Nos. 12-35221 & 12-35223

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STORMANS INC., doing business as Ralph's Thriftway, et al.,
Appellees,

v.

MARY SELECKY, et al.,
Defendant-Appellants

and

JUDITH BILLINGS, et al.,
Intervenor-Appellants.

On appeal from the United States District Court
for the Western District of Washington
Case No. 07-CV-05374-RBL (Hon. Ronald B. Leighton)

AMICUS CURIAE BRIEF OF ORGANIZATIONS AND EXPERTS DEDICATED TO ENDING RAPE AND INTIMATE PARTNER VIOLENCE, IN SUPPORT OF APPELLANTS AND APPELLANT-INTERVENORS

Sara L. Ainsworth, WSBA # 26656
Attorneys for Amici Curiae
Univ. of Washington School of Law*
William H. Gates Hall, Box 353020
Seattle, Washington 98195
(206) 650-2170
sains@uw.edu
*LAW SCHOOL AFFILIATION LISTED FOR IDENTIFICATION PURPOSES ONLY.

Michael S. Wampold, WSBA #26053
Attorneys for Amici Curiae
PETERSON | WAMPOLD
ROSATO | LUNA | KNOPP
1501 Fourth Avenue, Suite 2800
Seattle, WA 98101
(206) 624-6800
wampold@pwrlk.com

STATEMENT REGARDING CONSENT TO FILE

Per Federal Rule of Appellate Procedure 29(a), this brief is filed with the consent of all parties to the case.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rules 26.1 and 29(c)1 of the Federal Rules of Appellate Procedure, all *amici* organizations state that they are not publicly held corporations, they do not issue stock, and they do not have parent corporations. All *amici* organizations are non-profit organizations, with the exception of the National Alliance of Women Lawyers, which is organized under Section 501(c)6 of the Internal Revenue Code.

TABLE OF CONTENTS

Statement Regarding Consent to File i

Corporate Disclosure Statement ii

Table of Contents iii

Table of Authorities v

Interest of *Amici Curiae* 1

Introduction & Summary of Argument 1

Argument 2

I. Because rape and domestic violence are prevalent in the United States, many women will need emergency contraception to prevent rape-related pregnancy 3

II. Women also need access to emergency contraception when their abusive partners engage in "reproductive coercion" 7

III. Pregnancy prevention is a critical and immediate need of survivors of rape and intimate partner violence 9

A. Rape victims are at risk of pregnancy 9

B. Fear of pregnancy is one of the primary concerns of a rape survivor 10

C. Rape-related pregnancy puts women at additional risk for health problems, trauma and violence 11

1. Pregnancy is associated with an increased risk of severe intimate partner violence 11

2. Rape-related pregnancy may have lifelong consequences 12

IV. Emergency contraception safely and effectively prevents pregnancy after rape 15

V. Women in the United States face many barriers that impede access to emergency contraception 18

A. Misinformation impedes access to emergency contraception 18

B. Poverty and lack of access to health care impede access 19

C. Native American women and immigrant women face unique difficulties accessing emergency contraception 20

D. The effects of rape and intimate partner violence also make it more difficult for survivors to get the help they need 21

VI. The pharmacy should be a place of access to emergency contraception for all women, including rape victims 23

VII. Pharmacy access to emergency contraception furthers Washington State policies that promote the health and safety of survivors of rape and intimate partner violence 27

Conclusion 28

Certificate of Compliance 30

Statement of Related Cases 32

Certificate of Service 33

Appendix A (Statements of Interest of *Amici Curiae*)

TABLE OF AUTHORITIES

Federal Cases

Employment Div., Dept. of Human Res. of Oregon v. Smith, 494 U.S. 872, 110 S. Ct. 1595 (1990)....26

Planned Parenthood v. Casey, 505 U.S. 833, 112 S. Ct. 2791 (1992)....6

Tummino v. Torti, 603 F. Supp.2d 519 (E.D.N.Y. 2009).... 16, 18

Federal Statutes

Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. 109-162, 119 Stat. 2960, Title II § 201(1) (2006)....6

State Cases

Danny v. Laidlaw, 165 Wn.2d 200, 193 P.3d 128 (2008)....6, 28

State Statutes

WASH. REV. CODE § 7.90....27

WASH. REV. CODE § 7.90.005....5

WASH. REV. CODE § 26.50.303 Findings -- 1992 c 111....6

WASH. REV. CODE § 49.76....27

WASH. REV. CODE § 50.20.050(1)(b)(iv)....27

WASH. REV. CODE § 59.18.575....27

WASH. REV. CODE § 59.18.580....27

WASH. REV. CODE § 59.18.585....27

WASH. REV. CODE § 70.41....24

WASH. REV. CODE § 70.41.350 27

WASH. REV. CODE § 70.41.350 Findings – 2002 c 116 (1)(d)..................................4

WASH. REV. CODE § 70.41.350 Findings – 2002 c 116(1)(c)...................................4

Other Authorities:

Emergency Contraception

American Academy of Pediatrics, *Policy Statement: Emergency Contraception*, 116 PEDIATRICS 1038, 1042, 1044 (2005) 7

American College of Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 112*, 115 OBSTETRICS & GYNECOLOGY 1100, 1103 (2010) 16, 17

BOONSTRA, HEATHER, EMERGENCY CONTRACEPTION: THE NEED TO INCREASE PUBLIC AWARENESS, THE GUTTMACHER REPORT ON PUBLIC POLICY 1 (2002), http://www.guttmacher.org/pubs/tgr/05/4/gr050403.pdf 3, 15, 19

Ellertson, Charlotte, *History and Efficacy of Emergency Contraception: Beyond Coca Cola*, 28 Family Planning Perspectives 44, 44-45 (1996).............15

Foster, Diana G., *Emergency Contraception: Effective Use*, MEDSCAPE (2008) http://www.medscape.org/viewarticle/574157................................... 20-21

Gardner et al., *Increasing Access to Emergency Contraception Through Community Pharmacies: Lessons from Washington State*, 33 Family Planning Perspectives 172 (2001) 24

GATTOZI, ELLEN, & CHARON ASETOYER, NATIVE AMERICAN WOMEN'S HEALTH EDUCATION RESOURCE CENTER, INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE: A SURVEY OF THE ACCESSIBILITY OF PLAN B AND EMERGENCY CONTRACEPTIVES WITHIN INDIAN HEALTH SERVICE 8-10 (2008) http://nativeshop.ravenbuildersinc.com/images/stories/media/pdfs/SurveyofEC_PlanBintheIHSER2008.pdf 20

GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: EMERGENCY CONTRACEPTION (Aug. 1 2012), http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf................................24

NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S (NAPAWF) FORUM, ISSUE BRIEF: EMERGENCY CONTRACEPTION & ASIAN & PACIFIC ISLANDER WOMEN 5 (August 2007), http://napawf.org/wp-content/uploads/2009/working/pdfs/issuebrief_ec_updated.pdf.................. 20, 21

NATIONAL HEALTH LAW PROGRAM, OVER THE COUNTER OR OUT OF REACH? A REPORT ON EVOLVING STATE MEDICAID POLICIES FOR COVERING EMERGENCY CONTRACEPTION (2007) http://www.raisingwomensvoices.net/storage/JumpStart_files/6hNHeLP ecreport1.pdf...19

Noé , Gabriela, et al., *Contraceptive Efficacy of Emergency Contraception With Levonorgestrel Given Before or After Ovulation*, 81 CONTRACEPTION 414, 418-419 (2010) 17

Prescription Drug Products, Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610-01, 8611 (Feb. 25, 1997)..15

Reznik, Sandra E., *Plan B: How It Works*, Health Progress, J. CATHOLIC HEALTH ASSOC. OF THE U.S. 59 (2010) 16, 17

Smugar, Steven S., et al., *Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims*, 90 AM. J. PUB. HEALTH 1327 (2000); *see also Brownfield v. Marina Hospital*, 208 Cal.App. 3d 405, 414 (1989) 10, 18

Sommers, S.D., et al., *An Assessment of the Emergency Contraception Collaborative Prescribing Experience in Washington State*, 41 J. AM. PHARM. ASSOC. 1, 1-7 (2001) 24

Trussell, James, & Elizabeth G. Raymond, *Emergency Contraception: A Last Chance to Prevent Pregnancy*, Princeton University 6-7 (2012) http://ec.princeton.edu/references/index.html 17

Trussell, James, et al., *The Role of Emergency Contraception*, 190 AM. J. OBSTETRICS & GYNECOLOGY S30, S32 (2004) 17, 19

Wilkinson, Tracey A., et al., *Access to Emergency Contraception for Adolescents*, 307 JAMA 362 (2012) 19

