



**NARAL**  
Pro-Choice America

## **Emergency Contraception (EC): An Important and Underutilized Contraceptive Option**

Emergency contraception (EC), also known as the “morning-after” pill, can substantially reduce a woman’s chance of becoming pregnant when taken soon after sex.<sup>1</sup> EC does not cause abortion; rather it *prevents* pregnancy.<sup>2</sup> There are two main kinds of EC available in the United States. The first contains the same active ingredient as ordinary birth-control pills, the hormone progestin, and is marketed under the name Plan B<sup>®</sup>, Plan B One-Step<sup>®</sup>, and, in its generic form, Next Choice<sup>®</sup>.<sup>3</sup> The second, known as ella<sup>®</sup>, is a single-dose ulipristal acetate pill that acts like birth control and prevents pregnancy.<sup>4</sup> In addition to these medications, 19 brands of daily birth-control pills that can be used as EC in appropriate doses are available in the United States.<sup>5</sup> EC is safe, effective, and simple to use and is not associated with any serious or harmful side effects.<sup>6</sup> Moreover, EC is not dangerous to women with pre-existing medical conditions.<sup>7</sup>

Since the U.S. Food and Drug Administration (FDA) first approved the emergency contraceptive Plan B<sup>®</sup> for prescription use in 1999, there have been several developments.<sup>8</sup>

- In August 2006, after stalling for more than three years, the FDA approved Plan B<sup>®</sup> for over-the-counter sales for individuals ages 18 and older.<sup>9</sup>
- In April 2009, the FDA announced that it would comply with a federal court ruling calling for the agency to allow 17-year-olds to have over-the-counter access to EC and to reconsider its policy on age restrictions.<sup>10</sup>
- In June 2009, the FDA approved Next Choice<sup>®</sup>, the first-ever generic version of Plan B<sup>®</sup>, for prescription use for individuals ages 17 and under.<sup>11</sup> Two months later, the FDA approved the generic medication for over-the-counter use for individuals 17 and over.<sup>12</sup>
- In August 2010, the FDA approved the emergency contraceptive ella<sup>®</sup> for distribution in the United States.<sup>13</sup> Available only by prescription, ella<sup>®</sup> is safe and effective for use up to five days (120 hours) after sex.<sup>14</sup> Watson Pharmaceuticals, the manufacturer of ella<sup>®</sup>, officially launched the new medication in December 2010 and now it can be obtained with a prescription in retail pharmacies.
- In 2011, Teva, the manufacturer of Plan B<sup>®</sup>, filed an application with the FDA requesting that the contraceptive be made available over the counter for women of all ages.<sup>15</sup>
- Unfortunately, in December 2011 in response to Teva’s application, the Department of Health and Human Services overruled a recommendation from the FDA to

eliminate the age restriction on over-the-counter (OTC) access to emergency contraceptive Plan B®.<sup>16</sup>

EC may be used when other contraceptive methods fail or are not used, such as when women are sexually assaulted. Although EC is not a substitute for ongoing contraceptive use and does not protect against the transmission of sexually transmitted diseases, it can reduce unintended pregnancy and the need for abortion – *if* women know about EC's availability and use, and are able to access the medication in a timely manner.

Although EC has tremendous potential to help reduce unintended pregnancy, too few Americans are aware that contraceptive methods are available that can prevent pregnancy after sex. Among women aged 15-44 who have ever had sex, only 10 percent had ever used EC in 2006-2008.<sup>17</sup> In order for EC's full benefits to be realized, women must be educated about the medication's availability and effectiveness, they must have broader access to it, and they must use it correctly and consistently.

### **Greater Use of Emergency Contraception has the Potential to Prevent Unintended Pregnancies and Improve Women's Reproductive Health**

#### **EC and Unintended Pregnancy**

- Half of all pregnancies in the United States are unintended.<sup>18</sup> Approximately 3.1 million unintended pregnancies occurred in the United States in 2001, the last year for which data are available.<sup>19</sup> Increased use of EC could reduce unintended-pregnancy rates, and thereby reduce the need for abortion.
- At least one study has shown that many women do not use EC because they underestimate their chances of becoming pregnant.<sup>20</sup> Education about and advance distribution of EC are therefore critical components of the effort to reduce the rate of unintended pregnancy. Similarly, advance prescription of EC for individuals under the age of 17 has the potential to impact teen-pregnancy rates significantly.

