95] National Sexual Violence Resource Center 2.
[96] National Sexual Violence Resource Center 2
[97] National Sexual Violence Resource Center 11
[98] National Sexual Violence Resource Center 4

transmitted infections and 55 percent provide crisis intervention services.[99] This national survey shows a sample of the types of services that SARTs provide.

Some localities have developed manuals for how SARTs should operate. In April, 2001 San Diego County developed a Standards of Practice for SARTs that outline the priorities and protocols for dealing with sexual assault victims. This report outlines the role of forensic examiners when treating victims of sexual assault. Some of the standards for care include involving and informing the patient in the exam and maintaining confidentiality of the patient. However, there is no part of the report which mentions medical tests or drugs that should be provided for the victim.[100] The report fails to mention the importance of offering emergency contraceptives to victims of sexual assault. Although California law requires hospitals to give information about emergency contraceptives and dispense it upon request, it is important to outline the standards of care for victims of sexual assault in the SART guidelines. However, this report outlines the roles different resources for victims of sexual assault should play following an assault, a critical component to improving organization. Written guidelines have the potential to improve the overall quality of care for victims of sexual assault in San Diego County.

SARTs and SART Hospitals in LA County

There are 8 SART forensic nurse teams that provide services to 12 SART hospitals in Los Angeles County.[101] Because there are more SART hospitals than SARTs, some SARTs frequent more than one hospital. Many of these SART teams are

[99] National Sexual Violence Resource Center 16
[100] County of San Diego Board of Supervisors. "San Diego County Sexual Assault Team (SART): Standards of Practice for Members of the Interdisciplinary SART Team". April 2001. Online. Internet: http://www.mysati.com/Downloads/SART_Standards.pdf
[101] See Appendix 5a., pg. 71 for a list of SART Hospitals in Los Angeles County.

run out of advocacy organizations or rape crisis centers. A SART hospital is required to have an emergency room and there is a SART center at each SART hospital. Some hospitals have a separate area to perform sexual assault forensic examinations and other hospitals conduct the exams in the emergency room. If a victim of sexual assault visits a hospital that is not connected to a SART center, the victim is referred out to a hospital that provides these services. Due to the trauma of sexual assault, most victims do not receive medical care and therefore do not receive emergency contraceptives.

According to Peace Over Violence in Los Angeles, an agency dedicated to preventing and helping people who are victims of abuse, The Los Angeles Sexual Assault Coordinating Council developed LA County SART standards a number of years ago. However, these standards are not easily accessible or available on the LA County website. Additionally, a comprehensive list of SART teams and hospitals are not available online.

Rape Crisis Centers in LA County

There are 12 rape crisis centers in Los Angeles County that provide services to victims of sexual assault.[102] Of these 12 centers, only one, the Rape Treatment Center at the UCLA Medical Center in Santa Monica, is located within a SART hospital. Other rape crisis centers have SART organization on site, but do not provide emergency contraceptive services to patients. The East Los Angeles Women's Center indicated that costs of emergency contraceptives are too high to provide them to women. Additionally, most of the women who visit this center have either received information about emergency contraceptives from hospitals, or are dealing with sexual assault experiences from the past, for which they did not receive medical care or emergency contraception. If

[102] See Appendix 5c., pg. 71 for a list of rape crisis centers in Los Angeles County

a victim is in need of emergency contraception when she visits the center, the East Los Angeles Women's Center gets Plan B through the Pacific Women's institute, but does not provide referrals to pharmacy providers or other clinics.

Rape crisis centers in Los Angeles County mostly provide follow-up treatment for survivors of sexual assault including counseling, group sessions, and sponsor 24-hour hotlines. Therefore, most rape crisis centers are not ideal places for victims of sexual assault to receive emergency contraceptives. Ideally women who are sexually assaulted should receive emergency contraceptives during forensic examinations and can use rape crisis centers for follow-up care.

SPATIAL ANALYSIS

Examining differing levels of access to emergency contraceptives for victims of sexual assault based on race and ethnicity is important in determining how to improve and expand access in Los Angeles County. Female victims of sexual assault who do not live near SART hospitals, any medical facility or pharmacies that stock emergency contraceptives may be less likely to get the resources they need to prevent unwanted pregnancies. A spatial analysis database is an ideal way to represent multiple data layers simultaneously, and analyze the spatial results. This may be one of the first studies that examines the relationships between income and race and locations of sexual assault resources in Los Angeles County using spatial analysis tools.

Past Studies

Some studies have been conducted that look at the relationship between race and income and healthcare facilities. A recent study by the Community Institute for Policy Heuristics, Education and Research (CIPHER) in 2005 examines the role of race and income in determining access to healthcare services in Los Angeles County. Focusing primarily on hospitals, the report examines low-income and different racial community's access to healthcare in Los Angeles through GIS mapping, and linear regression analysis.[103]

Los Angeles County was the focus of this study because of its high levels of unemployment and racial segregation. Los Angeles County has an unemployment rate of 9.1 percent, which disproportionally affects people of color. The unemployment rate for Latinos is 9.9 percent and is 13.8 percent for African American, both higher than the

[103] Bowden, Angela and Joanna Lee. "The Role of Race and Class in Determining the Geographic Distribution of Healthcare Facilities and Healthcare Employees in Los Angeles County". Community Institute for Policy Heuristics, Education and Research. April 2005. pg. 2

county average.[104] African Americans and Latinos are concentrated in South and East Los Angeles, areas which have few hospitals. The study shows that there is a correlation between areas of high poverty and all healthcare facilities that are facing closure or have already been shut down. In fact, out of the 23 hospitals that were shut down prior to 2005, six were located in South Los Angeles. [105] Spatial analysis determined that "the census tracts in South Los Angeles that are not within a three mile radius of a healthcare facility providing basic emergency services have the highest concentrations of poverty uninsurance and people of color in the entire county".[106] These areas are also the only areas with average or above average population densities that are not within a 3 mile radius of emergency services.[107] These areas are placed at a significant disadvantage for accessing healthcare because many of them do not have insurance and rely on emergency hospitals for their primary source of medical care. Overall, the study determined that race does contribute to access to healthcare, but results were not conclusive about the effect of income on healthcare accessibility. The differing results between the linear regression and the mapping indicate that more work needs to be done to evaluate the role that race and class play in healthcare access in Los Angeles County.

This study will focus primarily on access to pharmacies and SART hospitals, depending on race and ethnicity. Comparing the locations of SART hospitals and general hospitals is also utilized to determine the level of access to emergency contraceptives. Since pharmacies that provide emergency contraceptives and SART hospitals are two

[104] Bowden 7-8
[105] Bowden 9-10
[106] Bowden 13
[107] Bowden 12

major resources for the distribution of emergency contraception, they were used to evaluate the level of access varying by race and income in Los Angeles County.

Spatial Analysis Methods

In order to determine if there are disparities in the accessibility of emergency contraception for victims from different racial and/or economic backgrounds, a geospatial database was utilized. Geographic Information System (GIS) tools like ArcMap and ArcCatalog allowed for analysis of several data layers including the locations of hospitals with Sexual Assault Response Team (SART) centers, pharmacies with one pharmacist trained to distribute emergency contraceptives, general Los Angeles County hospital data and racial and income demographics from the 2000 census. ArcCatalog was used to geocode non-spatial data into a data layer that could be referenced spatially in ArcMap, the program used to formulate and display the maps.

I defined access to pharmacies that could distribute emergency contraceptives and general healthcare facilities as within a half mile radius of residents. Although a half mile seems a short distance for residents with access to a car, there are many people who rely on walking or public transportation in Los Angeles County, especially residents who live in low-income communities. I defined access to SART hospitals as within a one mile radius of all residents, since many of these women may be escorted to these hospitals by police following an assault. The radius around SART hospitals is still small to account for women who seek hospital assistance without the help of police, friends or relatives. Due to a limited number of SART hospitals, adequate access is out of the question.

In the following sections, I will define my data sources, the challenges of defining and compiling data, and how I compiled the maps.

Data Sources

The following sources were used in my mapping analysis:

1) The US Census Bureau 2000 geographic data set for census tracts, racial demographics, population density and streets found on the ESRI website (http://arcdata.esri.com/data/tiger2000/tiger_download.cfm).
2) US Census Bureau 2000 demographics for median household income (www.census.gov).
3) The geographic data layer of healthcare facilities in Los Angeles County from The Teale Data Center of CalDTS (http://www.dts.ca.gov/).
4) Pharmacy locations from the Pharmacy Access Partnership (http://www.ec-help.org/single_list.asp?state=CA&county=Los+Angeles)
5) The list of SART hospital names from Peace Over Violence in Los Angeles and Google Maps (www.googlemaps.com) to find their addresses.

Data was compiled then analyzed in ArcMap. James Sadd, a Professor at Occidental College, helped locate data sources and geocode the pharmacy database.

Defining the Data

In order to look at differences in access based on race, I created maps to show access for Latinos, African Americans, Non-white, and white people. One map displays access in relation to median household income, which I defined by dividing incomes into five categories. The two lowest of the five classes, I defined as low-income, with the lowest class with incomes between 0 and 27,315 representing very low income. Additionally, I created a map to display variations in population density in order to see if pharmacies and SART hospitals were concentrated in areas of high population density.

The data layer composed of Los Angeles healthcare facilities includes all private and public hospitals, not all of which contain emergency rooms. All SART hospitals contain emergency rooms, thus limiting accurate comparisons of access between the two layers.

The pharmacy locations shown are pharmacies that have a pharmacist trained on how to distribute emergency contraceptives over-the-counter. There is no current list of all pharmacies that actually stock emergency contraceptives because the list compiled by Pharmacy Access Partnership is dependent on pharmacies notifying them about employee training and eligibility. However, it is reasonable to predict that pharmacies with trained pharmacists already do or will stock emergency contraceptives. Although this data layer does not show the locations of all pharmacies that stock emergency contraceptives in Los Angeles County, it is a step towards examining access.