Wilkinson, Tracey A., et al., *Pharmacy Communication to Adolescents and Their Physicians Regarding Access to Emergency Contraception*, 129 PEDIATRICS 624, 627 (2012)..19

Intimate Partner Violence and Sexual Assault

AMNESTY INTERNATIONAL, MAZE OF INJUSTICE: THE FAILURE TO PROTECT INDIGENOUS WOMEN FROM SEXUAL VIOLENCE IN THE USA 2 (2007), http://www.amnestyusa.org/pdfs/MazeOfInjustice.pdf 3, 20

Anderson, Michelle J., *Marital Immunity, Intimate Relationships, and Improper Inferences: A New Law On Sexual Offenses by Intimates*, 54 HASTINGS L. J. 1465, 1509-1513 (2003) 5

Anderson, Michelle, *New Voices on the New Federalism: Women Do Not Report the Violence They Suffer: Violence Against Women and the State Action Doctrine*, 46 VILL. LAW REV. 907, 922-923 (2001) 5

Basile, Kathleen C., and Sharon G. Smith, *Sexual Violence Victimization of Women: Prevalence, Characteristics, and the Role of Public Health and Prevention*, 5 AM. J. OF LIFESTYLE MED. 407, 411 (2011)...........................25

BERLINER, LUCY, ET AL., OFFICE OF CRIME VICTIM ADVOCACY, WASH. STATE OFFICE OF COMMUNITY DEV., SEXUAL ASSAULT EXPERIENCE AND PERCEPTIONS OF COMMUNITY RESPONSE TO SEXUAL ASSAULT: A SURVEY OF WASHINGTON STATE WOMEN 22 (2001), http://www.commerce.wa.gov/DesktopModules/CTEDPublications/CTEDPublicationsView.aspx?tabID=0&ItemID=1194&MId=950&wversion=Staging..4, 5

BLACK, MICHELE C., ET AL., CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (NISVS): 2010 SUMMARY REPORT 18 (2011), http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf..........3, 5

Buel, Sarah M., *Fifty Obstacles to Leaving, A.K.A., Why Abuse Victims Stay*, 28 COLO. LAW 19 (1999)..15

Cahn, Naomi, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 VAND. L. REV. 1041, 1051 (1991) 14

Campbell, Rebecca, *What Really Happened? A Validation Study of Rape Survivors' Help-Seeking Experiences with the Legal and Medical Systems*, 20 VIOLENCE & VICTIMS 55, 57 (2005) 22

Chang, Jeani, et al., *Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999,* 95 AM. J. PUB. HEALTH 471, 473 (2005) 12

Coker, Ann L., *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 TRAUMA, VIOLENCE, & ABUSE 149, 151-53 (2007) 7, 8

DAVIS, LEIGH ANN, THE ARC, PEOPLE WITH INTELLECTUAL DISABILITIES AND SEXUAL VIOLENCE 1-2 (2009) http://www.thearc.org/document.doc?id=3657 4

Dutton, Mary Ann, et al., *Characteristics of Help-Seeking Behaviors, Resources and Service Needs of Battered Immigrant Latinas: Legal and Policy Implications*, 7 GEO. J. ON POVERTY L. & POL'Y 245, 251-254 (2000) 23

FANFLIK, PATRICIA, VICTIM RESPONSES TO SEXUAL ASSAULT: COUNTER-INTUITIVE OR SIMPLY ADAPATIVE?, NATIONAL DISTRICT ATTORNEYS ASSOCIATION, SPECIAL TOPICS SERIES, 5-7, 21 (2007), http://www.ndaa.org/pdf/pub_victim_responses_sexual_assault.pdf 21, 22

Fischer, Rebecca, et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 S.M.U. L. REV. 2117, 2126-2127 (1993) 22, 23

FISHER, BONNIE S., ET AL., U.S. DEP'T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, NATIONAL INSTITUTE OF JUSTICE, THE SEXUAL VICTIMIZATION OF COLLEGE WOMEN 10 (2000), https://www.ncjrs.gov/pdffiles1/nij/182369.pdf 4

Frye, Victoria, *Editorial: Examining Homicide's Contribution to Pregnancy-Related Deaths*, 285 JAMA 1510 (2001) 12

Gazmararian, Julie A., et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996 11

GOODMARK, LEIGH, A TROUBLED MARRIAGE: DOMESTIC VIOLENCE AND THE LEGAL SYSTEM 42 (2012) 23

Gottschall, Jonathan, & Tiffani, *Are Per-incident Rape-pregnancy Rates Higher than Per-incident Consensual Pregnancy Rates?*, 14 HUMAN NATURE 1, 1-20 (2003) 10

GRECO, DONNA, & SARAH DAWGERT, PENNSYLVANIA COALITION AGAINST RAPE, POVERTY AND SEXUAL VIOLENCE: BUILDING PREVENTION AND INTERVENTION RESPONSES 73-81 (2007), http://www.pcar.org/sites/default/files/file/poverty.pdf 4

Holmes, Melisa M., et al., *Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 AM. J. OBSTETRICS & GYNECOLOGY 320, 320-25 (1996) 9, 13, 14

Janssen, Patricia A., et al., *Intimate Partner Violence and Adverse Pregnancy Outcomes: A Population-Based Study*, 188 AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 1341 (2003) 12

Kobernick, Marc E., et al., *Emergency Department Management of the Sexual Assault Victim*, 2 J. OF EMERGENCY MED. 205 (1985) 10, 15

Lathrop, Anthony, *Pregnancy Resulting from Rape*, 27 J. OBSTETRICAL AND GYNECOLOGICAL NURSING 25 (1998) 11, 12

Miller, Elizabeth, *Editorial: Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 CONTRACEPTION 457, 457 (2010) 8

Miller, Elizabeth, et al., *Male Partner Pregnancy Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females*, 7 AMBULATORY PEDIATRICS 360, 364-365 (2007) 8, 9

Miller, Elizabeth, et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 CONTRACEPTION 316 (2010) 7, 8

Moore, Anne M., et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 SOC. SCIENCE & MED. 1737 (2010) 7, 8, 9

National Domestic Violence Hotline, *1 in 4 Callers Surveyed at the Hotline Report Birth Control Sabotage and Pregnancy Coercion*, THE HOTLINE, http://www.thehotline.org/2011/02/1-in-4-callers-surveyed-at-the-hotline-report-birth-control-sabotage-and-pregnancy-coercion/ (last visited July 31, 2012)..8

NATIONAL SEXUAL VIOLENCE RESOURCE CENTER, CHILDBIRTH HARD FOR RAPE VICTIMS, Feb. 8 2010, http://www.nsvrc.org/news/news-field/2230..14

Prewitt, Shauna R., *Giving Birth to a "Rapist's Child": A Discussion and Analysis of the Limited Legal Protections Afforded Women Who Become Mothers Through Rape,"* 98 Geo. L. J. 827 (2010) 14

RENNISON, CALLIE MARIE, U.S. DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, RAPE AND SEXUAL ASSAULT: REPORTING TO POLICE AND MEDICAL ATTENTION, 1992-2000 2 (2002)..5, 9

Silverman, Jay G., et al., *Dating Violence and Associated Sexual Risk and Pregnancy Among Adolescent Girls in the United States*, 114 PEDIATRICS e220, e221 (2004) 8

Stark, Evan, *Re-Presenting Woman Battering: From Battered Woman Syndrome to Coercive Control*, 58 ALB. L. REV. 973, 985 (1995) 22, 25

Straight, Jeannette D., & Pamela D. Hinton, *Emergency Department Care for Victims of Sex Offense*, 64 AM. J. HEALTH-SYS. PHARMACISTS 1845 (2007)...9

Tuerkheimer, Deborah, *Conceptualizing Violence Against Pregnant Women*, 88 IND. L.J. 667 (2006)...12

WORLD HEALTH ORGANIZATION, GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE 64 (2003), http://whqlibdoc.who.int/publications/2004/924154628X.pdf 9, 10

Other

AMERICAN PSYCHOLOGICAL ASSOCIATION, TASK FORCE ON MENTAL HEALTH AND ABORTION, REPORT OF THE TASK FORCE ON MENTAL HEALTH AND ABORTION 91 (2008), http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf 13

Associated Press, *Denial of Rape Victim's Pill Raises Debate*, MSNBC.COM, Feb. 24, 2004, http://www.msnbc.msn.com/id/4359430/ns/health-womens_health/t/denial-rape-victims-pills-raises-debate/#.UA8vKGnC5e4..2, 26

Belluck, Pam, *Abortion Qualms on Morning-After Pill May Be Unfounded*, N.Y. TIMES, June 5, 2012, at A1..17