#### **EC Can Improve Women's and Children's Health**

Unintended pregnancies have serious health consequences for both women and children:<sup>21</sup>

- Women facing an unplanned pregnancy are less likely to identify health risks associated with pregnancy prior to conception and often do not take full advantage of the health options available to manage such conditions safely during pregnancy.<sup>22</sup>

- Unfortunately, research shows that children of unplanned pregnancies are at greater risk of suffering low birth weight, dying before reaching their first birthday, enduring child abuse, and lacking sufficient resources in order to ensure healthy development.<sup>23</sup>

### **Barriers to the Use of Emergency Contraception**

Despite the potential for EC to reduce unintended pregnancy, and thus prevent the need for abortion, anti-choice activists have mounted major campaigns to limit women's access to EC. Much of the opposition to EC arises from the misguided belief, and corresponding anti-choice rhetoric, that EC terminates pregnancy. In truth, EC *prevents* pregnancy. Pregnancy, as defined by the medical establishment (including the American College of Obstetricians and Gynecologists (ACOG) and the U.S. Department of Health and Human Services, among others), is the implantation of the fertilized egg in the uterine lining.<sup>24</sup> EC *prevents* pregnancy before implantation occurs, acting as regular birth control, not as abortion.<sup>25</sup>

Women's ability to obtain information about EC breaks down in many important settings:

#### **Many Hospitals Fail to Provide EC to Sexual-Assault Survivors**

Providing EC to sexual-assault survivors is an important means to help alleviate some of the trauma associated with sexual assault by restoring a sense of control and offering a safeguard to avoid the additional trauma of unintended pregnancy. Hospitals can play an important role in ensuring that information about and access to EC is distributed consistently. In fact, legal precedent indicates that failure to provide EC, a crucial preventive-health service, can constitute inadequate care, and give a woman standing to sue the hospital.<sup>26</sup> Nevertheless, many emergency rooms fail to offer this important medication.

- A 2005 nationwide telephone survey found that 42 percent of non-Catholic hospitals and 55 percent of Catholic hospitals do not provide EC under any circumstance, including to sexual-assault survivors. Among staff working in these hospitals, only about half gave callers a referral for EC, and most referrals proved ineffective.<sup>27</sup> (The most vocal opponents of EC tend to be Catholic hospitals. A directive for Catholic health-care services states that a sexual-assault survivor "may be treated with medications that would prevent sperm capacitation or fertilization"; however, it does not permit treatments that would interfere with the implantation of a fertilized ovum.<sup>28</sup>)
- The same survey revealed that even in states with "EC in the ER" laws—which require EC to be provided in hospital emergency rooms—a large portion of staff reported over the phone that EC was not available on-site. This legal violation may occur because mandates are not carefully enforced or because staff is not informed of policy changes regarding the provision of EC.<sup>29</sup>

- A 2005 study revealed that more than 25 percent of Illinois hospitals “never” or “sometimes” offer counseling on EC to sexual-assault survivors, even though Illinois law requires hospitals to develop protocols that ensure sexual-assault patients receive medically accurate written and oral information about EC, including a description of how and where to obtain EC.<sup>30</sup>

### **Pharmacist Refusals Create Unnecessary Barriers to EC**

Unfortunately, anti-choice refusal clauses that permit a broad range of individuals and institutions to refuse to provide, pay for, counsel for, or even refer for medical treatment deny women access to this important reproductive-health option.

A number of states have laws that could be construed to permit pharmacists to refuse to fill women’s prescriptions for contraception, including EC. Currently, six states explicitly allow pharmacists to refuse to dispense EC on the basis of moral or ethical objections: AZ, AR, GA, ID, MS, and SD.<sup>31</sup> Five additional states have broad refusal clauses that could be interpreted as applying to pharmacists.<sup>32</sup>