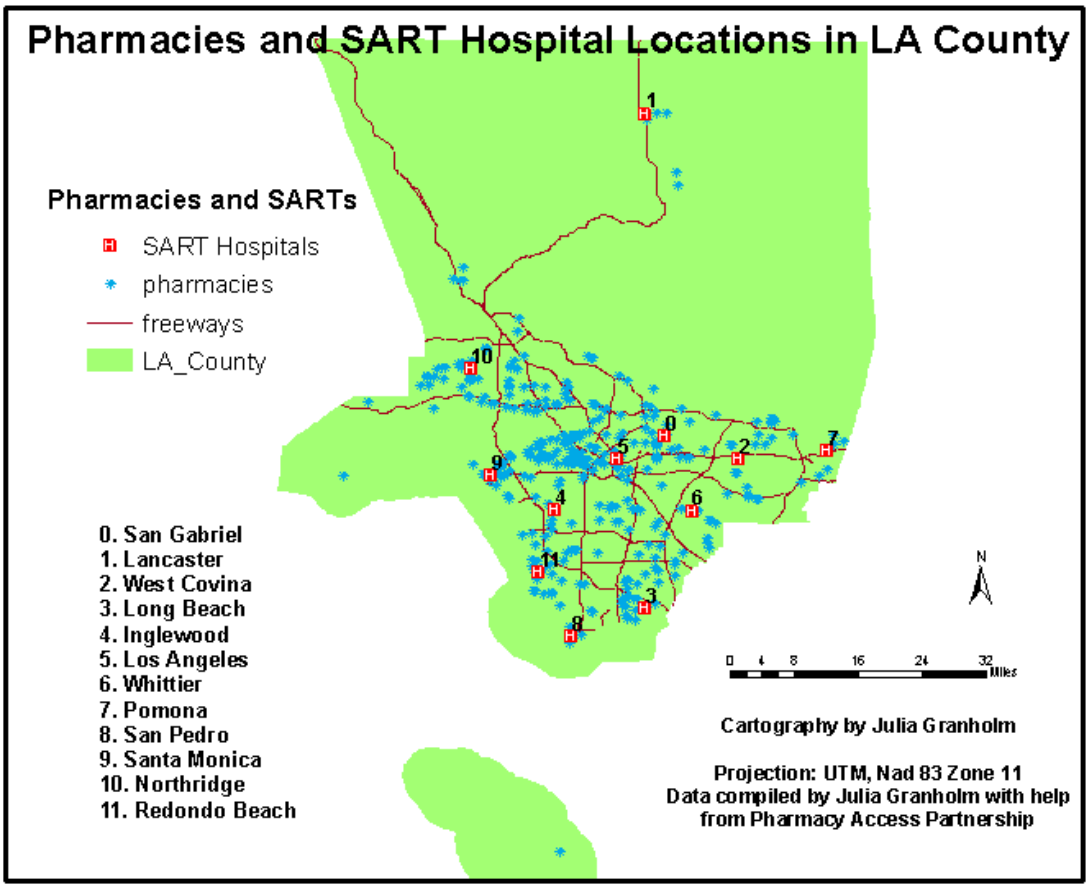
Mapping Process

The US Census Bureau and The Teale Center data could be imported into ArcMap directly after download, but Pharmacy and SART hospital locations were first compiled in excel, then imported into ArcMap as text files. Names and addresses were checked numerous times to ensure accuracy, but pharmacy addresses were difficult to locate geographically because they did not contain zip codes.

In order to show access depending on race and income, I created buffers of half a mile around hospitals and pharmacy locations and one mile buffers around SART hospitals. These areas the buffers encompass define the areas of access to these services. In order to show total access areas for victims of sexual assault, I combined the SART and pharmacy buffers by unioning them into one data layer. Areas outside the buffers represent inadequate access to hospitals and pharmacies. General spatial patterns were then analyzed based on whether racial and economic groups had different levels of access.

Spatial Analysis Results

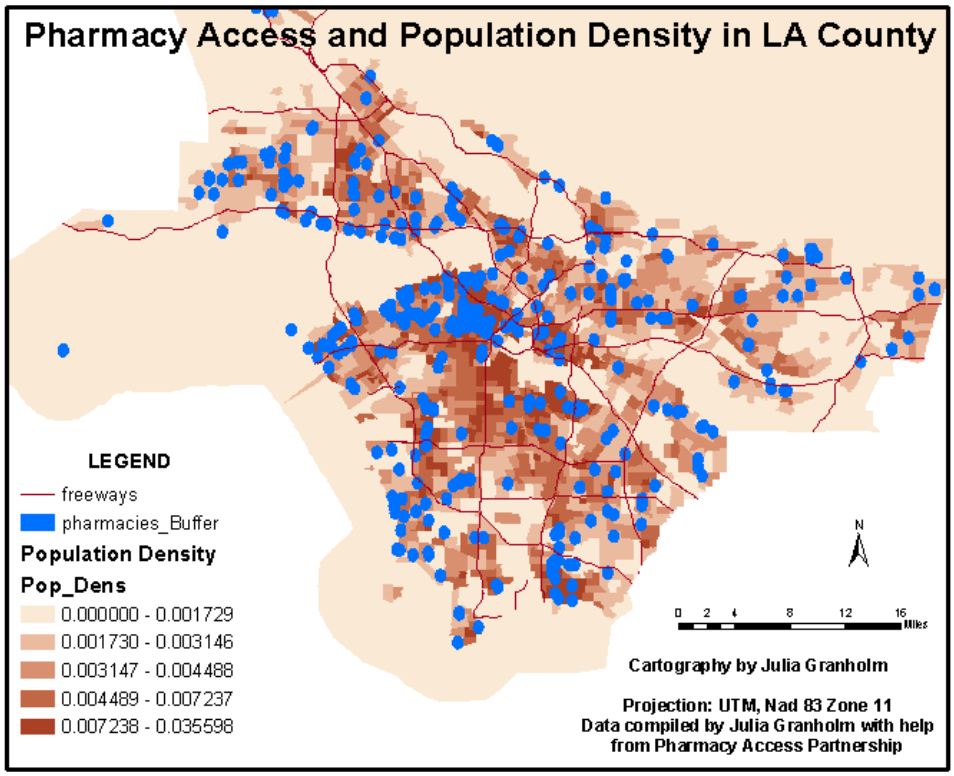
For women who do not live near pharmacies that dispense emergency contraceptives over the counter or SART hospitals, access to Plan B following an assault is limited. To determine access, the results are divided into access to pharmacies, access to SART teams and total access, comprised of the combination of the buffers around pharmacy and SART locations. Additionally, there is a comparison between the locations of general healthcare facilities and SART hospitals. Pharmacy and SART distribution, depending on different racial population densities and income levels, can be effectively evaluated spatially and visually through examining patterns on the maps.



General Findings

The majority of pharmacies and SART hospitals are not located in densely minority populated areas. Additionally, there is a shortage of pharmacies, healthcare facilities and SART hospitals in northern Los Angeles County. Although there are several pharmacies located in areas with minority populations, there are far more pharmacies in areas with majority white populations. The majority of SART hospitals are not within a mile radius of densely populated minority populated areas, indicated that access for minority racial populations may be difficult. Additionally, accessibility for women who live in the northern part of Los Angeles County, an area with high concentrations of white residents, may be difficult as well because most of the pharmacies and SART hospitals are located in central and south Los Angeles County. The lack of accessibility in the Northern half of Los Angeles County correlates with low population density in that region. Therefore, pharmacies and SART hospitals are thus more concentrated in areas with more people because there is more demand for their services. General healthcare facilities are fairly evenly distributed throughout densely populated minority areas, but the hospitals chosen as SART hospitals border these regions. Pharmacies and SART hospitals tend to be located in areas of moderate income.[108]

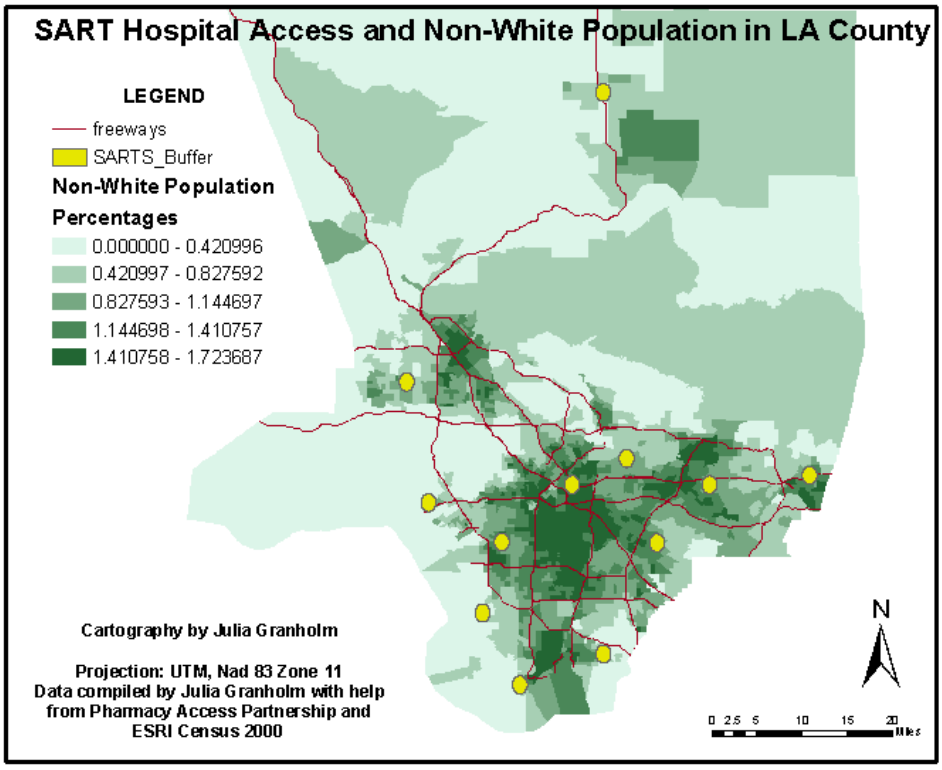
[108] See more maps in Appendix 1, pg. 62