Erdeley, Sabrina Rubin, *Doctors' Beliefs Can Hinder Patient Care*, SELF, NBC NEWS, June 22, 2007, http://www.msnbc.msn.com/id/19190916/ns/health-womens_health/t/doctors-beliefs-can-hinder-patient-care/#.UBwwhDHC5e4..26

Haskren, Holli Ann, and Kathaleen C. Bloom, *Postadoptive Reactions in the Relinquishing Mother*, 28 J. OBSTETRICAL & GYNECOLOGICAL NURSING 395, 396-399 (1999) 14

Holguin, Jaime, *Politics of Rape and Contraception*, CBS NEWS, Feb. 11, 2009, http://www.cbsnews.com/2100-18563_162-700791.html.........................10

Hooton, Angela, *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL'Y & L. 59, 72 (2005)..21

Jones, Rachel K., et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 6, 10-11 (2008)..13

Kacenek, Deborah, et al., *Medicaid Funding for Abortion: Providers' Experiences With Cases Involving Rape, Incest, and Life Endangerment*, 42 PERSPECTIVES ON SEXUAL & REPROD. HEALTH. 79 (2010)...13

KAISER FAMILY FOUNDATION ET AL., STATE MEDICAID COVERAGE OF FAMILY PLANNING SERVICES: SUMMARY OF STATE SURVEY FINDINGS 8 (2009), http://www.kff.org/womenshealth/upload/8015.pdf 28

Pharmacists for Life, “Plan B [Emergency Abortion Pill] FAQs” http://www.pfli.org/main.php?pfli=planbfaq (last visited August 2, 2012) 17

RICHARDSON, CHINUÉ TURNER, ADVOCATES AGAIN LOOK TO STATES TO PROMOTE EASED ACCESS TO EMERGENCY CONTRACEPTION, 9 GUTTMACHER POLICY REV. 11(2006) http://www.guttmacher.org/pubs/gpr/09/2/gpr090211.html 16

Severson, Kim, *Digital Age is Slow to Arrive in Rural America*, N.Y. TIMES, Feb. 17, 2011, at A1 20

The Emergency Contraception Website, Concerned About Cost?, http://ec.princeton.edu/locator/concerned-about-cost.html (last visited Aug. 2, 2012) 19-20

U.S. Food & Drug Administration, *FDA News Release: FDA Approves ella™ For Prescription Emergency Contraception*, Aug. 13, 2010, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm 222428.htm 16

U.S. Food & Drug Administration, *Plan B: Questions and Answers – August 24, 2006, updated December 14, 2006* http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm109783.htm 16

White House.gov, “1 is 2 Many,” http://www.whitehouse.gov/1is2many (last visited July 31, 2012)...6

World Health Organization, *Essential Medicines*, 14th Edition 18 (2005).............18

INTEREST OF *AMICI CURIAE*

Amici are more than fifty organizations and law professors with expertise in the social and legal responses to domestic and sexual violence. These organizations and individuals have extensive knowledge of the many barriers to safety and recovery for women and girls who have been raped or forced to risk unintended pregnancies by their intimate partners. Individual statements of interest are included in Appendix A.[1]

Amici work in communities, in legislatures or Congress, in the courts, and in academia, to urge the adoption and implementation of policies and practices that encourage the safety, health, and wellbeing of victims of rape and intimate partner violence. *Amici* are united in their support for immediate, unimpeded access to emergency contraception for survivors of rape and domestic violence.

INTRODUCTION & SUMMARY OF ARGUMENT

Women and girls in the United States are at high risk of experiencing sexual assault and violence perpetrated by an intimate. Preventing pregnancy after such an assault is, in most cases, critical to a woman's psychological recovery and physical health. Emergency contraception works effectively after an assault to prevent

[1] No party's counsel or their affiliated organizations authored or funded any part of this brief. Counsel for *Amici* Sara Ainsworth formerly represented the Defendant-Intervenors. Ms. Ainsworth's withdrawal from that representation was effective March of 2012, prior to her work on behalf of *Amici*.

pregnancy, and is the medical standard of care for treating women and girls of reproductive age after a sexual assault.

Given the prevalence of these crimes, refusals of emergency contraception at the pharmacy are bound to affect rape and domestic violence victims' access to this medication, increasing their risk of unintended pregnancies. While such pregnancies pose health risks for every woman, rape-related pregnancies hold profound consequences including compounded trauma and an increased vulnerability to violence.

Amici urge this Court to recognize the importance of access to emergency contraception for all women, and its critical nature for rape and domestic violence survivors. The interest of Washington State in ensuring women's access to this medication is a compelling one, and furthers numerous state policies that promote the safety of survivors of rape and intimate partner violence.

ARGUMENT

The collision of patient care and providers' religious beliefs has overshadowed the needs of victims of rape and reproductive coercion. Yet, the first instance of pharmacy refusal to garner national attention was the 2004 refusal of Texas pharmacists to dispense Plan B to a rape victim.[2] In fact, the first use of hormones

---

[2] *See* Associated Press, *Denial of Rape Victim's Pill Raises Debate*, MSNBC.COM, Feb. 24, 2004, http://www.msnbc.msn.com/id/4359430/ns/health-womens_health/t/denial-rape-victims-pills-raises-debate/#.UA8vKGnC5e4.

as emergency contraception was for a 13-year-old girl who had been raped.[3] Emergency contraception was first utilized with the needs of rape victims in mind, its provision is the standard of care for post-rape treatment, and rape and domestic violence survivors suffer severe consequences when denied access to it.

I. Because rape and domestic violence are prevalent in the United States, many women will need emergency contraception to prevent rape-related pregnancy.

Despite a decreasing national crime rate, and decades of law reform, rape remains an appallingly common crime in the United States. One woman in five in this country has been raped.[4] All women are at risk, but certain groups of women are particularly vulnerable to sexual assault. Those at heightened risk include young women,[5] Native American women,[6] women and girls with developmental disabilities,[7] and women attending college.[8] Low-income women are also more

---

[3] HEATHER BOONSTRA, EMERGENCY CONTRACEPTION: THE NEED TO INCREASE PUBLIC AWARENESS, THE GUTTMACHER REPORT ON PUBLIC POLICY 1 (2002), http://www.guttmacher.org/pubs/tgr/05/4/gr050403.pdf.

[4] MICHELE C. BLACK ET AL., CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (NISVS): 2010 SUMMARY REPORT 18 (2011), http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf.

[5] *Id*. at 25.

[6] *Id*. at 3 (more than 26% of Native American women reported being raped); *see also* AMNESTY INTERNATIONAL, MAZE OF INJUSTICE: THE FAILURE TO PROTECT INDIGENOUS WOMEN FROM SEXUAL VIOLENCE IN THE USA 2 (2007), http://www.amnestyusa.org/pdfs/MazeOfInjustice.pdf (one in three Native American women has been raped).

likely to experience rape and sexual victimization, because of unsafe housing, transportation, and lack of access to resources.[9]

Washington State is no exception. In a study conducted by the Washington State Office of Crime Victim Advocacy, approximately 23 percent of the women surveyed reported having been forcibly raped, a rate higher than the national average.[10] When other forms of sexual assault were included, the rate climbed to 38 percent.[11] The prevalence of *reported* rapes alone is "staggering": in 2001, there were 2,659 reported rapes in Washington State, or "seven rapes per day."[12]

Staggering as they are, these statistics do not capture the full extent of the problem, because the vast majority of women and girls never report that they were

---

[7] LEIGH ANN DAVIS, THE ARC, PEOPLE WITH INTELLECTUAL DISABILITIES AND SEXUAL VIOLENCE 1-2 (2009) http://www.thearc.org/document.doc?id=3657 (between 25% and 49% of people with intellectual disabilities experience sexual victimization).

[8] BONNIE S. FISHER ET AL., U.S. DEP'T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, NATIONAL INSTITUTE OF JUSTICE, THE SEXUAL VICTIMIZATION OF COLLEGE WOMEN 10 (2000), https://www.ncjrs.gov/pdffiles1/nij/182369.pdf (estimating that between one-fifth and one-quarter of women in college are raped).

[9] *See, e.g.*, DONNA GRECO & SARAH DAWGERT, PENNSYLVANIA COALITION AGAINST RAPE, POVERTY AND SEXUAL VIOLENCE: BUILDING PREVENTION AND INTERVENTION RESPONSES 73-81 (2007), http://www.pcar.org/sites/default/files/file/poverty.pdf.

[10] LUCY BERLINER ET AL., OFFICE OF CRIME VICTIM ADVOCACY, WASH. STATE OFFICE OF COMMUNITY DEV., SEXUAL ASSAULT EXPERIENCE AND PERCEPTIONS OF COMMUNITY RESPONSE TO SEXUAL ASSAULT: A SURVEY OF WASHINGTON STATE WOMEN 22 (2001), http://www.commerce.wa.gov/DesktopModules/CTEDPublications/CTEDPublicationsView.aspx?tabID=0&ItemID=1194&MId=950&wversion=Staging.