- A 2007 NARAL Pro-Choice North Carolina study found that nearly 40 percent of North Carolina pharmacies do not stock EC.<sup>33</sup>
- When women are denied EC, they are left with the task of finding it elsewhere – and quickly, given the time sensitivity of preventing pregnancy. Low-income women and women of color already face numerous barriers to accessing health-care services that make it particularly burdensome for them to find alternate providers, should their primary provider refuse to offer services. A study by the Kaiser Family Foundation found that low-income women face twice as much difficulty as other women in obtaining the flexible work schedules, transportation, and child care necessary to access health-care services for themselves.<sup>34</sup> In addition, the United States Office on Women’s Health in the Department of Health and Human Services found that multiple factors limit the access of minority women to the U.S. health care system, including social disadvantages, discrimination, lack of translators or culturally appropriate services, difficulty securing childcare, and lack of adequate transportation.”<sup>35</sup>
- Pharmacists refusing to dispense EC have received increased media attention. For example, in 2010, Walgreens stores in Texas and Mississippi routinely denied EC to male customers. In response to pressure from the American Civil Liberties Union, Walgreens’ headquarters instructed all pharmacies nationwide that EC could be sold to men and women age 17 and older, and that men seeking to purchase EC did not need to be accompanied by a female or identify for whom they were purchasing the medication.<sup>36</sup>

## Strategies for Improving Access to Emergency Contraception

Although the FDA approved EC for over-the-counter sales for individuals ages 17 and older, women still face barriers to obtaining the medication. Research demonstrates that EC is more effective the earlier it is taken.<sup>37</sup> Thus, finding ways to facilitate access to EC without delay is crucial. There are at least seven ways to improve women's access to EC: (1) ensure that sexual-assault survivors receive information about and access to EC in hospital emergency rooms; (2) require pharmacies to dispense emergency contraception or to ensure timely access for their customers; (3) allow pharmacists to provide women under the age of 17 with EC without a doctor's prescription through collaborative drug-therapy agreements; (4) ensure access to affordable EC; (5) ensure Medicaid coverage of EC; (6) provide women with information about and access to EC at routine check-ups; and (7) label ordinary birth-control pills with instructions for use as EC.

### Provide Information About and Access to EC in Hospital Emergency Rooms

- In 2010, more than 188,000 rapes or sexual assaults were reported in the United States.<sup>38</sup> EC, when used correctly and consistently, can significantly reduce a woman's chances of becoming pregnant. Thus, hospitals can alleviate some of the trauma associated with sexual assault by offering EC to sexual-assault survivors. However, too few women know about the medication. Educational efforts should be carried out to ensure that all women know to request EC if they are victims of sexual assault.
- Currently, 16 states and the District of Columbia have laws that improve sexual-assault survivors' access to EC or information about EC in hospitals: AR, CA, CO, CT, DC, IL, MA, MN, NJ, NM, NY, OR, PA, SC, UT, WA, WI.<sup>40</sup> Thirteen states and the District of Columbia explicitly require hospitals to dispense EC upon request to sexual-assault victims, and 15 states and the District of Columbia have laws ensuring that sexual-assault survivors receive information about EC in hospitals.<sup>41</sup>
- Nearly 80 percent of American women believe that hospitals should provide EC to rape survivors – regardless of whether the hospital is affiliated with the Catholic church.<sup>42</sup>

#### EC IS A COST-EFFECTIVE WAY TO PREVENT UNINTENDED PREGNANCY

Estimates show that in a managed-care setting, a single treatment of EC saves \$142, and advance provision of EC to women using spermicides, barrier contraceptives, withdrawal, or periodic abstinence saves \$263 to \$498 annually. When women obtain EC directly from a pharmacist, private payers save \$158 and public payers save \$48 per woman having unprotected sex.<sup>39</sup>

### Require Pharmacies or Pharmacists to Dispense Emergency Contraception

- Eight states (CA, IL, ME, MA, NV, NJ, WA, WI) have policies requiring pharmacies and/or pharmacists to dispense contraception, including EC, or to ensure timely access to the medication. In some states, must-dispense policies have the force of law, either through statute or regulation; in others, pharmacy boards have interpreted state laws and regulations to require distribution of all medication, including contraception. Pharmacy board interpretations do not have the force of law, but provide important guidance about standards of practice.<sup>43</sup>

