Women's Health Issues 26-1 (2016) 67–73

ELSEVIER

WOMEN'S HEALTH ISSUES

www.whijournal.com

Original article

Practices Regarding Rape-related Pregnancy in U.S. Abortion Care Settings

Rachel Perry, MD, MPH [a,*,1], Molly Murphy, MPH [b], Kristin M. Rankin, PhD [b], Allison Cowett, MD, MPH [a,1], Bryna Harwood, MD, MS [a,1]

[a] Department of Obstetrics and Gynecology, University of Illinois at Chicago College of Medicine, Chicago, Illinois
[b] Department of Community Health Sciences, University of Illinois at Chicago, School of Public Health, Chicago, Illinois

Article history: Received 21 May 2015; Received in revised form 27 October 2015; Accepted 28 October 2015

A B S T R A C T

Objective: We aimed to explore current practices regarding screening for rape and response to disclosure of rape-related pregnancy in the abortion care setting.
Methods: We performed a cross-sectional, nonprobability survey of U.S. abortion providers. Individuals were recruited in person and via emailed invitations to professional organization member lists. Questions in this web-based survey pertained to providers' practice setting, how they identify rape-related pregnancy, the availability of support services, and their experiences with law enforcement. Providers were asked their perceptions of barriers to care for women who report rape-related pregnancy.
Results: Surveys were completed by 279 providers (21% response rate). Most respondents were female (93.1%), and the majority were physicians in a clinical role (69.4%). One-half (49.8%) reported their practice screens for pregnancy resulting from rape, although fewer (34.8%) reported that screening is the method through which most patients with this history are identified. Most (80.6%) refer women with rape-related pregnancy to support services such as rape crisis centers. Relatively few (19.7%) have a specific protocol for care of women who report rape-related pregnancy. Clinics that screen were 79% more likely to have a protocol for care than centers that do not screen. Although the majority (67.4%) reported barriers to identification of women with rape-related pregnancy, fewer (33.3%) reported barriers to connecting them to support services.
Conclusion: Practices for identifying and providing care to women with rape-related pregnancy in the abortion care setting are variable. Further research should address barriers to care provision, as well as identifying protocols for care.

In the United States, 18% of women will experience rape or attempted rape in their lifetimes (Black et al., 2011; Tjaden & Thoennes, 2000). Results of a population-based survey indicated that approximately 5% of women who experienced rape became pregnant as a result of the assault (Holmes, Resnick, Kilpatrick, & Best, 1996), and were more likely to terminate those pregnancies than to continue them. One percent of women in a cross-sectional study of women's reasons for choosing abortion reported that their pregnancy had resulted from rape (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005). For women who choose to terminate rape-related pregnancies, abortion care can be an opportunity to disclose the assault to their medical providers and be provided with health care, emotional support, and referrals pertaining to the assault, in addition to the abortion procedure. Although the Hyde Amendment limits federal Medicaid funding for abortion, rape-related pregnancy (in addition to incest and life endangerment) is an exception for which such funds can be used (Guttmacher Institute, 2014).

Little is known about current practices for identifying and responding to rape in the abortion care setting, because these activities have been deemed primarily relevant for emergency

None of the authors report a conflict of interest.

* Correspondence to: Rachel Perry, MD, MPH, Department of Obstetrics and Gynecology, University of California-Irvine Medical Center, 101 The City Drive South, Building 56, Suite 800, Orange, CA 92868. Phone: +1-714-456-6277; fax: +1 714-456-7180.
E-mail address: rachel.perry@uci.edu (R. Perry).
[1] Dr. Perry is currently affiliated with the University of California, Irvine Department of Obstetrics and Gynecology, Orange, CA. Dr. Cowett is currently affiliated with Northwestern University, Chicago, Illinois. Dr. Harwood is currently affiliated with Cedars-Sinai Department of Obstetrics and Gynecology, Los Angeles, California.

1049-3867/$ - see front matter Copyright © 2016 by the Jacobs Institute of Women's Health. Published by Elsevier Inc.
http://dx.doi.org/10.1016/j.whi.2015.10.006

and primary care providers (Linden, 2011; Patel, Panchal, Piotrowski, & Patel, 2008). Additionally, there is no standardized tool to screen specifically for pregnancy resulting from rape, or a recommended protocol for care of women with rape-related pregnancy. Although several tools to screen for sexual violence are available (Basile, Hertz, & Back, 2007), none has been validated for use in the abortion care setting, and existing tools lack questions regarding rape-related pregnancy.