[11] *Id.* at 10-11; *see also* WASH. REV. CODE § 70.41.350 Findings – 2002 c 116(1)(c).

[12] WASH. REV. CODE § 70.41.350 Findings – 2002 c 116 (1)(d).

raped.[13] The reasons women do not report are many and complex,[14] but one significant factor is that women are most often raped by someone they know: a family member, an intimate partner, or an acquaintance.[15] Rape frequently co-occurs with intimate partner violence, and the victims of such rapes are even less likely to report it.[16] Women raped by their intimate partners are often more traumatized than victims of other perpetrators, and are more likely to suffer multiple rapes; as a consequence, they are also more likely to suffer acute and chronic physical and reproductive injuries.[17]

Unfortunately, thousands of women are at risk of domestic violence. All three branches of the federal government have recognized the severity and extent of

---

[13] CALLIE MARIE RENNISON, U.S. DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, RAPE AND SEXUAL ASSAULT: REPORTING TO POLICE AND MEDICAL ATTENTION, 1992-2000 2 (2002) (only 36 percent of victims of completed rapes reported these crimes to the police); *see also* WASH. REV. CODE § 7.90.005 ("rape is recognized as the most underreported crime; estimates suggest that only one in seven rapes is reported to authorities"); *see also* OCVA Study, *supra* note 10 at 22, 25 (in Washington State, many women had never told *anyone* that they had been raped).

[14] *See, e.g.,* Michelle Anderson, *New Voices on the New Federalism: Women Do Not Report the Violence They Suffer: Violence Against Women and the State Action Doctrine*, 46 VILL. LAW REV. 907, 922-923 (2001) (arguing that the intense scrutiny and humiliation rape survivors experience during the criminal justice process is an important factor in women's decisions not to report these crimes).

[15] *See, e.g.,* NISVS Report, *supra* note 4, at 39 (nearly 1 in 10 women in the United States have been raped by an intimate partner); *see also* OCVA Study, *supra* note 10, at 24.

[16] Michelle J. Anderson, *Marital Immunity, Intimate Relationships, and Improper Inferences: A New Law On Sexual Offenses by Intimates*, 54 HASTINGS L. J. 1465, 1509-1513 (2003) (analyzing the research on the experiences of victims of marital rape and noting that victims are both less likely to report "and less likely to receive support when they do").

[17] *Id.*

domestic violence in the United States. *See Planned Parenthood v. Casey*, 505 U.S. 833, 891, 112 S. Ct. 2791 (1992) ("[O]n an average day in the United States, 11,000 women are assaulted by their male partners. Many of these incidents involve sexual assault."). As Congress found when reauthorizing the Violence Against Women Act in 2005, intimate partner violence affects nearly one third of women in the United States.[18] The Executive Branch has recognized the high incidence of rape and domestic violence through its "1 is 2 Many" campaign.[19] In Washington State, too, the problem is also one of ". . . immense proportions affecting individuals as well as communities." WASH. REV. CODE § 26.50.303 Findings -- 1992 c 111; *accord Danny v. Laidlaw*, 165 Wn.2d 200, 214, 193 P.3d 128 (2008).

In short, women in Washington and throughout the nation face a significant risk of rape and intimate partner sexual assault. It is obvious, then, that some women seeking emergency contraceptives from pharmacies are trying to prevent pregnancy after a rape, whether by a stranger, acquaintance, or an intimate partner.

---

[18] Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. 109-162, 119 Stat. 2960, Title II § 201(1) (2006).

[19] White House.gov, "1 is 2 Many," http://www.whitehouse.gov/1is2many (last visited July 31, 2012).

II. Women also need access to emergency contraception when their abusive partners engage in "reproductive coercion."

Rape is not the only means by which abusive partners injure women's reproductive and sexual health. Women and girls in violent relationships also experience reproductive control and "pregnancy coercion."[20] For them, access to emergency contraception is critical for preventing pregnancy and regaining control of reproductive autonomy.[21]

"Reproductive coercion" describes a spectrum of conduct, ranging from rape to threats of physical harm, to sabotaging a woman's birth control.[22] In the context of violent relationships, "abused women face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning, including fear of condom negotiation."[23] Violent partners may prevent women's access to barrier contraception methods, such as condoms, and hormonal

---

[20] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 CONTRACEPTION 316 (2010); *see also* Anne M. Moore, et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 SOC. SCIENCE & MED. 1737 (2010).

[21] *See, e.g.,* American Academy of Pediatrics, *Policy Statement: Emergency Contraception*, 116 PEDIATRICS 1038, 1042, 1044 (2005) (supporting adolescents' over-the-counter access to emergency contraception).

[22] Miller, *supra* note 20, at 316-317; Moore, *supra* note 20, at 1738.

[23] Miller, *supra* note 20, at 316; *see also* Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 TRAUMA, VIOLENCE, & ABUSE 149, 151-53 (2007).

contraception;[24] a respondent to one study described how her partner "repeatedly flushed her birth control pills down the toilet and refused to use condoms."[25]

Experiences like this are not unique. When the National Domestic Violence Hotline surveyed over 3,000 women who called their national hotline, more than 25 percent reported that their abusive partner sabotaged birth control and tried to coerce pregnancy.[26] As one caller explained: "I better be pregnant, or I'm in trouble with him."[27] Such tactics, when used by a physically abusive partner, double the risk that the abused woman has an unintended pregnancy.[28]

Adolescents' unintended pregnancies are also associated with abuse and reproductive coercion.[29] Reproductive coercion of teenagers may include rape, coerced sex, pressure to have unsafe intercourse, and pressure to get pregnant as a

---

[24] *Id.*; *see also* Miller, *supra* note 20, at 316-317, 319.

[25] Moore, *supra* note 20, at 1740.

[26] National Domestic Violence Hotline, *1 in 4 Callers Surveyed at the Hotline Report Birth Control Sabotage and Pregnancy Coercion*, THE HOTLINE, http://www.thehotline.org/2011/02/1-in-4-callers-surveyed-at-the-hotline-report-birth-control-sabotage-and-pregnancy-coercion/ (last visited July 31, 2012).

[27] *Id.*

[28] Elizabeth Miller, *Editorial: Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 CONTRACEPTION 457, 457 (2010); *see also* Miller, *supra* note 20, at 320.

[29] Elizabeth Miller et al., *Male Partner Pregnancy Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females*, 7 AMBULATORY PEDIATRICS 360, 364-365 (2007); *see also* Jay G. Silverman et al., *Dating Violence and Associated Sexual Risk and Pregnancy Among Adolescent Girls in the United States*, 114 PEDIATRICS e220, e221 (2004).

means of proving loyalty to the abusive partner.[30] For adolescents in this situation, emergency contraception is a last recourse to prevent pregnancy.

III. Pregnancy prevention is a critical and immediate need of survivors of rape and intimate partner violence.

The majority of women who are raped do not seek medical care at an emergency room.[31] Yet, regardless of whether she seeks hospital care, the rape survivor's immediate health-related needs are the same: appropriate care for her physical injuries and psychological distress, prophylaxis for sexually-transmitted infection, and pregnancy prevention.[32]

A. Rape victims are at risk of pregnancy.

While estimates of the rate of rape-related pregnancy range widely, the most commonly cited study, based on the largest number of women surveyed in the United States, estimates that approximately five percent of rape victims – or about 32,000 women every year – will become pregnant.[33] Using the same statistics, but controlling for the numbers of women who would likely be using hormonal

---

[30] Miller, *supra* note 29, 363-364; Moore, *supra* note 20, at 1737, 1740.

[31] Rennison, *supra* note 13, at 1-3 (only 17% of rape victims sought care at a hospital).

[32] *See* WORLD HEALTH ORGANIZATION, GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE 64 (2003), http://whqlibdoc.who.int/publications/2004/924154628X.pdf; *accord* Jeannette D. Straight & Pamela D. Hinton, *Emergency Department Care for Victims of Sex Offense*, 64 AM. J. HEALTH-SYS. PHARMACISTS 1845 (2007).

[33] Melisa M. Holmes et al., *Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 AM. J. OBSTETRICS & GYNECOLOGY 320, 320-25 (1996).

contraception, the authors of a more recent study found that the actual incidence of rape-related pregnancy was almost eight percent.[34] *Amici* posit that these statistics are of value to this Court, but conclusive statistics are not necessary to establish the obvious fact that women of reproductive age who are raped are at risk of pregnancy.