### **Allow for Direct Distribution by Pharmacists**

- Nine states (AK, CA, HI, ME, MA, NH, NM, VT, and WA) have adopted measures that allow pharmacists to provide EC to all women regardless of age without a prescription, typically through arrangements with health-care providers known as collaborative-therapy agreements.<sup>44</sup> These agreements allow pharmacists to provide drugs, when medically appropriate, directly to patients requesting them without an advance prescription from a physician.<sup>45</sup> Allowing pharmacists to provide EC directly to women regardless of age is a critical means of improving access for women under the age of 17 who are not able to purchase EC over the counter. No medical reasons necessitate EC to be a prescription-only product, and improving young women's access to EC has the potential to reduce teen-pregnancy rates significantly.<sup>46</sup>

### **Ensure Access to Affordable EC**

- Under the Affordable Care Act, all newly issued health plans must cover EC without a copay or deductible.<sup>47</sup> In 2011, as part of its implementation of Section 2713(a)(4) of the health-care law, which requires health plans to cover—at no cost—certain preventive-health services that are specific to women, the Department of Health and Human Services (HHS) appointed an Institute of Medicine (IOM) panel to recommend which services should be defined as preventive care. The IOM panel recommended that the full range of FDA-approved contraceptive methods, including EC, be covered.<sup>48</sup> In August 2011, HHS adopted this recommendation in full.<sup>49</sup> Now, plans issued on or after August 1, 2012 must include no-cost coverage of EC. Plans issued before this date have a full plan year to come into compliance with the law. (As part of this otherwise-laudable policy, however, the administration is proposing to allow certain religious employers to refuse to comply with the requirement.)
- Another provision of the health-care law requires federal officials to identify a package of essential health benefits that all plans must offer with low cost-sharing requirements.<sup>50</sup> This provision is under consideration by HHS, and a final decision is forthcoming. A determination of benefits that includes family-planning services, including contraception and EC, would complement the law's policy on no-cost contraceptive coverage in newly issued health plans, described above.

### **Ensure Medicaid Coverage of Emergency Contraception**

- While the FDA's approval of generic EC and over-the-counter sale of EC to individuals 17 years of age and older marked significant steps forward in advancing women's access to contraception, the medication's retail cost is too expensive for many women. In many states, women eligible for Medicaid need to obtain a prescription in order to have the cost of the medication covered. Because EC is effective only if used within a very brief time period, going to a physician to obtain a prescription for the medication hinders timely access to the medication. Accordingly, state efforts to provide Medicaid coverage of EC without a prescription are critical to ensuring access to the medication.
- Medicaid coverage of EC is particularly important for women of color, who disproportionately work in low-wage jobs that do not offer benefits<sup>51</sup> and therefore turn at higher rates to public programs such as Medicaid to access affordable health care.
- In 2011, at least nine states provided Medicaid coverage of EC without a prescription, including HI, IL, MD, NJ, NM, NY, OK, OR, and WA.<sup>52</sup>

### **Provide Women with Information About and Access to EC at Routine Check-Ups**

- Health-care providers, well-positioned to provide women with accurate information about and access to emergency contraception, should include EC education in routine office visits.<sup>53</sup> The American College of Obstetricians and Gynecologists recommends this approach.<sup>54</sup> In addition, at least one study has found that advance provision increases the likelihood that women will use EC; women who received an advance supply of EC were nearly three times more likely to use the treatment than women who received only information about EC.<sup>55</sup> In fact, a 2008 report found that use of EC was strongly linked to having received counseling from a clinician within the past year.<sup>56</sup>
- Studies suggest that women still rarely discuss EC in clinical settings. In 2008, only three percent of women ages 15-44 reported that they had discussed EC with their health-care provider in the past year, and only four percent had received counseling on EC from their gynecologists.<sup>57</sup>
- In 2003, only 31 percent of ob/gyns prescribed EC on a regular basis (more than five times per year). Moreover, only 25 percent of ob/gyns discussed EC with their patients most or all of the time as part of routine contraceptive counseling.<sup>58</sup>

### **Label Ordinary Birth-Control Pills for Use as EC**

- More than 10 million American women are currently using birth-control pills and 82 percent of sexually experienced women have used birth-control pills at one time or another.<sup>59</sup> The FDA has approved several types of oral contraceptives for use as emergency contraceptives.<sup>60</sup> If these ordinary birth-control pills were labeled with instructions for use as emergency contraceptives, millions more women and their

physicians would be aware that something can be done to prevent unintended pregnancy if unprotected sex occurs.

