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Prevention and Response to Rape-Related Pregnancy
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Purpose of this Brief
Misconceptions about the prevalence, context and preventability of rape-related pregnancy can hinder effective community responses to survivors. The following brief uses empirical literature to:
- Review the prevalence and context of rape-related pregnancy in the United States
- Identify consequences of rape-related pregnancies
- Highlight standards of care for preventing rape-related pregnancy or supporting healthier outcomes
- Propose recommendations to improve treatment of sexual assault survivors and decrease risks of rape-related pregnancy.

A Few Facts….
- It is estimated that 18% of women in the US are raped in their lifetime (Black et al, 2010) and nearly 5% of those rapes result in pregnancy (Holmes et al. 1996).
- It is estimated that between 25,000 and 32,000 adult women become pregnant as a result of sexual assault in the United States every year (Stewart & Trussell, 2000; Holmes et al. 1996).
- Many relationships that involve intimate partner violence include both physical and sexual assaults. As many as 20% of battered women have been found to have experienced a rape-related pregnancy (McFarlane et al., 2005).
- Fewer than one-fifth of U.S. hospitals provide the recommended comprehensive medical care management (CMCM) model of services to sexual assault patients (Patel, et al., 2013).
Rape-Related Pregnancy: Prevalence.

It is estimated that every year 25,000 - 32,000 women in the United States become pregnant as a result of rape (Stewart & Trussell, 2000). This number would be higher if it included children and adolescents. Although assertions have been made that the risk of pregnancy is lowered during a rape, research has revealed that it is comparable or higher than that found during consensual sex. In a large-scale study, Gottschall (2003) found a per-incident, rape-pregnancy rate of 6.42%, as compared with a per-incident, pregnancy rate of 3.1% for women engaged in consensual, unprotected intercourse. A similar rate (5%) of rape-related pregnancy was found in a three-year national survey of 4,008 women (Holmes et al. 1996).

Rape-Related Pregnancy: Intimate Partner Violence

Most forms of sexual violence are perpetrated by someone the victim knows, e.g., family member, intimate partner, friend or acquaintance (Bureau of Justice Statistics 2013). Data from the 2010 National Intimate Partner and Sexual Violence Survey show that 9.4% of women in the U.S. experience rape and 16.9% experience other sexual violence by an intimate partner during their lifetime (Black et al. 2011). In addition, de Bocanegra (2010) found high rates of birth control sabotage by abusive partners: refusal to wear condoms, preventing victims from obtaining birth control, getting refills for oral contraception, and thwarting their ability to obtain an abortion. It is important to recognize that pregnancy can be a life-threatening time in violent relationships. Studies have indicated that the severity of physical abuse increases significantly during pregnancy (Saftlas et al. 2010).

Rape-Related Pregnancies: Consequences.

There are many negative consequences associated with rape-related pregnancies. These include negative health outcomes for both the mother and the child – lower birth weight and failure to thrive for the child and more complications both during and after pregnancy for the mother. Increased rates of PTSD, anxiety, depression and other psychiatric disorders; maternal rejection, and treatment resistant malnutrition can all cause long-lasting effects on children’s physical, emotional and cognitive development (McFarlane 2007; van Ee and Kleber 2013). In addition, McFarlane (2007) found that women who were victims of intimate partner rape reported fewer live births, significantly more symptoms of PTSD, more risk factors for suicide, and more substance abuse than women who were physically abused alone.

Rape-Related Pregnancies: Response to Sexual Assault Survivors

Studies indicate that about 20% of rape victims seek medical care following the incident (Zinzow et al., 2012). Because of the focus on pregnancy, this brief is limited to highlighting response by medical professionals. It is critical that health care professionals be aware of and follow best practices that address health as well as mental health needs. The comprehensive medical care management (CMCM) model of services to sexual assault patients is based on best-practice recommendations from the CDC, the U.S. Department of Justice, the American College of Obstetricians and Gynecologists, and the American College of Emergency Physicians (Patel et al. 2013). In addition to pregnancy, rape may result in a sexually transmitted disease. Health personnel should be familiar with CDC guidelines for preventive treatment of such infections (Linden, 2011). PTSD is one of the most common psychological consequences of rape and the presence of PTSD significantly increases risk for adverse pregnancy related health outcomes (Munro, Rietz & Seng, 2012). It is essential that survivors receive psychological and medical services from trauma informed systems of care that recognize the complexity of her situation and that will fully support her choices. Trauma informed community resources available include the St. Louis Regional Sexual Assault Program (314- 531-7273); The Missouri Coalition Against Domestic & Sexual Violence (573-634-4161); The National Sexual Assault Hotline (1-800-656-4673); and Planned Parenthood (1-800-230-7526). The remainder of the brief reviews evidence related to the pregnancy itself.
Rape-related Pregnancy: Prevention