B. Fear of pregnancy is one of the primary concerns of a rape survivor.

Even if the likelihood of rape-related pregnancy is low, a woman who has just been raped is not comforted by statistics. Rather, one of her foremost concerns, if she is of reproductive age, is preventing pregnancy.[35] As Lori Robinson, the author of *I Will Survive: The African American Guide to Healing from Sexual Assault and Abuse*, explained, when she received emergency contraception "in that time of total devastation, it was a relief."[36] Emergency contraception is the standard of care for medical treatment of a rape victim in the aftermath of an assault[37] – not only

---

[34] Jonathan Gottschall & Tiffani Gottschall, *Are Per-incident Rape-pregnancy Rates Higher than Per-incident Consensual Pregnancy Rates?*, 14 HUMAN NATURE 1, 1-20 (2003).

[35] *See, e.g.,* WHO Guidelines*, supra* note 32, at 64.

[36] Jaime Holguin, *Politics of Rape and Contraception*, CBS NEWS, Feb. 11, 2009, http://www.cbsnews.com/2100-18563_162-700791.html.

[37] Steven S. Smugar et al., *Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims*, 90 AM. J. PUB. HEALTH 1327 (2000); *see also Brownfield v. Marina Hospital*, 208 Cal.App. 3d 405, 414 (1989) (rape victim states a claim for medical malpractice when hospital physician failed to inform her about and provide access to emergency contraception); *see also* Marc E. Kobernick et al., *Emergency Department Management of the Sexual Assault Victim*, 2 J. OF EMERGENCY MED. 205 (1985).

because it is important for a woman's health to avoid a rape-related pregnancy, but also because it is critical that her fear and need to reestablish control over her life be immediately addressed.

C. Rape-related pregnancy puts women at additional risk for health problems, trauma and violence.

Women also need access to emergency contraception to avoid the psychological and physical trauma of a rape-related pregnancy.[38] Becoming pregnant through rape also puts a woman in the position of having to decide whether to continue or end the pregnancy, a decision complicated by her access to health care, economic resources, and social support, and one that may have life-long ramifications.[39]

1. Pregnancy is associated with an increased risk of severe intimate partner violence.

Those ramifications are particularly disturbing for women in abusive relationships. Pregnant women experience high rates of domestic violence, and this abuse is often severe, frequently resulting in serious injuries to both the woman and her pregnancy.[40] Women who are abused during pregnancy are more likely to

---

[38] *See, e.g.*, Anthony Lathrop, *Pregnancy Resulting from Rape*, 27 J. OBSTETRICAL AND GYNECOLOGICAL NURSING 25 (1998).

[39] *Id*. 27-28.

[40] Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996).

experience poor birth outcomes, including miscarriage or stillbirth.[41] The extreme levels of violence directed at pregnant women by their abusers may have the ultimate horrific result: the murder of the pregnant woman.[42] In the United States, homicide is a leading cause of the deaths of pregnant women.[43]

2. Rape-related pregnancy may have lifelong consequences.

In addition to these risks, the woman who becomes pregnant as a result of rape must face the ongoing psychological impact of the pregnancy itself and the potential childbearing and childrearing that comes with it. She must decide whether to continue the pregnancy, and if so, whether to keep or give up the child for adoption.[44]

---

[41] Patricia A. Janssen et al., *Intimate Partner Violence and Adverse Pregnancy Outcomes: A Population-Based Study*, 188 AM. J. OBSTETRICS & GYNECOLOGY 1341, 1346-47 (2003); *see also* Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 88 IND. L.J. 667, 672 (2006).

[42] Victoria Frye, *Editorial: Examining Homicide's Contribution to Pregnancy-Related Deaths*, 285 JAMA 1510 (2001) (". . . [A]cross the United States, homicide is a considerable source of mortality for pregnant and post-partum women").

[43] Jeani Chang et al., *Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999,* 95 AM. J. PUB. HEALTH 471, 473 (2005) (homicide ranked third among causes of pregnant women's deaths; African American women and very young women were most likely to be murdered during pregnancy).

[44] Lathrop, *supra* note 38, at 28.

Approximately half of the women who become pregnant as a result of rape will terminate their pregnancies.[45] For most women, having an abortion is not in and of itself a psychologically distressing event.[46] But undoubtedly – as the context of this case suggests – there are women who would find the decision troubling.[47] Having to obtain an abortion after a rape also prolongs the health consequences of the rape itself; abortion is an additional medical expense and physical experience that would have been unnecessary had pregnancy been avoided.

A significant number of women in these circumstances will carry a rape-related pregnancy to term. Some may do so because they could not access abortion.[48] Others may do so intending to raise the child.[49] Regardless of their reasons, women who carry rape-related pregnancies to term face all the health risks that attend other

---

[45] *See, e.g.*, Holmes, *supra* note 33, at 322 (50 percent of the women with rape-related pregnancies had abortions).

[46] AMERICAN PSYCHOLOGICAL ASSOCIATION, TASK FORCE ON MENTAL HEALTH AND ABORTION, REPORT OF THE TASK FORCE ON MENTAL HEALTH AND ABORTION 91 (2008), http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf.

[47] *Id*.

[48] Only 17 states pay for low-income women's abortions through their Medicaid programs. While federal law requires all states to cover abortion in cases of rape, this requirement is "inconsistently implemented." *See* Deborah Kacenek et al., *Medicaid Funding for Abortion: Providers' Experiences With Cases Involving Rape, Incest, and Life Endangerment*, 42 PERSPECTIVES ON SEXUAL & REPROD. HEALTH. 79 (2010). Access to abortion is also limited by the lack of providers. Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 6, 10-11 (2008) (in 2005, 35 percent of women in the U.S. lived in a county without an abortion provider).

[49] *See* Holmes, *supra* note 33, at 322 (approximately 32 percent of women in this study raised their children conceived through rape).

unintended pregnancies. They must also go through childbirth, an experience which may be riskier for sexual assault survivors than for other women.[50]

Some rape survivors will give up the child conceived through rape for adoption.[51] This is an additional life-altering experience, that, for many women, is experienced as traumatic for years if not a lifetime.[52] The rape survivor who decides to raise her child faces the prospect of being legally tied to the rapist by virtue of his genetic (and potentially legal) parenthood of that child.[53] For victims of intimate partner violence, having a child with an abusive partner makes it exponentially more difficult to safely leave the relationship.[54] In short, the optimal

---

[50] *See, e.g.,* NATIONAL SEXUAL VIOLENCE RESOURCE CENTER, CHILDBIRTH HARD FOR RAPE VICTIMS, Feb. 8 2010, http://www.nsvrc.org/news/news-field/2230 (citing research published in the British Journal of Obstetrics and Gynecology that found that women who had been raped had a significantly higher likelihood of birth difficulties).

[51] *See* Holmes, *supra* note 33, at 322 (just under six percent of women in this study gave up for adoption their children conceived through rape).

[52] Holli Ann Haskren and Kathaleen C. Bloom, *Postadoptive Reactions in the Relinquishing Mother*, 28 J. OBSTETRICAL & GYNECOLOGICAL NURSING 395, 396-399 (1999) (noting that "a woman who . . . relinquishes her child is at risk for the additional emotional stress of long-term grief").

[53] *See* Shauna R. Prewitt, *Giving Birth to a "Rapist's Child": A Discussion and Analysis of the Limited Legal Protections Afforded Women Who Become Mothers Through Rape,"* 98 Geo. L. J. 827 (2010) (in the context of arguing that some of the rhetoric supporting rape victims' abortion and contraception rights undermines survivors' reproductive autonomy, relating her own experience of having a child through rape, with no legal recourse to prevent the rapist's establishment of paternity).

[54] *See, e.g.*, Naomi Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 VAND. L. REV. 1041, 1051 (1991) (describing abused women's legal difficulties when leaving with children and their reluctance to flee without them); *see also*

outcome for the survivor of rape or reproductive coercion is to have timely access to emergency contraception so that it is in her power to avoid pregnancy.

IV. Emergency contraception safely and effectively prevents pregnancy after rape.

Emergency contraception is a safe and effective way of preventing pregnancy after a rape or coerced (or consensual) sexual intercourse.[55] The use of hormones for this purpose dates back to the mid-1960s, when a Dutch physician treated a 13-year-old rape victim with a high dose of estrogen to prevent pregnancy.[56] This method was used until the early 1970s, when a Canadian physician, A. Albert Yuzpe, developed a regimen using both estrogen and progestin.[57] The "Yuzpe method" was the one used most frequently in the U.S. to treat women trying to prevent pregnancy after a rape or consensual intercourse.[58]

It was not until the 1990s that the FDA approved dedicated emergency contraceptive products. Plan B, until recently the only such product on the U.S.