### **Public and Professional Education will Improve Access to and Increase Use of Emergency Contraception**

Much more needs to be done to increase education among women and their doctors about EC, including where to obtain it, how it works, and how to take it, in order to improve its use and effectiveness. Many women do not know of the medication's availability – and many doctors fail to include EC information as part of their routine check-ups. Until this information is commonly known and distributed, EC's full potential to prevent unintended pregnancy, and therefore the need for abortion, will not be realized.

- Studies have shown that physician-knowledge deficits regarding EC are significantly associated with lower prescription rates.<sup>61</sup> Emergency medicine physicians are twice as likely to prescribe EC to adolescents if they are knowledgeable about EC and when it should be administered.<sup>62</sup>
- A 2009 study found that most emergency medicine physicians infrequently prescribe EC to adolescents (fewer than five times a year). Lack of physician knowledge about emergency contraception was a key reason for why EC was not prescribed in the emergency department setting.<sup>63</sup> This is particularly problematic, as many adolescents use the emergency room as their primary source of health care, and teens often choose to seek EC at an emergency room - rather than from their pediatrician - to preserve confidentiality and anonymity.<sup>64</sup>
- One survey found that almost 25 percent of North Carolina pharmacists thought that EC was the same as mifepristone, the medication that induces abortion. Some even told callers that EC caused an abortion and that if “the egg is fertilized, you have a live person.” Only one pharmacist out of 583 knew that EC could be effective up to 120 hours after unprotected sex.<sup>65</sup>

### **EC Public-Education Campaigns Can Increase Awareness of EC**

- More than 15 years ago, the Reproductive Health Technologies Project inaugurated a national toll-free hotline (1-888-NOT-2-LATE) that provides information about EC and referrals to health-care professionals who are able to prescribe it. In conjunction with Princeton University, the project later launched the Emergency Contraception Website ([www.not-2-late.com](http://www.not-2-late.com)) that includes similar information. The website is completely confidential and is available in multiple languages.

- The Hawaii health department conducted a public service advertising campaign about EC in 1999. The ads directed listeners to contact the national toll-free hotline or the state's family-planning information line. The average number of calls to the family-planning information line increased from eight to 10 calls per day to 40 to 50 calls per day during the month the radio spots aired.<sup>66</sup>
- Colorado's Boulder County health department educated the University of Colorado campus and surrounding community about EC using wallet cards and posters in the spring of 2000. The number of EC prescriptions filled increased substantially during the education program, with twice as many prescriptions filled in April 2000 as in April 1999.<sup>67</sup>
- A paid public-education media campaign in Philadelphia and Seattle resulted in significant increases in knowledge about EC. In addition, the number of calls to the Emergency Contraception Hotline (1-888-NOT-2-LATE) also significantly increased.<sup>68</sup>

### **Conclusion**

Emergency contraception is an important but underutilized contraceptive option that has the potential to improve women's reproductive health significantly. Ensuring that women have timely access to EC at doctor's offices, pharmacies, and hospitals, and encouraging women to use the medication correctly and consistently, may help reduce unintended pregnancy and the need for abortion. Instead of blocking access to EC, policymakers should focus on public education, education for health-care professionals, and innovative programs to make EC more accessible to all women.

January 1, 2012

#### **Notes:**

<sup>1</sup> Press Release, Women's Capital Corporation, *A New Generation of Emergency Contraception Has Arrived* (July 28, 1999). While labels for FDA-approved ECPs indicate that they should be used within 72 hours after unprotected sex, recent research shows that ECPs can be effective up to 120 hours after sex. However, ECPs are more effective the sooner they are taken. Charlotte Ellertson et al., *Extending the Time Limit for Starting the Yuzpe Regimen of Emergency Contraception to 120 Hours*, 101 *OBSTETRICS & GYNECOLOGY* 1168, 1168-71 (2003); Helena von Hertzen et al., *Low Dose Mifepristone and Two Regimens of Levonorgestrel for Emergency Contraception: a WHO Multicentre Randomised Trial*, 360 *THE LANCET* 1803, 1803-10 (2002); Gilda Piaggio et al., *Timing of Emergency Contraception with Levonorgestrel or the Yuzpe Regimen*, 353 *THE LANCET* 721 (1999).