Pharmacy Access

There is not a significant disparity in accessibility of emergency contraceptives in pharmacies between races. However, there is a lack of pharmacies in densely populated racial areas. There appear to be several more pharmacies in densely populated Latino areas than African American or Asian areas, but the difference small. Overall, white people who live in central and south Los Angeles County have higher accessibility than other groups, but north and parts of east Los Angeles County, which have high populations of white residents, have limited access to Plan B in pharmacies. These areas have low population densities, which limits the services available. Areas with medium-high concentrations of all races seemed to have the best accessibility to pharmacy services, but areas of high concentration had poor access to emergency contraceptives

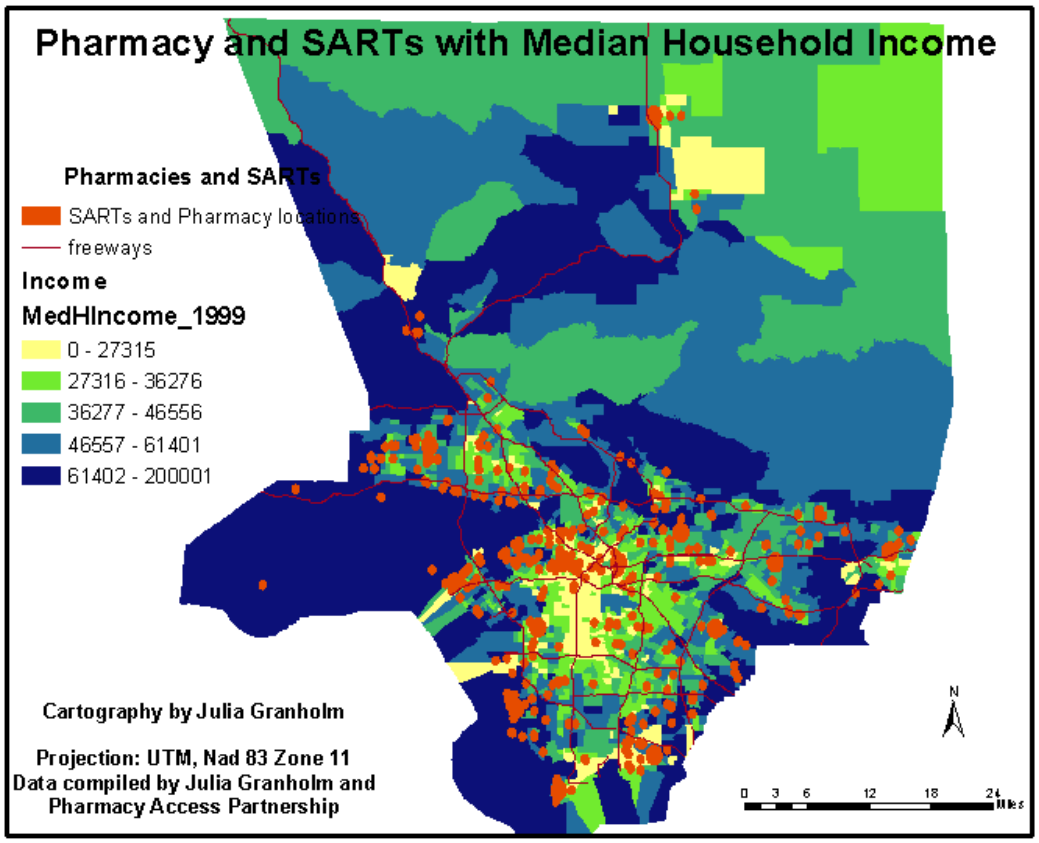
from pharmacies. A similar pattern occurred for income. Most of the pharmacies were located in the areas with moderate median household incomes.



SART Access

Generally, SART hospitals are not located in the highest populated minority neighborhoods, but they are located right on the outskirts. SART hospitals, for the most part, are also not located in areas with the highest density of white people. Many of the areas with high concentrations of high residents have low population densities, so there are fewer resources for these residents. In areas with the highest concentrations of Latino, Black and Asian populations, there are very few SART hospitals and therefore, little access to SART hospitals. SART hospitals are also located in areas with moderate median household income. Generally, the areas with the best access to SART hospitals

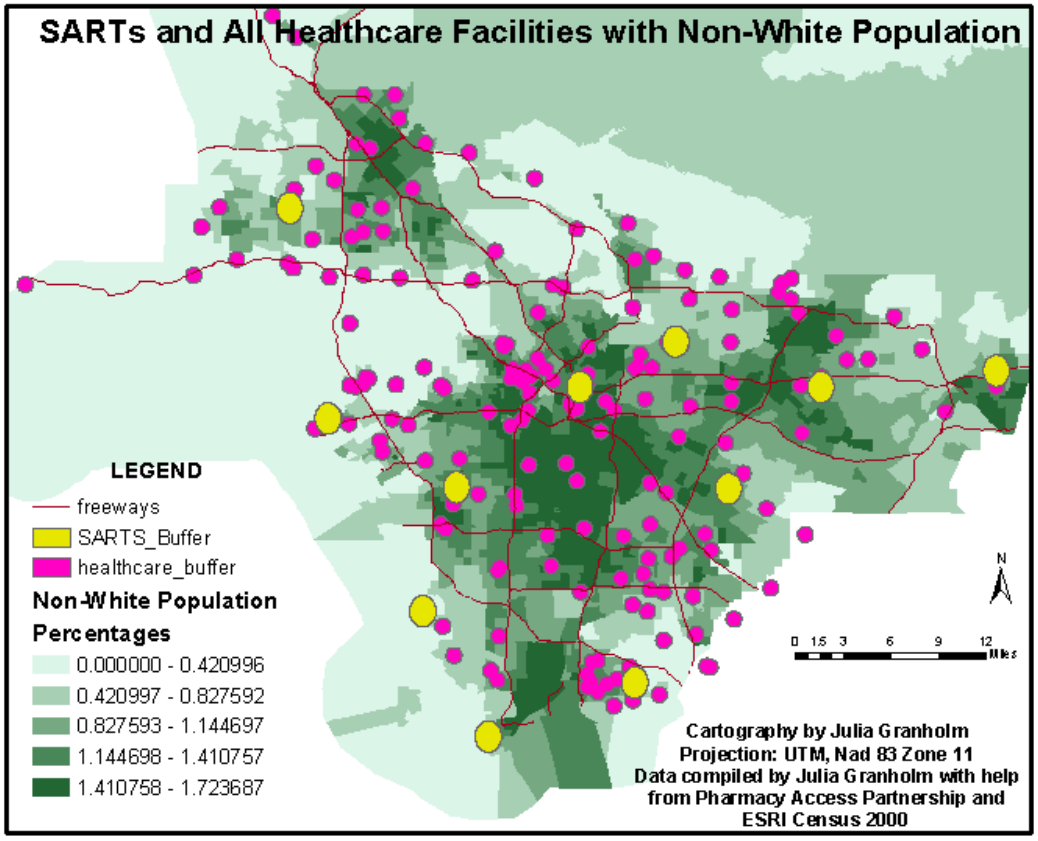
were areas with medium high levels of each racial population and incomes, not the areas with the highest concentration.



Pharmacy and SART Access

By combining SART and pharmacy access, the area of total access to emergency contraceptives increases. Although the variables together show similar results as the variables do apart, more resources mean more access for women in these areas. However, there is insufficient access in areas with high concentrations of each racial group, and there is inadequate access for low-income residents. Most pharmacies and SART hospitals are located on the border between areas with high minority population and areas with high numbers of white people. Most of these resources are also located in areas medium to high income levels. This indicates that access for people who live in areas

with moderate racial concentrations and moderate income levels is better than access for residents in areas of high racial densities and areas with high low-income populations.



SART Hospitals vs. General Healthcare Facilities

There are more general healthcare facilities located in areas with densely populated minority areas than there are SART hospitals in these areas. It seems as though SART hospitals were picked to accommodate both minority groups and the white population in LA and therefore locations were picked where racial concentration of any one group is not as strong. Similarly, there are more general healthcare facilities in low-income areas than SART hospitals. This could be due to the fact that there are significantly more general hospitals than SART hospitals. However, the lack of SART hospitals in low-income areas is limiting. Many low-income residents cannot afford cars,

and may not be able to travel long distances to healthcare facilities. In general there is better access to general healthcare facilities than there is to SART hospitals.

Spatial Analysis Results Summary

Access to emergency contraceptives in Los Angeles County is not sufficient. Areas with densely populated minority groups and low-income populations do not have adequate access to SART hospitals or pharmacies. For most groups and in most areas of Los Angeles County, access is limited and insufficient.[109] Access needs to improve to ensure that female victims of sexual assault can utilize this important resource.

[109] For more maps see Appendix 1, pg. 62

RECOMMENDATIONS

Based on the existing information about emergency contraceptives on a federal, state and local level and results collected in this study, there are several recommendations that could help improve the state of access to emergency contraceptives for all women and victims of sexual assault.

I. Recommendations for Policy and National Standards

There are several federal and statewide policies that could improve access to emergency contraceptives. Additionally, changes in national standard protocol for dealing with victims of sexual assault could be expanded to include distribution of emergency contraceptives. Some of these policies specifically target helping victims of sexual assault. However, some policy changes would expand access for women of all ages and backgrounds nationwide. Although many of these policy recommendations largely depend on federal and state policy makers, the general public and advocacy groups can put pressure on affiliates to pass laws that expand access to emergency contraceptives.