Sarah M. Buel, *Fifty Obstacles to Leaving, A.K.A., Why Abuse Victims Stay*, 28 COLO. LAW 19 (1999).

[55] Prescription Drug Products, Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610-01, 8611 (Feb. 25, 1997).

[56] Boonstra, *supra* note 3.

[57] *Id.*

[58] Charlotte Ellertson, *History and Efficacy of Emergency Contraception: Beyond Coca Cola*, 28 Family Planning Perspectives 44, 44-45 (1996); *see also* Kobernick, *supra* note 37, at 210-211.

market,[59] is a pill containing levonorgestrel, a synthetic progestin.[60] The drug is most effective at preventing pregnancy if taken as soon as possible after intercourse, but is considered ineffective after 120 hours.[61] It is available to women ages 17 and older without a prescription, although it must be kept behind the pharmacy counter and purchasers are subject to age verification.[62] Adolescents under age 17 may obtain the medication by prescription or, in Washington and eight other states, directly from pharmacists with collaborative practice agreements.[63]

---

[59] *See* U.S. Food & Drug Administration, *FDA News Release: FDA Approves ella™ For Prescription Emergency Contraception*, Aug. 13, 2010, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm (announcing the agency's approval of a ella, a prescription-only emergency contraceptive). Because ella (ulipristal acetate) works through a similar method of action and has essentially the same efficacy rates as Plan B, this brief will not discuss it separately.

[60] Sandra E. Reznik, *Plan B: How It Works*, Health Progress, J. CATHOLIC HEALTH ASSOC. OF THE U.S. 59 (2010).

[61] *Id*. at 61; *see also* American College of Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 112*, 115 OBSTETRICS & GYNECOLOGY 1100, 1103 (2010).

[62] U.S. Food & Drug Administration, *Plan B: Questions and Answers – August 24, 2006, updated December 14, 2006* http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm109783.htm; *see also Tummino v. Torti*, 603 F. Supp.2d 519, 544-549 (E.D.N.Y. 2009) (finding the FDA's decision to limit over-the-counter access to Plan B to adults contrary to the agency's scientific findings and improperly politically-motivated, and ordering the FDA to immediately allow access to 17-year-olds and revisit its decision to deny over-the-counter access to teens 16 and under).

[63] *See* CHINUÉ TURNER RICHARDSON, ADVOCATES AGAIN LOOK TO STATES TO PROMOTE EASED ACCESS TO EMERGENCY CONTRACEPTION, 9 GUTTMACHER POLICY REV. 11(2006) http://www.guttmacher.org/pubs/gpr/09/2/gpr090211.html.

Although Plan B cannot harm an existing pregnancy,[64] some have likened it to an abortifacient because they believe it may prevent implantation of a fertilized ovum.[65] But recent scientific literature establishes that the drug does not, in fact, prevent pregnancy after fertilization, but prevents fertilization in the first place.[66] Even the Catholic Health Association of the United States has published a journal article that asserts that Plan B does not prevent implantation of a fertilized ovum.[67] What should be an uncontroversial and welcome method of preventing unintended and rape-related pregnancies has been miscast as a star player in the American abortion debate.[68]

---

[64] *See ACOG Practice Bulletin*, *supra* note 61, at 1102; *see also* James Trussell et al., *The Role of Emergency Contraception*, 190 AM. J. OBSTETRICS & GYNECOLOGY S30, S32 (2004).

[65] *See* Gabriela Noé et al., *Contraceptive Efficacy of Emergency Contraception With Levonorgestrel Given Before or After Ovulation*, 81 CONTRACEPTION 414, 418-419 (2010); *see also* James Trussell & Elizabeth G. Raymond, *Emergency Contraception: A Last Chance to Prevent Pregnancy*, Princeton University 6-7 (2012) http://ec.princeton.edu/references/index.html (follow "Trussel, J . . . hyperlink) (while some "may always feel that this question is not unequivocally answered . . . the best available evidence shows that levonorgestrel . . . ECPs prevent pregnancy primarily by delaying or inhibiting ovulation and inhibiting fertilization, mechanisms that do not involve interference with post-fertilization").

[66] Noé, *supra*, at 420.

[67] Reznik, *supra* note 60.

[68] *See, e.g.,* Pharmacists for Life, "Plan B [Emergency Abortion Pill] FAQs" http://www.pfli.org/main.php?pfli=planbfaq (last visited August 2, 2012); *see also* Pam Belluck, *Abortion Qualms on Morning-After Pill May Be Unfounded*, N.Y. TIMES, June 5, 2012, at A1.

V. Women in the United States face many barriers that impede access to emergency contraception.

Despite the controversy in this country, emergency contraceptive products are available over the counter, with no age restrictions, in countries throughout the world, "including most industrialized nations." *Tummino v. Torti,* 603 F. Supp.2d 519, 522 (E.D.N.Y. 2009). Emergency contraception is considered such standard treatment for post-coital pregnancy prevention that the World Health Organization has designated levonorgestrel and other similar drugs an "essential medicine."[69]

A. Misinformation impedes access to emergency contraception.

Yet, American politics and misinformation have hindered women's access to this drug for almost 15 years. Politics have kept Plan B behind the pharmacy counter for everyone, and prescription-only for young women. Some health care providers, whether they object to the drug for religious or moral reasons, or misapprehend its role in pregnancy prevention, continue to deny rape survivors this critical medication.[70] But these are not the only barriers women face when they try to get emergency contraception.

Many women are unaware that emergency contraception exists.[71] Others confuse it with mifepristone, the drug that actually causes abortion.[72]

---

[69] World Health Organization, *Essential Medicines*, 14th Edition 18 (2005).

[70] *See, e.g.,* Smugar, *supra* note 37, at 1374 (many hospitals failed to provide information about emergency contraception to rape survivors).

Misinformation is especially problematic for adolescents: in a recent study of pharmacies in five major U.S. cities, researchers were misinformed by almost 20 percent of pharmacies that teens could not access emergency contraception under any circumstances.[73] An even larger percentage told callers that over-the-counter access was restricted to people 18 and over (as noted above, it is available to women 17 and older).[74]

B. Poverty and lack of access to health care impede access.

In the same study, pharmacies located in low-income neighborhoods were more likely to give misinformation to adolescents.[75] This is disturbing enough, but access problems for low-income women are also measured by cost. In states where Medicaid does not cover over-the-counter Plan B, or for women who are not eligible for medical assistance by virtue of income or immigration status, the price of Plan B may be prohibitive.[76] This is one of the reasons why online availability is

---

[71] Trussel, *supra* note 64, at S34.

[72] *Id.*; *see also* Boonstra, *supra* note 3, at 5.

[73] Tracey A. Wilkinson et al., *Pharmacy Communication to Adolescents and Their Physicians Regarding Access to Emergency Contraception*, 129 PEDIATRICS 624, 627 (2012).

[74] *Id.*

[75] Tracey A. Wilkinson et al., *Access to Emergency Contraception for Adolescents*, 307 JAMA 362 (2012).

[76] NATIONAL HEALTH LAW PROGRAM, OVER THE COUNTER OR OUT OF REACH? A REPORT ON EVOLVING STATE MEDICAID POLICIES FOR COVERING EMERGENCY CONTRACEPTION (2007) http://www.raisingwomensvoices.net/storage/JumpStart_files/6hNHeLPecreport1.pdf; *see also*

an unsatisfactory solution; it is also inadequate because many low-income women lack Internet access,[77] and delayed access to the medication reduces its efficacy.

C. Native American women and immigrant women face unique difficulties accessing emergency contraception.

Native American women have had a particularly difficult time obtaining Plan B, despite the federal requirement that the Indian Health Service cover and provide this medication.[78] This failure to ensure access to Plan B is especially stunning given that Native American women experience extremely high rates of sexual violence.[79]

Immigrant women also face significant challenges to access to emergency contraception, including lack of health insurance and language barriers.[80] For

---

The Emergency Contraception Website, Concerned About Cost?, http://ec.princeton.edu/locator/concerned-about-cost.html (last visited Aug. 2, 2012) (Plan B ranges in cost from $35 to $60 or more).

[77] This is especially true of people living in rural communities. *See, e.g.,* Kim Severson, *Digital Age is Slow to Arrive in Rural America*, N.Y. TIMES, Feb. 17, 2011, at A1 (only 60 percent of rural households have broadband Internet access).

[78] ELLEN GATTOZI & CHARON ASETOYER, NATIVE AMERICAN WOMEN'S HEALTH EDUCATION RESOURCE CENTER, INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE: A SURVEY OF THE ACCESSIBILITY OF PLAN B AND EMERGENCY CONTRACEPTIVES WITHIN INDIAN HEALTH SERVICE 8-10 (2008) http://nativeshop.ravenbuildersinc.com/images/stories/media/pdfs/SurveyofEC_PlanBintheIHSER2008.pdf.