<sup>2</sup> Robert A. Hatcher et al., *EMERGENCY CONTRACEPTION: THE NATION'S BEST KEPT SECRET* 29-30 (1995); American College of Obstetricians & Gynecologists (ACOG), *Statement on Contraceptive Methods* (July 1998). In fact, EC does not work if a woman is already pregnant.

**Notes, cont.**

- <sup>3</sup> Kaiser Family Foundation, *Emergency Contraception* (August 2010).
- <sup>4</sup> Press Release, Food and Drug Administration, *FDA approves ella™ tablets for prescription emergency contraception* (Aug. 13, 2010) at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm> (last visited Sept. 28, 2011).
- <sup>5</sup> The Emergency Contraception Website, *Answers to Frequently Asked Questions About Types of Emergency Contraception*, at <http://ec.princeton.edu/questions/dose.html#dose> (last visited Sept. 28, 2011).
- <sup>6</sup> AF Glasier, et al., *Ulipristal acetate versus levonorgestrel for emergency contraception: a randomized non-inferiority trial and meta-analysis*, 375 THE LANCET, 555 – 562 (2010). Kaiser Family Foundation, *Emergency Contraception* (August 2010).
- <sup>7</sup> Charlotte Ellertson et al., *Should Emergency Contraceptive Pills Be Available Without Prescription?*, 53 JAMWA 226, 227-28 (1998); David A. Grimes, *Switching Emergency Contraception to Over-the-Counter Status*, 347 NEW ENGLAND JOURNAL OF MEDICINE 846, 846-47 (2002).
- <sup>8</sup> Press Release, Women's Capital Corporation, *A New Generation of Emergency Contraception Has Arrived* (July 28, 1999).
- <sup>9</sup> Press Release, Barr Pharmaceuticals, Inc., *FDA Grants OTC Status to Barr's Plan B® Emergency Contraceptive* (Aug. 26, 2006); Press Release, U.S. Food and Drug Administration, *FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older, Prescription Remains Required for Those 17 and Under* (Aug. 24, 2006).
- <sup>10</sup> Press Release, Reproductive Health Technologies Project, *FDA revises restriction on over-the-counter access to Plan B emergency contraception to women 17 and over* (Apr. 22, 2009).
- <sup>11</sup> Press Release, Food and Drug Administration, *FDA Approves Generic Prescription-Only Version of Plan B Emergency Contraception for Women Ages 17 and Under* (Jun. 24, 2009) at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm168870.htm> (last visited Oct. 28, 2011).
- <sup>12</sup> Reproductive Health Technologies Project, *FDA Approved Emergency Contraceptive Products Currently on the US Market* at <http://www.rhtp.org/contraception/emergency/documents/FDAApprovedEmergencyContraceptiveChartAugust2011-PRINTABLE.pdf> (last visited Sept. 28, 2011).
- <sup>13</sup> Press Release, Food and Drug Administration, *FDA approves ella™ tablets for prescription emergency contraception* (Aug. 13, 2010) at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm> (last visited Sept. 28, 2011).
- <sup>14</sup> Press Release, Food and Drug Administration, *FDA approves ella™ tablets for prescription emergency contraception* (Aug. 13, 2010) at <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm> (last visited Sept. 28, 2011).
- <sup>15</sup> Center for Reproductive Rights, *The Center Takes the FDA Back to Court*, at <http://reproductiverights.org/en/feature/the-center-takes-the-fda-back-to-court> (last visited Oct. 27, 2011).