Pass national legislation to promote accessibility of emergency contraceptives for victims of sexual assault:

Several bills have been introduced into Congress that would help victims of sexual assault obtain emergency contraceptives. One such bill, called the "Compassionate Assistance for Rape and Emergencies Act of 2007", was introduced in the House of Representatives in January 2007 and in the Senate in April 2007. This bill would require that all hospitals that receive Federal funds through Medi-Care, provide information about and dispense emergency contraceptives upon request to victims of sexual

assault.[110] This bill would put economic pressure on hospitals to provide emergency contraceptives to sexual assault victims. If passed, this piece of legislation could challenge existing laws in states that prevent emergency contraceptive distribution in hospitals and increase opportunities for victims of sexual assault around the nation.

Legislation for women in the military like the "Compassionate Care for Servicewomen Act", introduced by Senator Clinton (D, New York) in July 2007, would increase emergency contraceptive access for servicewomen.[111] Because sexual assault rates for women in the military are increasing, legislation to help these women obtain emergency contraceptives is essential.

Pass state legislation to expand pharmacy access to emergency contraceptives:

Currently, only 9 states allow pharmacies to distribute emergency contraception without a prescription.[112] Since emergency contraception is the most effective the sooner it is used within 72 hours of unprotected sex, getting emergency contraceptives directly from pharmacies will cut down the time it takes to process a prescription. For victims of sexual assault this service is especially important if victims are wary of seeking doctor's assistance. Male or female friends are also able to obtain emergency contraceptives from a pharmacy without a prescription for a victim if she is unable to pick up the drug on her own. Expanding access to emergency contraception without a prescription may help speed up the process for obtaining emergency contraceptives and would give victims of sexual assault a greater chance of remaining anonymous.

There are laws in 7 states that allow pharmacists to dispense emergency contraceptives under a collaborative-practice agreement and several other states that have

[110] "Compassionate Assistance for Rape and Emergencies Act of 2007"
[111] Press Office for Hilary Clinton 1
[112] Guttmacher Institute. "State Policies in Brief: Emergency Contraception" 1

passed legislation to allow for more efficiency in filling prescriptions. However, pharmacy access to emergency contraceptives without a prescription is the most effective way to ensure that women are receiving services most efficiently and anonymously. States that actually limit distribution of emergency contraceptives in any form deny women and victims of sexual assault from receiving these valuable resources. Moving towards state policies that make it easier for women to receive emergency contraceptives in a time of need is essential for victims of sexual assault.

Pass legislation to increase Medi-Caid coverage for emergency contraceptives:

Medi-Caid does not cover emergency contraceptives in many states and even in those states where emergency contraceptives are covered, women have to wait long periods of time for reimbursement. Two states, Arkansas and North Carolina, have passed policies that exclude emergency contraceptives from contraceptive coverage mandates.[113] Emergency contraceptives should be covered for women in all states to ensure that women of all ages and income levels are able to afford the drug.

Finalize approval for women and men under age 18 to obtain emergency contraceptives from pharmacies without a prescription:

After approving Plan B as an over-the-counter drug in 2006, the Food and Drug Administration has still not come to a conclusion about the status of allowing women under the age of 18 from obtaining the drug.[114] The FDA chose to set an age cut-off for emergency contraceptives not because Plan B was deemed unsafe for women under the age of 18, but because it was an easy age restriction for pharmacists to remember. The lack of concrete reasons for barring over-the-counter access for girls under the age of 18

[113] Guttmacher Institute. "State Policies in Brief: Emergency Contraception" 2.
[114] Guttmacher Institute. "State Policies in Brief: Emergency Contraception" 1

should be addressed and the FDA should be pressured to change these regulations. Availability of emergency contraceptives to women under 18 would cause additional scrutiny because some opponents claim that increasing access to emergency contraceptives for minors will increase promiscuity. However no studies have proven that this theory is correct.[115]

Teenage accessibility is crucial for many reasons. By age 18, six out of ten women have had sexual intercourse and of the approximately 750,000 teen pregnancies in the US each year, 82 percent are unintended.[116] Additionally, 44 percent rape victims are under the age of 18.[117] Providing safe and accessible ways to access emergency contraceptives for teenagers may help them feel more comfortable seeking help. Going to a family doctor to obtain a prescription for emergency contraceptives may feel unsafe for many teenage girls, especially if they fear their families will find out. For teenage victims of sexual assault, the fear may be even greater, especially if they were abused by men they know. Since 73 percent of sexual assaults are committed by non-strangers, fear of retribution for these teenagers may seem daunting if they have to tell a doctor.[118]

Pass state legislation that requires emergency rooms to provide information about emergency contraceptives and dispense them upon request:

There are only 12 states that require emergency rooms to give information about emergency contraceptives and 13 states that mandate that hospital emergency rooms provide these services to victims of sexual assault.[119] Requiring that hospitals provide

[115] Boonstra 13
[116] Guttmacher Institute. "Sex and Pregnancy Among Teens". In Brief: Facts on Sex Education in the United States. December 2006. Online. Internet: http://www.guttmacher.org/pubs/fb_sexEd2006.html
[117] RAINN. "Statistics: Key Facts" 1
[118] RAINN. "Statistics: Key Facts" 2
[119] Guttmacher Institute. "State Policies in Brief: Emergency Contraception" 1.

emergency contraceptives is a crucial step towards increasing access for victims of sexual assault. The U.S. Department of Justice found that Forty eight percent of women who were treated for rape related injuries were treated at a hospital. For injured victims, the hospital is often their first avenue for help. Therefore, it is important they are given the option of taking emergency contraceptives. Even though less than half of female rape victims are treated at a hospital, it is important that these services are provided immediately and as part of protocol when dealing with victims of sexual assault especially.

Include emergency contraceptives in *National Protocol for Sexual Assault Medical Forensic Examinations:*

The most recent report issued by the Department of Justice entitled the *National Protocol for Sexual Assault Medical Forensic Examinations* does not mention providing information about or distributing emergency contraceptives to victims of sexual assault. Because national standards for Sexual Assault Response Teams do not include emergency contraceptives as part of the forensic examination plan, it is reasonable to assume that these protocols might be lacking in states and/or areas that do not require hospitals to distribute or mention emergency contraceptives to patients.

Providing information about emergency contraceptives should be a crucial component of a SART examination because it gives the woman the right to make an educated decision about her body. Even medical professional associations like the American College of Obstetricians and Gynecologists believe that emergency contraception should be provided for victims of sexual assault.[120] Therefore, areas that

[120] "Compassionate Assistance for Rape and Emergencies Act of 2007"

adapt their policies from the DOJ's report are not adequately prepared to give their sexual assaulted patients the best care possible.

II. Recommendations to Help Improve Existing Access

There are several ways existing access and knowledge about emergency contraceptives could be improved. By educating people about emergency contraceptives, increasing patient confidentiality, lowering costs and expanding resources where emergency contraceptives are available, access will improve. These recommendations can take place with the help of state and local governments, advocacy and non-profit groups, and medical organizations dedicated to the struggle of increasing accessibility of emergency contraceptives in California and nationwide.

Educational campaigns about emergency contraceptives:

Several organizations, including Pharmacy Access Partnership and Ogilvy Public Relations Worldwide, have tried to increase education about emergency contraception by sending out mailings, constructing helpful websites and creating emergency contraceptive hotlines. Additionally, emergency contraceptive initiatives have been featured in several newspapers including the *Los Angeles Times*, the *San Francisco Chronicle* and the *Sacramento Bee.*[121] However, more mainstream media attention, in the form of educational advertising campaigns, could be more effective in educating people about emergency contraceptives and where to access them. The state of California, along with local city governments should work together to promote Plan B as a safe and accessible form of pregnancy prevention.

Expand knowledge of emergency contraceptives through provider practices:

[121] Pharmacy Access Partnership. "EC story in California".

Primary and reproductive healthcare physicians rarely provide information about emergency contraception to patients on a regular basis. Currently, only 25 percent of gynecologists and 14 percent of general physicians regularly discuss emergency contraception with patients. Education for doctors about the benefits of emergency contraceptives will help them pass on critical information to their patients. Additionally, medical organizations like the American College of Obstetricians and Gynecologists are encouraging the distribution of emergency contraceptives though posters, audio tools, brochures and wallet information cards. Pressure from other medical organizations may help set a standard of care that encourages doctors to discuss emergency contraceptives with patients.

Confidentiality in pharmacies:

In states where women are able to obtain emergency contraceptives from pharmacies without a prescription, women often have to speak to a pharmacist and/or fill out a questionnaire to get Plan B. The pharmacist might ask questions such as: the start of the woman's last period and when the unprotected sex took place.[122] The woman is also given a written description of key facts about emergency contraceptives.[123] For female rape victims this process could be damaging and triggering, especially if they are forced to relay the circumstances of the attack or think about the event itself. Additionally, pharmacies can be crowded and if it is a local pharmacy the victim might be scared of being seen when obtaining emergency contraceptives.

In 2007, the Pharmacy Access Partnership and the Pacific Institute of Women's Health introduced the Client Confidentiality Card in California, which allows the patient

[122] Pharmacy Access Partnership. "Emergency Contraceptives: Getting EC".
[123] See Appendix 4 pg. 69 for Fact Sheet

to request emergency contraceptives through non-verbal communication.[124] These confidentiality cards were developed in response to a study that revealed that young women were hesitant to ask for emergency contraceptives in a pharmacy due to a lack of privacy.[125] However, Client Confidentiality Cards are not widely accessible. Organizations may order them directly from the Pharmacy Access Partnership or the Pacific Institute of Women's Health, but not all pharmacies or women have access to this helpful tool. This should be an option at all pharmacies that stock emergency contraceptives so that more client confidentiality is maintained.

Get rid of the pharmacy consultation fee to get emergency contraception:

Some pharmacies in states that allow emergency contraceptives to be distributed over-the-counter charge a fee for a pharmacist consultation. In California, a pharmacy may charge 10 dollars for a pharmacist consultation fee.[126] For women without insurance, this cost significantly increases the cost of receiving emergency contraception. Removing this cost will also help young women who have limited funds.