[79] *See* MAZE OF INJUSTICE, *supra* note 6.

[80] *See* Diana G. Foster, *Emergency Contraception: Effective Use*, MEDSCAPE (2008) http://www.medscape.org/viewarticle/574157; *see also* NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S (NAPAWF) FORUM, ISSUE BRIEF: EMERGENCY CONTRACEPTION & ASIAN & PACIFIC

example, "it is estimated that over one-third (37%) of Latinas in the United States do not have health insurance, the highest rate of uninsured among any racial/ethnic group."[81] Asian and Pacific Islander women, both immigrants and non-immigrants, are also frequently uninsured.[82] Immigrant women also struggle with access to Plan B because they may lack identification to meet the verification of age requirement.[83] On top of all this, being a victim of rape or domestic violence adds additional layers of difficulty in accessing emergency contraception.

D. The effects of rape and intimate partner violence also make it more difficult for survivors to get the help they need.

Rape survivors and women abused by their intimate partners often must surmount additional hurdles when trying to get the care they need from a pharmacy or other health care provider. While there is no universal reaction to having been raped, many rape survivors experience intense feelings of fear, shame, and self-blame.[84] They may suffer from depression or even Post-Traumatic Stress

---

ISLANDER WOMEN 5 (August 2007), http://napawf.org/wp-content/uploads/2009/working/pdfs/issuebrief_ec_updated.pdf.

[81] Angela Hooton, *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL'Y & L. 59, 72 (2005).

[82] *See* NAPAWF Issue Brief, *supra* note 80, at 5.

[83] *Id*. at 6.

[84] *See* PATRICIA FANFLIK, VICTIM RESPONSES TO SEXUAL ASSAULT: COUNTER-INTUITIVE OR SIMPLY ADAPATIVE?, NATIONAL DISTRICT ATTORNEYS ASSOCIATION, SPECIAL TOPICS SERIES, 5-7, 21 (2007), http://www.ndaa.org/pdf/pub_victim_responses_sexual_assault.pdf.

Disorder.[85] These responses to having been raped affect women's willingness to seek help afterwards, and color their experiences when they do seek help.[86] A negative response from others –including health care providers – may be experienced as a second trauma.[87]

These difficulties are compounded for many victims of intimate partner violence by the actions of the abuser. Perpetrators of domestic violence are often extremely controlling of all aspects of the abused person's life.[88] For many women, leaving the relationship is not a realistic option, because the risk of severe physical assault and homicide is heightened when a woman tries to leave.[89] Thus, the abused woman must often attempt to get help while still subject to the control of the abuser.

This is no easy task. Abusers commonly control their victims by limiting their access to financial resources, monitoring their use of transportation, and

---

[85] *Id*.

[86] *Id*. at 21.

[87] *See* Rebecca Campbell, *What Really Happened? A Validation Study of Rape Survivors' Help-Seeking Experiences with the Legal and Medical Systems*, 20 VIOLENCE & VICTIMS 55, 57 (2005).

[88] Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 S.M.U. L. REV. 2117, 2126-2127 (1993); *see also* Evan Stark, *Re-Presenting Woman Battering: From Battered Woman Syndrome to Coercive Control*, 58 ALB. L. REV. 973, 985 (1995).

[89] Fischer, *supra*, at 2138-39.

cataloguing their time spent out of the home.[90] They frequently threaten to retaliate against their partners by harming or kidnapping their children.[91] These difficulties are heightened for abuse victims who are immigrants or whose first language is not English.[92]

Access to Plan B varies based on where a woman lives, her knowledge of the drug, her language and socioeconomic status, and other factors. For survivors of rape and domestic violence who manage to overcome these obstacles and get to a pharmacy, a refusal – even one accompanied by a referral to another pharmacy – may create an insurmountable barrier.

VI. The pharmacy should be a place of access to emergency contraception for all women, including rape victims.

This is not to say that women who have suffered these forms of violence lack strength and resilience. But public policy should support their efforts to break free of abuse and reclaim their health and safety. Some states, like Washington, have done this by enacting legislation that will increase the likelihood that a rape victim

---

[90] *Id.* at 2121-2122, 2131-32; *see also* LEIGH GOODMARK, A TROUBLED MARRIAGE: DOMESTIC VIOLENCE AND THE LEGAL SYSTEM 42 (2012) (these behaviors contribute to an abused woman's economic insecurity, making it even more difficult to leave the relationship).

[91] Fischer, *supra* note 88, at 2122-2123.

[92] *See, e.g.*, Mary Ann Dutton et al., *Characteristics of Help-Seeking Behaviors, Resources and Service Needs of Battered Immigrant Latinas: Legal and Policy Implications*, 7 GEO. J. ON POVERTY L. & POL'Y 245, 251-254 (2000).

will get emergency contraception in a hospital.[93] However, hospital access alone is insufficient. As explained above, the majority of women do not go to a hospital after a rape, leaving pharmacies as their primary access point for emergency contraception.

Washington State's experience has demonstrated that pharmacies are important providers of emergency contraception for all women, including rape survivors. After Washington State pharmacists established collaborative protocols that allowed certain trained pharmacists to dispense Plan B directly, without the need for a physician's prescription, almost 12,000 women obtained the drug within the first sixteen months of the program.[94] While we cannot know how many sought Plan B after a rape or incident of reproductive coercion, it is statistically likely that many were, in fact, victims of these crimes; indeed, 7% of pharmacists surveyed within the first four months of the project indicated referring patients for additional care because of rape.[95] For them, these pharmacies' practices may have made a critical difference to their post-rape recovery; pharmacies that turn women away

---

[93] *See* WASH. REV. CODE § 70.41; *see also* GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: EMERGENCY CONTRACEPTION (Aug. 1 2012), http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf (12 states and the District of Columbia require emergency rooms to dispense emergency contraception to rape victims; 4 additional states require emergency rooms to inform women about the drug).

[94] Gardner et al., *Increasing Access to Emergency Contraception Through Community Pharmacies: Lessons from Washington State*, 33 Family Planning Perspectives 172 (2001).

[95] S.D. Sommers et al., *An Assessment of the Emergency Contraception Collaborative Prescribing Experience in Washington State*, 41 J. AM. PHARM. ASSOC. 1, 1-7 (2001).

would, presumably, have the opposite effect, and deter rape survivors from receiving appropriate medical care.

Amici are aware of no research that measures the impact of a pharmacy refusal on a rape victim. However, the literature describing women's common reactions after a rape informs the understanding of how rape survivors would experience such an event. As noted above, the support and responsive care of others – including health care providers – is often necessary for a rape victim's recovery and long-term wellbeing.[96] The same is true for a survivor of domestic violence; an unsupportive health care encounter may reaffirm her sense of entrapment in the abusive relationship.[97] A rejection at the pharmacy counter, no matter the motive, may result in the victim giving up on her attempt to prevent pregnancy, and may increase her psychological distress.

Anecdotal reports illustrate this point. In the first widely publicized incident of a pharmacist refusal, the woman who accompanied her friend, a rape victim, to the pharmacy to help her request the drug described her friend's experience as a

---

[96] *See, e.g.*, Kathleen C. Basile and Sharon G. Smith, *Sexual Violence Victimization of Women: Prevalence, Characteristics, and the Role of Public Health and Prevention*, 5 AM. J. OF LIFESTYLE MED. 407, 411 (2011) (negative social responses have detrimental effects on the health of rape survivors, and for some, "negative or hurtful disclosure responses can be worse for the victim than receiving no support at all").

[97] *See* Stark, *supra* note 88, at 1005-06 (describing the detrimental effect on survivors when health care providers miss or ignore signs of abuse, noting that "[f]rustrated help-seeking is so consequential for the battered woman because it converges with the batterer's pattern of denial, minimization, isolation, and blame").

"second victimization."[98] As Lori Boyer, who was refused emergency contraception at a hospital in Pennsylvania, explained, "I was so vulnerable. . . I felt victimized all over again. First the rape, and then the doctor making me feel powerless."[99]

When pharmacies refuse to dispense emergency contraception, the real and immediate needs of patients, including survivors of violence, are at stake. A state may act to protect those interests, even over a religious objection, because neutral laws of general applicability may restrict religious practices without violating the First Amendment, so long as they bear a rational relationship to a state interest. *Employment Div., Dept. of Human Res. of Oregon v. Smith*, 494 U.S. 872, 879-890, 110 S. Ct. 1595 (1990). Here, Washington has more than a rational reason to require pharmacies to ensure timely access to medication – it has a compelling interest in ensuring the health and safety of victims of rape and domestic violence, evidenced by its numerous policies designed to do just that.