**Notes, cont.**

- <sup>16</sup> Press Release, U.S. Department of Health and Human Services, *A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius* (Dec. 7, 2011) at <http://www.hhs.gov/news/press/2011pres/12/20111207a.html> (last visited Dec. 19, 2011).
- <sup>17</sup> Kaiser Family Foundation, *Emergency Contraception* (Aug. 2010). WD Mosher, J. Jones, *Use of Contraception in the United States: 1982-2008*, National Center for Health Statistics, VITAL HEALTH STAT 23 (29), 2010 available at [http://www.cdc.gov/nchs/data/series/sr\\_23/sr23\\_029.pdf](http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf).
- <sup>18</sup> WD Mosher, J. Jones, *Use of Contraception in the United States: 1982-2008*, National Center for Health Statistics, VITAL HEALTH STAT 23 (29), 2010 available at [http://www.cdc.gov/nchs/data/series/sr\\_23/sr23\\_029.pdf](http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf).
- <sup>19</sup> James Trussell, et al. *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy* (October 2011) at <http://ec.princeton.edu/questions/ec-review.pdf>.
- <sup>20</sup> Caroline Moreau, et al., *The remaining barriers to the use of emergency contraception: perception of pregnancy risk by women undergoing induced abortions*, 71 CONTRACEPTION 202-207 (2005), finding that unperceived risk of pregnancy appears to be the most limiting factor to EC use.
- <sup>21</sup> COMMITTEE ON UNINTENDED PREGNANCY, INSTITUTE OF MEDICINE, *THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 80-82* (Sarah S. Brown & Leon Eisenberg eds., 1995).
- <sup>22</sup> COMMITTEE ON UNINTENDED PREGNANCY, INSTITUTE OF MEDICINE, *THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 80-82* (Sarah S. Brown & Leon Eisenberg eds., 1995).
- <sup>23</sup> COMMITTEE ON UNINTENDED PREGNANCY, INSTITUTE OF MEDICINE, *THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 80-82* (Sarah S. Brown & Leon Eisenberg eds., 1995).
- <sup>24</sup> ACOG, *Statement on Contraceptive Methods* (July 1998); 45 C.F.R. § 46.202(f).
- <sup>25</sup> James Trussell, et al. *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy* (October 2011) at <http://ec.princeton.edu/questions/ec-review.pdf> (last visited Oct. 17, 2011).
- <sup>26</sup> James Trussell, et al. *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy* (October 2011) at <http://ec.princeton.edu/questions/ec-review.pdf> (last visited Oct. 17, 2011).
- <sup>27</sup> Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS OF EMERGENCY MED. 105, 107-108 (2005).
- <sup>28</sup> Directive 36 of the U.S. Bishops' ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES provides, in part: "A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization." IBIS REPRODUCTIVE HEALTH & CATHOLICS FOR A FREE CHOICE, *SECOND CHANCE DENIED: EMERGENCY CONTRACEPTION IN CATHOLIC HOSPITAL EMERGENCY ROOMS 9* (2002), citing U.S. CONFERENCE OF CATHOLIC BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES Directive 36*.

**Notes, cont.**

- <sup>29</sup> Teresa Harrison, *Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff*, 46 ANNALS OF EMERGENCY MED. 105, 107 (2005); Press Release, American College of Emergency Physicians, *Study Finds Hospitals Need Clearer, Stronger Policies on Providing Emergency Contraception in Emergency Departments* (May 5, 2005).
- <sup>30</sup> Judith Graham, *Hospitals Ignore Rape Victim Law; Contraception and Counseling Not Given*, CHI. TRIB. (May 11, 2005); 410 Ill. Comp. Stat § 70/2.2 (Enacted 2001); Ill. Admin. Code tit. 77, § 545.20, -.35, -.60, -.95 (effective Jan. 15, 2003).
- <sup>31</sup> Guttmacher Institute, *State Policies in Brief: Emergency Contraception* (November 2011).
- <sup>32</sup> Guttmacher Institute, *State Policies in Brief: Refusing to Provide Health Services* (November 2011).
- <sup>33</sup> NARAL Pro-Choice North Carolina Foundation, *Access to Emergency Contraception in North Carolina Pharmacies*, at 4 (2007).
- <sup>34</sup> Kaiser Family Found., *Women and Health Care: A National Profile* (July 2005), available at <http://www.kff.org/womenshealth/7336.cfm> (last visited Oct. 17, 2011).
- <sup>35</sup> U.S. Dept. of Health & Human Services, Office on Women's Health, *Literature Review on Effective Sex- and Gender-Based Systems/Models of Care* (Jan. 2007), available at <http://www.womenshealth.gov/archive/owh/multidisciplinary/reports/GenderBasedMedicine/FinalO WHReport.pdf> (last visited Oct. 17, 2011).
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