Pharmacies should provide lists of nearby family planning services for women without insurance:

Pharmacies should collaborate with nearby family planning clinics such as Planned Parenthood to ensure that women without insurance can get emergency contraceptives. Because the cost of Plan B can range anywhere from $20 to $50 in a pharmacy, it is important that women have other resources to turn to. Many family

[124] Pharmacy Access Partnership. "In the News". Online. Internet: http://www.pharmacyaccess.org/InTheNews.htm#June_1_2007
[125] Pharmacy Access Partnership and Pacific Institute for Women's Health. "Got Plan B?: The Client Confidentiality Card". May 2007. Online. Internet: http://www.pharmacyaccess.org/pdfs/CCC_ConceptPaper.pdf
[126] Pharmacy Access Partnership. "Getting EC".

planning clinics provide emergency contraceptives at sliding scales based on income and are a valuable resource for low-income women without insurance. Pharmacists should have lists of nearby clinics and provide information to women who cannot afford to purchase emergency contraceptives at a pharmacy.

III. Recommendations for Los Angeles County

There are several recommendations to help improve access to emergency contraceptives that are specific to Los Angeles County. These recommendations specifically target victims of sexual assault, but some these changes would also help all women and men in Los Angeles County who need emergency contraception.

Increased organization in the sexual assault resources community:

There should be more organization in the sexual assault resource network. Lack of organization in the sexual assault resource community made it difficult to gain sufficient information about access for victims of sexual assault. It was difficult to get in touch with anyone who knew how many SARTs there were, where the SART hospitals were and the components of the forensic nurse examination. It was especially difficult to obtain protocol for medical treatment of victims in SART hospitals and the follow-up care to which they are directed.

Organizations, medical professionals and crisis centers should work more closely together to maximize information and resources available for victims of sexual assault. For example, rape crisis centers should know nearby pharmacies that stock emergency contraceptives as well as the locations of SART hospitals and SART team information. In order to help female victims of sexual assault effectively, all these groups should meet regularly and be updated on current changes and events. One way to organize would be to

create an interactive website that provides information about all of these resources. Therefore, victims of sexual assault and the community that supports them will have the tools to get and stay informed about access to emergency contraceptives and other important services for victims.

Written SART guidelines for LA County:

Written guidelines for SARTs in Los Angeles County would help improve communication between SARTs, hospitals and local government. These standards should be developed through collaboration between the health community, women's resource groups and county officials to ensure that the process addresses the needs of victims of sexual assault and lives up to national, state and local standards. San Diego County created guidelines for an interdisciplinary SART team which determines responsibilities of all parties involved in the process of caring for victims of sexual assault. By outlining the roles of law enforcement officers, medical professional, advocates, counselors and prosecutors, San Diego formed a valuable collaborative network that can be utilized by victims of sexual assault.[127] This type of report would increase organization between resources for victims of sexual assault, therefore helping both victims of sexual assault and their allies.

Additionally, there should be an accessible report outlining the specific duties of Sexual Assault Forensic Examiners; created with the intention to standardize the process of care for Los Angeles County. Consistent standards of care will ensure that these examiners are following the best practices when treating victims of sexual assault. Furthermore, when SARTs in Los Angeles County meet they will be able to use this

[127] County of San Diego Board of Supervisors 2.

resource to discuss obstacles and successes in the system, leaving room for general systematic changes.

More SART hospitals:

There are only 12 SART hospitals to serve the needs of nearly 10 million people in Los Angeles County.[128] For low-income residents without insurance or reliable transportation, access to these hospitals is especially limited. Hospitals that can have SART programs have to have an emergency room. The SART examinations may take place in a separate area or directly in the emergency room. However, to provide SART services a SART center must be connected to the hospital. More hospitals should have the resources for SART programs to ensure that victims have more access to important services.

Better advertisement of the location of SART hospitals:

Finding all the hospitals with SARTs was extremely difficult. It is important that the locations of these hospitals be readily accessible for residents of Los Angeles County. Building a SART website that shows written SART protocol, locations of SART hospitals and other important resources for victims of sexual assault, would provide victims and allies with valuable information about available resources in Los Angeles County. Because there are so few hospitals that provide SART services, it is important that these hospitals also display information about their SART centers on their general websites.

Increased pharmacy access to emergency contraceptives:

[128] U.S. Census Bureau. "State & County Quickfacts: Los Angeles County, California". Online. Internet: http://quickfacts.census.gov/qfd/states/06/06037.html

Areas with high concentrations of racial groups and areas with low income have less access to emergency contraceptives. Most of the areas where access is especially limited are in low-income minority neighborhoods. Because many low income residents rely on public transportation, this limits access to pharmacies even more. Better pharmacy access to emergency contraceptives in low-income, minority neighborhoods would help increase services available to victims of sexual assault and may help prevent traumatic pregnancies.

Increased advertisement for pharmacies that do stock emergency contraceptives:

Information about availability of emergency contraceptives should be displayed on pharmacy websites and in the stores themselves. Pharmacies that do not provide over-the-counter access to Plan B should have a visible sign that informs customers so that patients do not have to ask at the counter. Additionally, pharmacies should have incentives to report that they stock emergency contraceptives to organizations like Pharmacy Access Partnership. Increase advertisement will increase education about emergency contraceptives and provide awareness about where to access emergency contraception.

CONCLUSION

Access to emergency contraception for all women and victims of sexual assault is inadequate nationwide, at a state level, and in Los Angeles County. Legislation that prevents and discourages accessibility continues to plague the US and only a small number of states have passed laws that further accessibility. Emergency contraceptives are largely invisible to the national public because of their absence in national medical guidelines, the news and educational campaigns, preventing them and from being thoroughly utilized. Additionally, emergency contraceptive access for victims of sexual assault in Los Angeles County is insufficient. Even though California has some of the best laws for enhancing access to the drug, resources for victims are limited at both the pharmacy and hospital level in Los Angeles County both in numbers and if residents live in densely populated racial and low-income neighborhoods. The lack of organization among SARTs in Los Angeles County also limits the services that victims can receive. If access in California is not sufficient it is startling how much work other states must need to take to improve access to emergency contraceptives.

Many of the recommendations provide avenues to improve access. However, much work needs to occur to enact change. Putting pressure on legislators to pass laws like the "Compassionate Assistance for Rape and Emergencies Act of 2007", would help increase the standards of care and accessibility to emergency contraceptives for victims of sexual assault. Additionally, getting involved with local organizations and non-profits that promote the expansion of contraception and work to improve rights for victims of sexual assault will help in the struggle to expand access. Putting pressure on legislators, government offices like the FDA, and local sexual assault resource networks is also

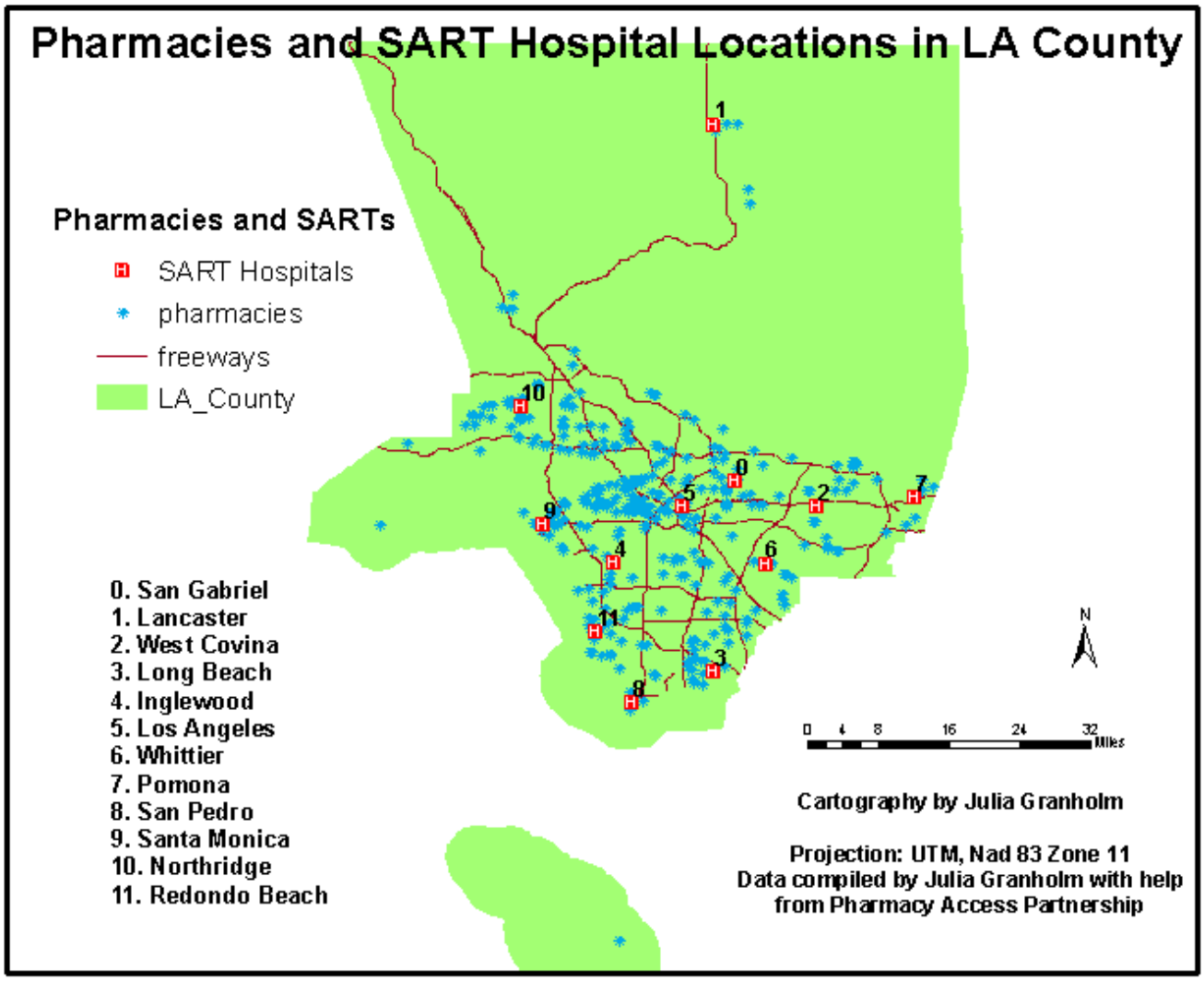
possible by conducting research that focuses on issues surrounding access to emergency contraception, especially for victims of sexual assault.