In addition to pregnancy, the health consequences of rape can include physical injury, sexually transmitted disease, and mental health problems, including posttraumatic stress disorder and substance abuse (Linden, 2011). The American College of Obstetricians and Gynecologists recommends that postassault care for all rape survivors include attention to acute physical trauma, counseling and provision of emergency contraception if indicated, mental health care, and tests or prophylaxis for sexually transmitted infections (American College of Obstetricians and Gynecologists, 2011). Once rape has resulted in a pregnancy, provision of emergency contraception and sexually transmitted infection prophylaxis are no longer relevant, but other unique opportunities may be available to patients, including the collection of forensic evidence from products of conception for prosecution of assailants (Johnson, Matthies, Roberts, & Yorker, 2010). Therefore, screening for rape, and rape-related pregnancy in particular, among patients seeking abortion may provide opportunities for sexually transmitted infection screening, support service referral, and expanded criminal justice options. Because the majority of rape survivors do not seek immediate medical care (Black et al., 2011), abortion care may be the first encounter women who conceive after rape have with care providers. This makes abortion care an important site for identifying rape history and providing appropriate follow up care. A qualitative study indicated that women terminating rape-related pregnancies appreciate the opportunity to discuss forensic evidence collection and think that it is important to offer support service referral (Perry, Murphy, Haider, & Harwood, 2015). This study aims to explore U.S. abortion providers' experiences with women who terminate rape-related pregnancies.

Materials and Methods

Survey Design

We developed a web-based survey for distribution to U.S. abortion providers in conjunction with the University of Illinois-Chicago Survey Research Lab. The 37-item survey instrument (available on request) contained closed- and open-ended questions regarding providers' practice setting, personal demographics, practices for identifying rape-related pregnancy at their clinics, referral patterns for support services, experiences with law enforcement, and opinions on barriers to care of women who report rape-related pregnancy. Table 1 shows sample survey questions. With the exception of demographic questions and questions regarding barriers to care, participants were asked about their center's practices, not their personal practices. Of note, although the term "rape-related pregnancy" is used in the scholarly literature (Holmes et. al., 1996), it is not commonly used in medical terminology, and therefore participants were asked regarding patients who had "pregnancy resulting from sexual assault." No specific definition of this term was provided. Participants who provided abortion care at more than one center were asked to answer questions about the setting in which they were most likely to care for rape survivors.

Table 1
Sample Survey Questions Regarding Care of Patients Presenting for Abortion who Report Rape-related Pregnancy

Identification of Rape-related Pregnancy

1. When a patient is pregnant due to sexual assault, how does this information become known to your center? (Please select all that apply)
   a. Screening for sexual assault
   b. Patient's voluntary disclosure of sexual assault at the time of scheduling an appointment
   c. Patient's voluntary disclosure of sexual assault during her appointment
   d. Referral from another facility
   e. Other (please specify)

2. Does your center
   a. Screen for whether a patient is pregnant due to sexual assault
   b. Not screen specifically for this history
   c. Do not know

Protocols and referrals following disclosure of rape-related pregnancy

3. When a patient has been identified as currently pregnant due to a sexual assault, is there
   a. A specific protocol for providing care to these patients
   b. A specific protocol for referring these patients elsewhere
   c. No specific protocol
   d. Do not know

4. Does your center
   a. Refer patients who are pregnant due to sexual assault for support services
   b. Not refer such patients to other agencies for support services
   c. Do not know

5. Where are patients referred?* (Please select all that apply)
   a. Rape crisis center or rape victim advocacy group
   b. Counselor at your facility
   c. Counselor at another facility/in the community
   d. Law enforcement
   e. Other (please specify)

6. Have you…
   a. Ever worked with law enforcement for transfer of DNA specimens from products of conception for patients who are pregnant due to sexual assault
   b. Worked with law enforcement but never for transfer of DNA specimens
   c. Never worked with law enforcement

Barriers

7. In your experience, are there
   a. Factors preventing centers like yours from connecting patients with a known history of pregnancy due to sexual assault to support services like counseling, social work, or advocacy agencies
   b. No such factors
   c. Do not know

* Question asked only if answered affirmatively to previous question.

Surveys took 15 to 30 minutes to complete. The only identifier collected was email address, which was removed and destroyed prior to data analysis.

Sample and Recruitment

This study was approved by the University of Illinois-Chicago Institutional Review Board. Eligible clinicians were those currently involved in abortion care in the United States, including