Emergency contraception (EC) “has been shown to reduce pregnancy risk by more than 85% when given no later than 72 hours following assault and up to 70% when given up to 120 hours post-assault” (Bakhru, 2010, p. 168). The FDA has approved a time limit of 72 hours for EC (Kavanaugh, 2012) and use of it has been found not to threaten an established pregnancy (Espey, 2009). One of the CMCM’s primary components is EC – counseling and provision (Patel et al. 2013).

Emergency Contraception: Barriers to Access

Despite the importance of providing access to emergency contraception following a rape, many survivors encounter barriers to obtaining EC in emergency departments which are the primary source of care for rape victims (Campbell, Patterson & Lichty, 2005; Resnick et al., 2000). The evidence of effectiveness for EC and the CMCM model, service delivery rates for EC in hospital Emergency Departments are only 20% - 38% (Campbell, Patterson, & Lichty, 2005). It is estimated that only 50% of physicians in emergency departments regularly offer EC (Bakhru, 2010). Although the drug is 85% effective up to 72 hours post-assault, only 47% of doctors surveyed indicated a willingness to use it within that 72-hour window of time and 22% of the physicians indicated they would use it only within the first 24 hours (Espey, 2009). Kavanaugh (2012) found that 24% of providers limited their use of EC to a period of 48 hours or less and another 24% were simply unsure of the time within which EC could be provided. In the U.S. only 21 states have enacted statutes regulating protocols for provision of and access to EC and 16 of those states are requiring hospitals or health care facilities to provide information about and/or initiate EC therapy to women who have been sexually assaulted. Missouri still lacks a statute covering provision of EC to sexual assault victims (NCSL, 2012).

Rape –Related Pregnancy: Support When Medical Care is Delayed

Unfortunately, many survivors do not seek immediate medical care. Pregnant survivors are faced with either abortion or carrying the child to term. Although federal law allows the use of Medicaid funding for rape and incest survivors seeking an abortion, too frequently inaccurate information is given. Studies reveal a lack of reimbursement in numerous cases (as high as 50%) that should have qualified for Medicaid coverage (Kacanek, 2010; Dennis et al., 2011). Dennis and colleagues (2011) found that 21% of Medicaid representatives were uncertain about the availability of coverage and 18% provided coverage information that contradicted Medicaid policy on either the state or federal level. Coverage by private insurance may be impacted by state law. Several states, including Missouri, have statutes preventing coverage of abortion by private insurance policies written in the state or for public employees, unless the pregnancy endangers the life of the mother (Guttmacher Institute, 2013).

It is important to recognize that some women who experience a rape-related pregnancy choose to carry to term with the intention of either becoming the child’s parent or giving the child up for adoption. As indicated above, there can be significant pre and post natal psychological and health risks to both the mother and child in cases of rape-related pregnancy. Part of the CM MD model includes comprehensive attention to the mental health and health needs of sexual assault victims (Patel et al,.2013), but no research could be found regarding best practices to support healthy birth outcomes for rape-related pregnancies.
Rape-Related Pregnancies: Evidence-Informed Recommendations

- Emergency room and other response personnel should be made aware of the need for trauma-informed mental health care and appropriate medical services, which victims of sexual assault should receive whether pregnant or not. All private and public insurance companies should allow for costs related to such care.
- The comprehensive medical care management (CMCM) model is supported by expert guidelines and evidence-based research. Widespread education about CMCM and its use by emergency departments and other providers will improve outcomes for sexual assault patients (Patel et al. 2013).
- Increase training of emergency department physicians and awareness in the general public on the importance and effectiveness of Emergency Contraception in rape cases.
- Increase training for Medicaid and other insurance representatives on policies related to the availability of coverage for abortions in the case of rape and incest.

References