The complexity of this topic leaves many open-ended research questions available for future studies. More research needs to be conducted about the organization and components of SART teams in Los Angeles County including who is involved in these groups, how decisions are made, how often they meet and what are their protocols for treating victims of sexual assault. An examination of where sexual assaults take place in relation to pharmacies and SART hospitals could also enhance research on this topic and an evaluation of the role police play as resources to victims of sexual assault would be an important addition to this research. Additionally, research that includes experiences of victims of sexual assault would be helpful in painting a comprehensive picture of what is needed to help increase education and accessibility for victims of sexual assault, in addition to the need for confidentiality when obtaining the drug. Research that further addresses the implications of race and income in accessibility of emergency contraceptives would also add to the analysis and recommendations of improving access for victims of sexual assault and women nationwide. Determining the locations of other healthcare facilities and clinics would help expand the definition and the range of access to emergency contraceptives in Los Angeles County.

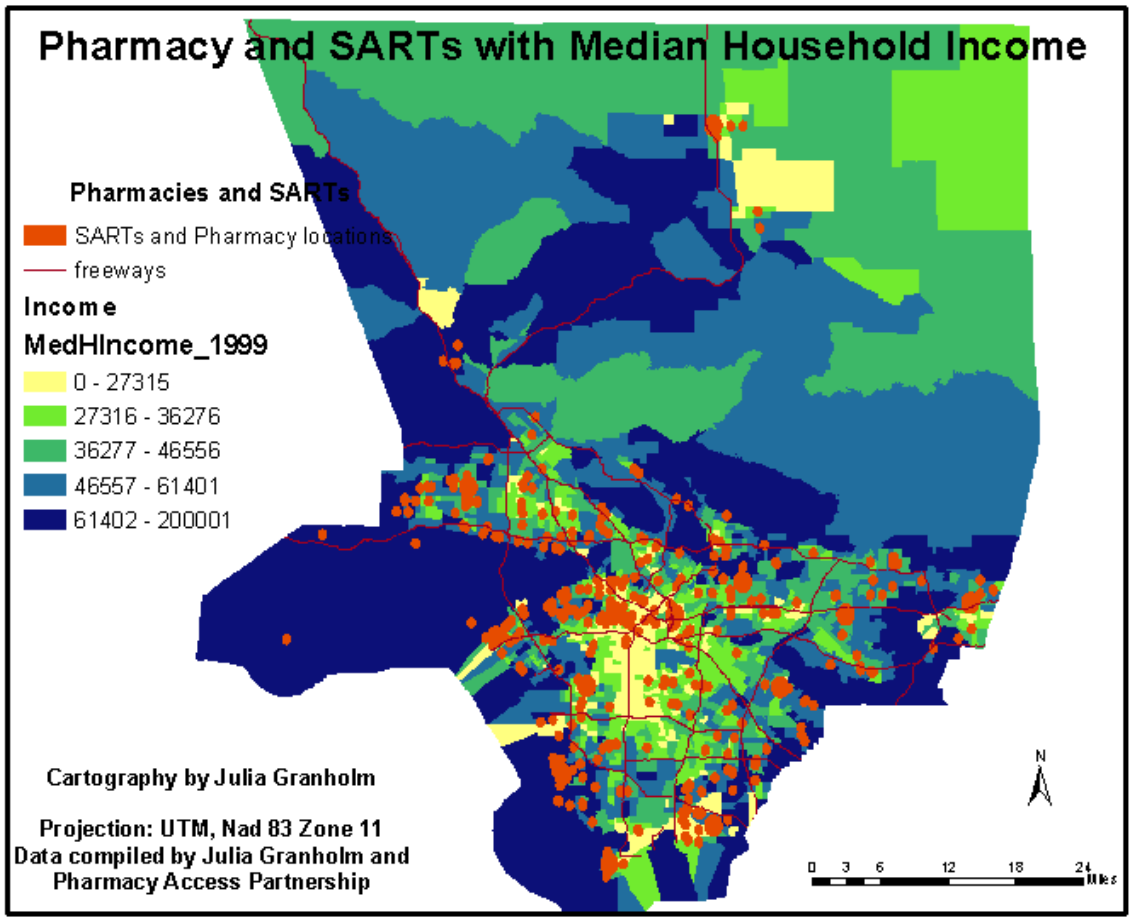
More work needs to be done to help improve access to emergency contraceptives for victims of sexual assault to ensure that these women can utilize the resources they need to protect themselves from unwanted pregnancies. It is only through an evaluation of access that the system can change to accommodate victims and their needs.

APPENDIX

1. Maps of Los Angeles County

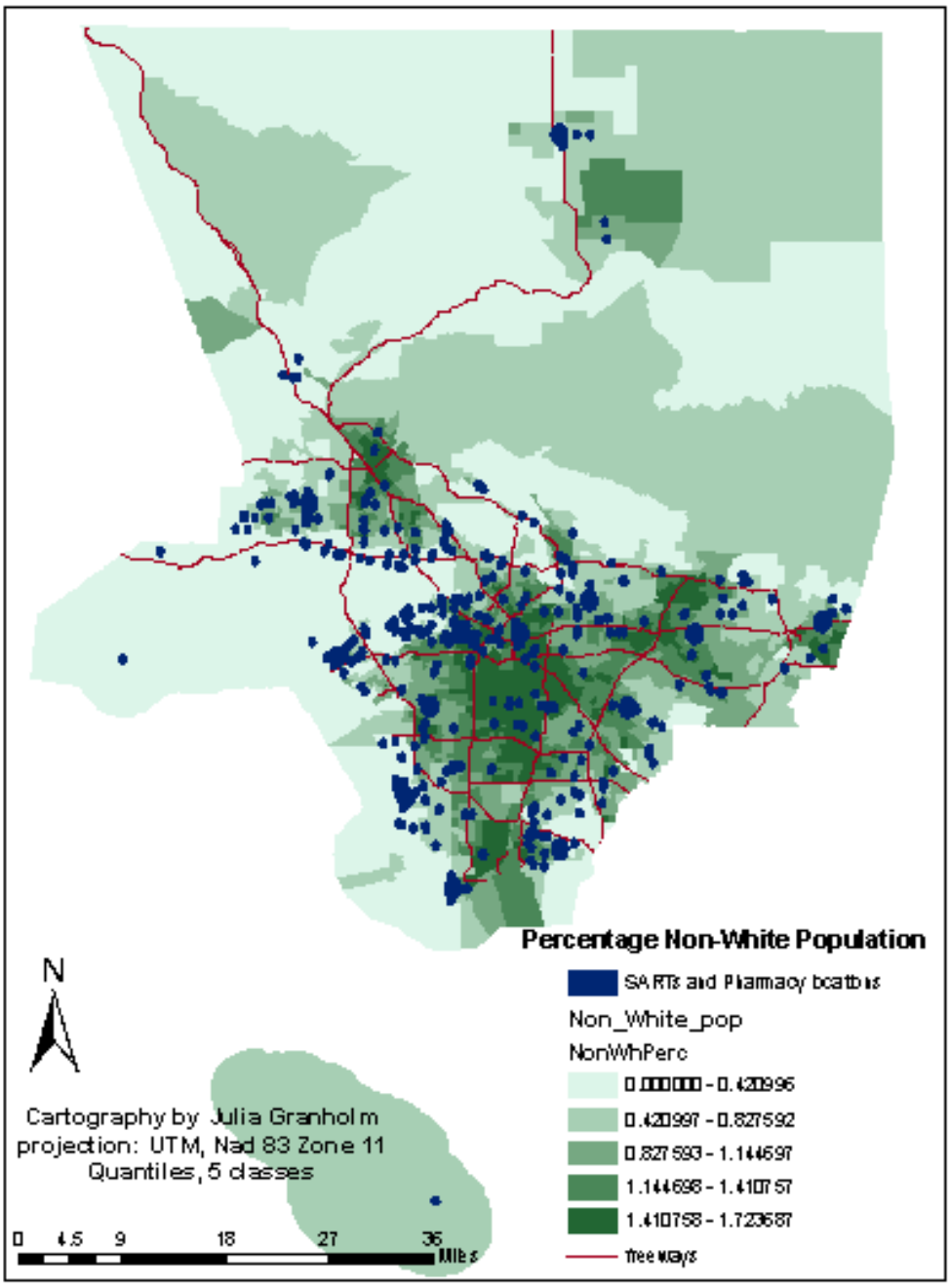


This map shows the locations of pharmacies with a pharmacist trained to dispense emergency contraceptives and SART hospitals in Los Angeles County.

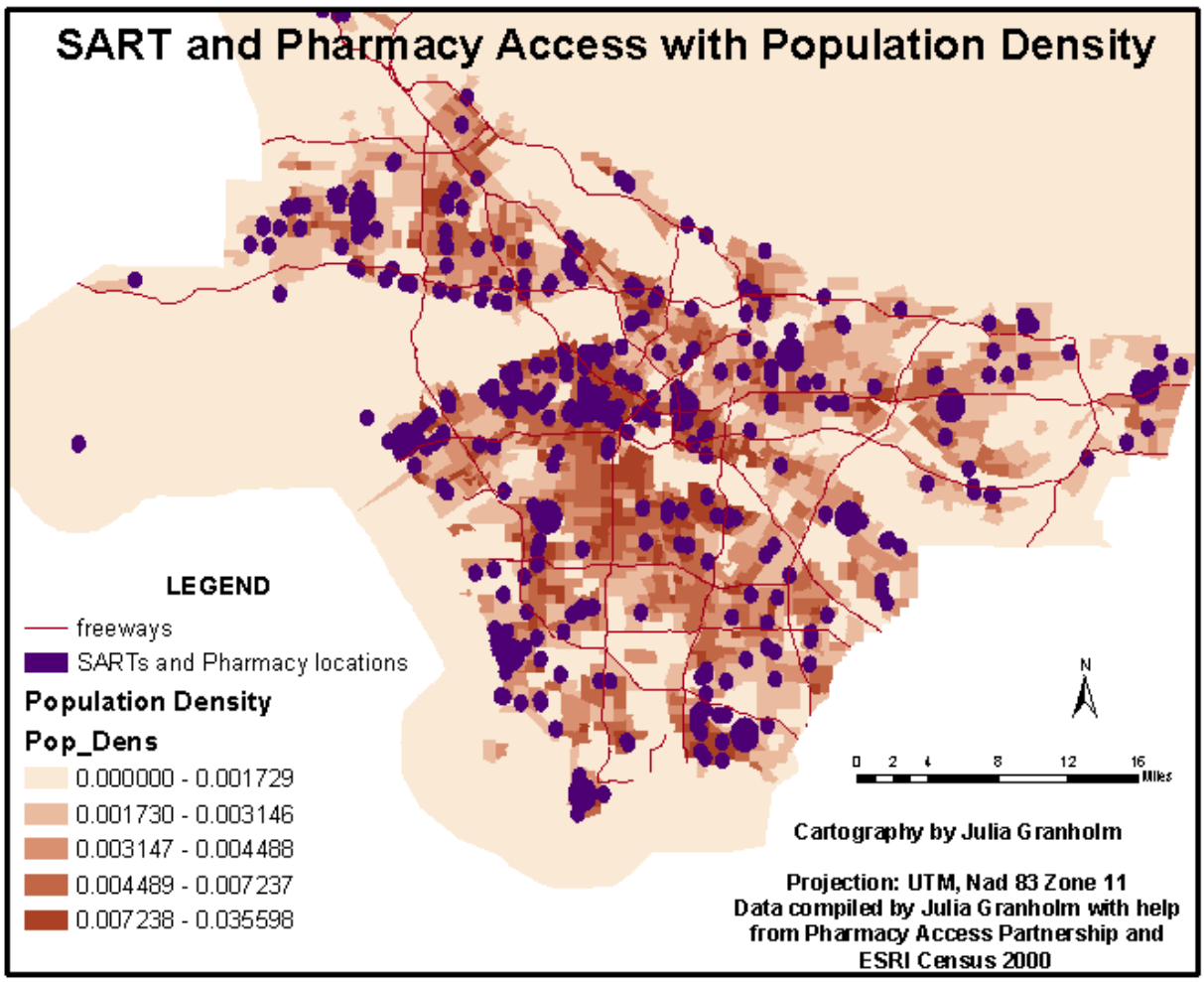


This map shows the total area of access to emergency contraceptives for victims of sexual assault (pharmacy and SART locations) with median household income (with percentages from 1999). The area of total access combines areas within a one mile radius of a SART hospital and/or within a half a mile of a pharmacy with a staff trained to dispense emergency contraceptives.

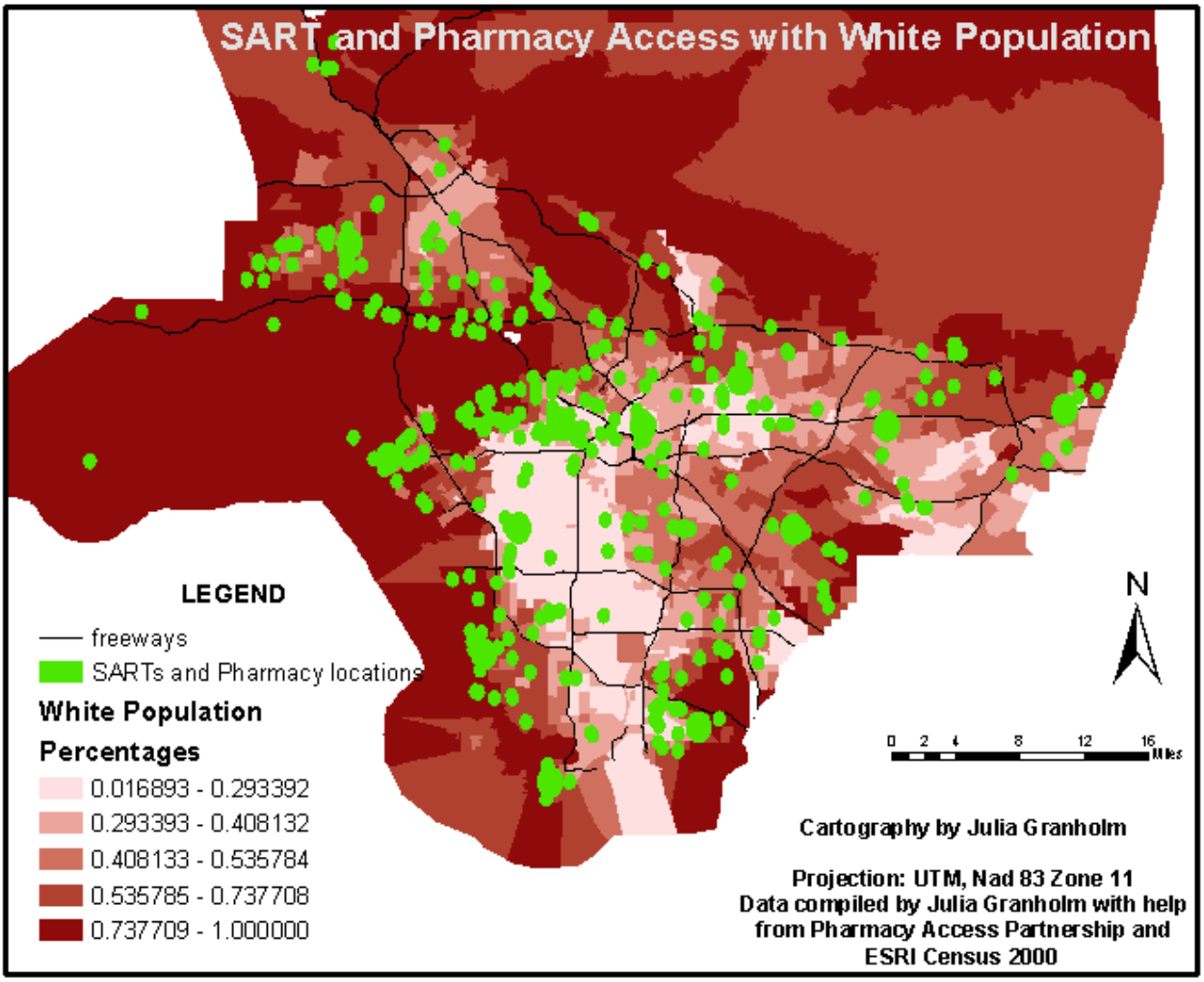
SARTs and Pharmacies with Non-White Population



This map shows the total area of access to emergency contraceptives for victims of sexual assault (pharmacy and SART locations) with the non-white population percentages in Los Angeles County.

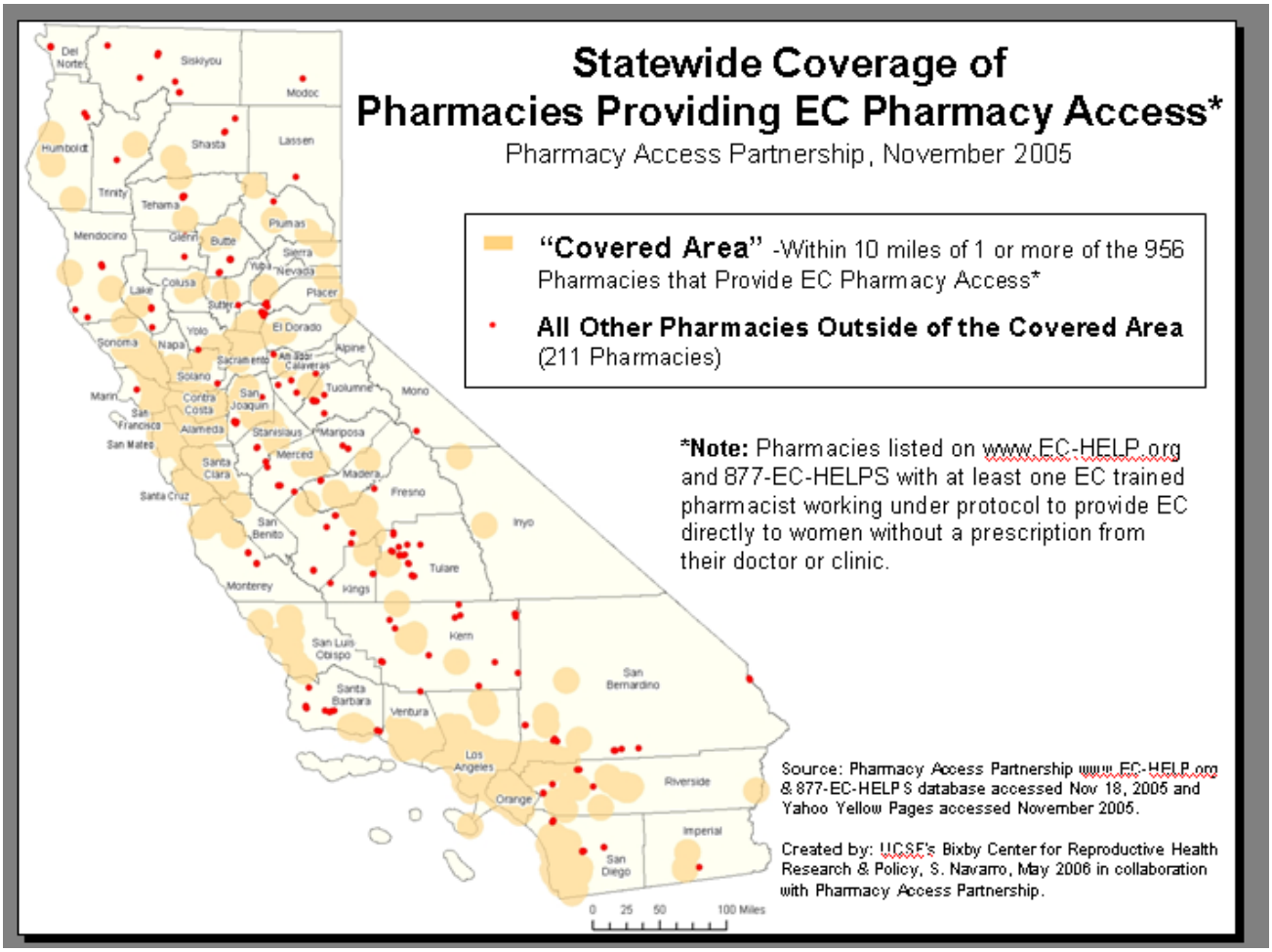


This map shows the total area of access to emergency contraceptives for victims of sexual assault (pharmacy and SART locations) with population density in Los Angeles County.



This map shows the total area of access to emergency contraceptives for victims of sexual assault (pharmacy and SART locations) with the white population percentages in Los Angeles County.

2. Pharmacy Access Partnership Access Map for California



Source: Pharmacy Access Project, courtesy of Sharon Landau

3. Emergency Contraceptive State Policy Chart

EMERGENCY CONTRACEPTION POLICIES

STATE	EXPANDING ACCESS						RESTRICTING ACCESS			
	EMERGENCY ROOMS REQUIRED TO:		PHARMACISTS MAY DISPENSE EC WITHOUT PHYSICIAN PRESCRIPTION UNDER:		PHARMACY STOCKING BIRTH CONTROL MUST DISPENSE EC	PHARMACY MUST FILL VALID PRESCRIPTIONS	STATE LAW EXCLUDES EC FROM:		STATE LAW ALLOWS REFUSAL TO DISPENSE EC BY:	
	Provide Information About EC	Dispense EC upon Request	Collaborative Practice Agreement	State-Approved Protocol			Medicaid Family Planning Expansion	Contraceptive Coverage Mandate	Pharmacist	Pharmacy
Alaska			X							
Arkansas	X							X	X	†
California	X	X	X	X		X				
Colorado	X								†	†
Connecticut	X†	X†								
Florida									†	
Georgia									X	
Hawaii			X							
Illinois	X				X				†	
Indiana							Φ			
Maine				X					†	†
Massachusetts	X	X	X							
Minnesota	X	X								
Mississippi									X	X
New Hampshire			X							
New Jersey	X	X				X				
New Mexico	X	X		X						
New York	X	X								
North Carolina								X		
Ohio	Ω	Ω								
Oregon	X	X								
Pennsylvania	X	Ψ								
South Carolina		X								
South Dakota									X	
Tennessee									†	†
Texas	X						Φ			
Vermont			X							
Washington	X	X	X			§				
Wisconsin	X	X								
TOTAL	**15**	**11**	**7**	**3**	**1**	**2**	**2**	**2**	**4**	**1**

§ Policy is not in effect pending the outcome of a court case.

* Pharmacists may dispense any prescription drug, including emergency contraception.

† A broadly worded refusal policy may apply to pharmacists or pharmacies, but does not specifically include them.

‡ A hospital may contract with an independent medical professional in order to provide the emergency contraception services.

Φ Waiver application will exclude emergency contraception explicitly in Texas, implicitly in Indiana.

Ω Policy does not include an enforcement mechanism.

Ψ A hospital may refuse based on religious or moral beliefs to provide emergency contraception when requested by a woman who has been sexually assaulted. However, a refusing hospital is then required to immediately transport the woman to the closest medical facility that will provide her with the medication.

Source: Guttmacher Institute. "State Policies in Brief: Emergency Contraception". 1 April, 2008. pg 2. http://guttmacher.org/statecenter/spibs/spib_EC.pdf

4. Fact Sheet For Patients Purchasing Emergency Contraceptives at Pharmacies

Key Facts About Emergency Contraception

Emergency Contraception (EC) is a safe and effective way to prevent pregnancy after sex.

Consider using Emergency Contraception if:

- You didn't use a contraceptive during sex, or
- You think your contraceptive didn't work.

What are Emergency Contraceptive pills?

Emergency Contraceptive pills contain the same medication as regular birth control pills, and help to prevent pregnancy. There are two basic types of Emergency Contraceptive pills:

- Plan B™ progestin-only pills
- High doses of regular oral contraceptive pills.

Don't wait! Take EC as soon as possible.

- It is best to take EC within three days of unprotected sex.
- The sooner you take EC the more effective it is.
- For more information talk to your pharmacist or doctor.

EC is safe and effective.

- Progestin-only pills reduce the risk of pregnancy by 89 percent.*
- Combined estrogen/progestin pills reduce the risk of pregnancy by 75 percent.*
- For regular, long-term use, other contraceptive methods are more effective than EC.
- Emergency Contraceptive pills do not protect against sexually transmitted infections, including HIV/AIDS.

** Pregnancy risk reduction based on one-time use.*

EC won't cause an abortion.

- Emergency Contraceptive pills are NOT the same as RU-486 (the abortion pill).
- Emergency Contraceptive pills are not effective after pregnancy has occurred and cannot interrupt it.

EC won't harm a developing fetus.

- If Emergency Contraceptive pills are taken mistakenly during pregnancy, they will not harm the developing fetus.
- Using Emergency Contraceptive pills will not affect a woman's ability to become pregnant in the future.

Women can keep pills at home in case of an emergency.

- Many women find it convenient to have Emergency Contraceptive pills on hand in case of an emergency.
- Medical providers or your pharmacist can provide Emergency Contraceptive pills before they are needed.

Medical follow-up after taking Emergency Contraceptive pills

- If you don't get a normal period within three weeks, take a pregnancy test.
- It is important to visit your doctor or clinic if you need a regular birth control method or information about preventing sexually transmitted infections, such as HIV/AIDS.

In California all women and men with eligible incomes may receive free family planning services through the Family PACT program.

If you don't have a doctor or clinic, call **1-800-942-1054** to find a Family PACT provider near you.

Source: Pharmacy Access Partnership website:
http://ec-help.org.FactSheetEng.htm

5. Resources for Victims of Sexual Assault in Los Angeles

a. Sexual Assault Response Team Hospitals

San Gabriel Valley Medical Center	438 W. Las Tunas Dr.	San Gabriel	CA	91776
Antelope Valley Hospital	1600 W. Ave. J	Lancaster	CA	93534
Citrus Valley Medical Center	1115 Sunset Ave.	West Covina	CA	91790
Community Hospital	1720 Termino Ave.	Long Beach	CA	90804
Daniel Freeman Memorial Hospital	333 N. Prairie Ave.	Inglewood	CA	90301
LA County + USC Medical Center	1200 N. State St.	Los Angeles	CA	90033
Presbyterian Intercommunity Hospital	12401 Washington Blvd.	Whittier	CA	90602
Pomona Valley	1798 N. Garey Ave.	Pomona	CA	91767
Little Company of Mary - San Pedro Hospital	1300 W. 7th St.	San Pedro	CA	90732
Rape Treatment Center, UCLA Medical Center	1250 Sixteenth St.	Santa Monica	CA	90404
Northridge Hospital Medical Center	18300 Roscoe Blvd.	Northridge	CA	91325
Little Company of Mary	514 N. Prospect Ave.	Redondo Beach	CA	90277

b. Pharmacies with a Pharmacist Trained to Dispense Emergency Contraception

- Visit http://www.ec-help.org/PharmacyLocations.asp for the pharmacies shown on the maps in this study.

- Or visit www.not-2-late.com for locations by zip code.

c. Rape Crisis Centers

Center for the Pacific Asian Family, Inc. | 323-653-4045
543 N. Fairfax Ave., Suite 108
Los Angeles, CA 90036
tel: 323-653-4045, fax: 323-653-7913

East Los Angeles Women's Center | 323-526-5819
1255 S. Atlantic Blvd.
Los Angeles, CA 90022
tel: 323-526-5819, fax: 323-526-5822

Peace Over Violence | 213-955-9090
605 West Olympic Blvd., Suite 400
Los Angeles, CA 90015
tel: 213-955-9090, fax: 213-955-9093

Peace Over Violence – Pasadena | 626-793-3385
892 N. Fair Oaks Avenue, Suite D
Pasadena, CA 91103-3046
tel: 626-584-6191, fax: 626-584-6193

Project Sister Sexual Assault Crisis Services, Inc. | 909-623-1619
P.O. Box 1390
Claremont, CA 91711
tel: 909-623-1619, fax: 909-622-8389

Rape Treatment Center, UCLA Medical Center | 310-319-4503
1250 Sixteenth Street
Santa Monica, CA 90404
tel: 310-319-4503, fax: 310-319-4809

Rosa Parks Sexual Assault Crisis Center | 323-290-4119
4182 S. Western Avenue
Los Angeles, CA 90062
tel: 323-290-4119, fax: 323-296-4742

Sexual Assault Crisis Agency | 562-494-5046
1703 Termino Ave., Suite 103
Long Beach, CA 90804
tel: 562-494-5046, fax: 562-494-1741

Sexual Assault Response Services | 661-949-5566
1600 W Avenue J
Lancaster, CA 93534
tel: 661-949-5566, fax: 661-949-3940

Valley Trauma Center – Van Nuys | 818-886-0453
7116 Sofia Avenue
Van Nuys, CA 91406
tel: 818-756-5330, fax: 818-756-5443

Valley Trauma Center – Valencia | 661-253-0258
25115 Avenue Stanford, Suite 122
Valencia, CA 91355-4819
tel: 661-253-1772, fax: 661-253-2316

YWCA of Greater LA Sexual Assault Crisis Program | 310-763-9995
1600 E. Compton Blvd.
Compton, CA 90221
tel: 310-763-9995, fax: 310-763-9590

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