---

[98] Associated Press, *Denial of Rape Victim's Pill Raises Debate*, NBC NEWS, Feb. 24, 2004, http://www.msnbc.msn.com/id/4359430/ns/health-womens_health/t/denial-rape-victims-pills-raises-debate/#.UA8vKGnC5e4.

[99] Sabrina Rubin Erdeley, *Doctors' Beliefs Can Hinder Patient Care*, SELF, NBC NEWS, June 22, 2007, http://www.msnbc.msn.com/id/19190916/ns/health-womens_health/t/doctors-beliefs-can-hinder-patient-care/#.UBwwhDHC5e4.

VII. Pharmacy access to emergency contraception furthers Washington State policies that promote the health and safety of survivors of rape and intimate partner violence.

In Washington State, lawmakers have taken significant steps to remove barriers to safety and health for women who are victims of rape or intimate partner violence. In the last decade alone, the Legislature has enacted laws that allow survivors of domestic violence, rape, and stalking to end their rental housing leases early to flee violence;[100] extended unemployment compensation to domestic violence victims who are forced to leave their jobs as a result of the violence;[101] and required all employers to provide reasonable unpaid leave to survivors of these crimes who need leave from work.[102] In 2006, Washington created a civil order of protection specific to sexual assault survivors.[103]

And, as noted above, Washington State requires all hospitals, religiously-affiliated or not, to counsel women about emergency contraception and dispense the medication to them upon request.[104] For low-income women, the state's Medicaid program covers emergency contraception, whether dispensed over-the-

---

[100] *See* WASH. REV. CODE § 59.18.575, .580, .585.

[101] *See* WASH. REV. CODE § 50.20.050(1)(b)(iv).

[102] *See* WASH. REV. CODE § 49.76.

[103] *See* WASH. REV. CODE § 7.90.

[104] *See* WASH. REV. CODE § 70.41.350.

counter or by prescription.[105] These are but a handful of the many laws this state has enacted to further its policies in favor the safety and health of women, including survivors of sexual and domestic violence. *See, e.g., Danny v. Laidlaw*, 165 Wn.2d at 214 (recounting myriad laws, judicial pronouncements, and executive orders directed at ensuring the safety of domestic violence survivors and their families). Washington's pharmacy access rules, while protecting all patients, further its compelling interest in ensuring the health and recovery of survivors of sexual assault and intimate partner violence.

CONCLUSION

Emergency contraception is a critical medication for any woman at risk of unintended pregnancy; for survivors of rape and victims of reproductive coercion, it is a lifeline. The concerns of women who have been raped or subjected to intimate partner violence should figure prominently in any analysis of the interests at stake when pharmacies object to providing emergency contraception. The dismissal of such concerns does not comport with Washington State policy, and ignores the fact that sexual and domestic violence is a matter of great public importance throughout the United States. Every system should work together to address and prevent sexual and domestic violence, and ensure that survivors

---

[105] KAISER FAMILY FOUNDATION ET AL., STATE MEDICAID COVERAGE OF FAMILY PLANNING SERVICES: SUMMARY OF STATE SURVEY FINDINGS 8 (2009), http://www.kff.org/womenshealth/upload/8015.pdf.

receive the care they need to recover and move on with their lives. In short, public policies should promote – not hinder – access to emergency contraception.

Respectfully submitted this 17th day of August, 2012.

/s Sara L. Ainsworth
Sara L. Ainsworth, WSBA # 26656
Univ. of Washington School of Law*
William H. Gates Hall, Box 353020
Seattle, Washington 98195
(206) 650-2170 sains@uw.edu

/s Michael S. Wampold
Michael S. Wampold, WSBA # 26053
1501 4th Avenue, Suite 2800
206-624-6800 wampold@pwrlk.com
Attorneys for *Amici Curiae*

*Law school affiliation listed for identification purposes only.

CERTIFICATE OF COMPLIANCE
PURSUANT TO FED. R. APP. P. 32(A)(7)(C) AND
CIRCUIT RULE 32-1 FOR CASE NUMBERS 12-35221 & 12-35223

I certify that: (check appropriate option(s))

☐ 1. Pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Rule 32-1, the attached opening brief is

☐ Proportionately spaced, has a typeface of 14 points or more and contains _____ words (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 14,000 words; reply briefs must not exceed 7,000 words),

or is

☐ Monospaced, has 10.5 or fewer characters per inch and contains _____ words or __________ lines of text (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 14,000 words or 1,300 lines of text; reply briefs must not exceed 7,000 words or 650 lines of text).

☐ 2. The attached brief is **not** subject to the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because

☐ This brief complies with Fed. R. App. P. 32(a)(1)-(7) and is a principal brief of no more than 30 pages or a reply brief of no more than 15 pages,

☐ This brief complies with a page or size-volume limitation established by separate court order dated ____________________ and is

☐ Proportionately spaced, has a typeface of 14 points or more and contains _____ words,

or is

☐ Monospaced, has 10.5 or fewer characters per inch and contains _____ pages or _______ words or __________ lines of text.

☐ 3. *Briefs in Capital Cases*

☐ This brief is being filed in a capital case pursuant to the type-volume limitations set forth at Circuit Rule 32-4 **and is**

☐ Proportionately spaced, has a typeface of 14 points or more and contains _____ words (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 21,000 words; reply briefs must not exceed 9,800 words),

or is

☐ Monospaced, has 10.5 or fewer characters per inch and contains _____ words or __________ lines of text (opening, answering, and the second and third briefs filed in cross-appeals must not exceed 75 pages or 1,950 lines of text; reply briefs must not exceed 35 pages or 910 lines of text).

☒4. *Amicus Briefs*

☒ Pursuant to Fed. R. App. P. 29(d) and 9th Cir. R. 32-1, the attached amicus brief is proportionally spaced, has a typeface of 14 points or more and contains 7,000 words or less,

or is

☐ Monospaced, has 10.5 or fewer characters per inch and contains not more than either 7,000 words or 650 lines of text,

or is

☐ **Not** subject to the type-volume limitations because it is an amicus brief of no more than 15 pages and complies with Fed. R. App. P. 32(a)(1)(5).

DATED this 17th day of August, 2012.

/s Sara L. Ainsworth
Sara L. Ainsworth, WSBA # 26656

STATEMENT OF RELATED CASES

Amici are aware of Case Number 12-35224, in which Legal Voice (formerly the Northwest Women's Law Center), a non-party to the litigation, appeals the district court's orders related to third-party discovery. The issues presented there have nothing to do with the merits issues presented in these consolidated appeals, however.

CERTIFICATE OF SERVICE

When All Case Participants Are Registered for the Appellate CM/ECF System

U.S. Court of Appeals Docket Number(s): 12-35221 & 12-35223

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on August 17, 2012.

I certify that all parties in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s Sara L. Ainsworth
Sara L. Ainsworth, WSBA # 26656

Appendix A

STATEMENTS OF INTEREST OF *AMICI CURIAE*

Organizations

API Chaya, located in Seattle, Washington, brings together the long-term community work of Chaya for South Asian Women (formed 1996) and the Asian & Pacific Islander Safety Center (formed 1993) to support survivors and communities in dealing with domestic violence, sexual violence, and human trafficking. API Chaya is the only organization in Washington State whose mission is to provide survivor advocacy and support specific to the Asian, South Asian and Pacific Islander communities. Prior to the founding of these organizations, very few API and South Asian women accessed mainstream services when they were in crisis, because of language barriers, social stigma and lack of awareness of legal and safety options. API Chaya recognizes that women experiencing intimate partner and sexual violence need immediate, confidential and reliable access to a full range of healthcare services, including emergency contraception to prevent unwanted pregnancy.

Asian Counseling & Referral Service is a nationally recognized nonprofit organization offering a broad array of human services and behavioral health programs to Asian Pacific Americans in King County, Washington. ACRS is the largest multiservice organization serving all the different Asian Pacific American communities – immigrants, refugees and American born – in the Pacific

Northwest. Since 1973, ACRS has worked to promote social justice and the wellbeing and empowerment of Asian Pacific American individuals, families and communities by developing, providing and advocating for innovative community-based multilingual and multicultural services.

The Battered Women's Justice Project – Domestic Abuse Intervention Programs, Inc., is a national technical assistance center that provides training and resources for advocates, battered women, legal system personnel, policymakers, and others engaged in the legal response to domestic violence. The BWJP promotes systemic change within community organizations and governmental agencies engaged in the civil and criminal legal response to domestic violence, to hold these institutions accountable for the safety and security of battered women and their children. The BWJP is an affiliated member of the Domestic Violence Resource Network, a group of national resource centers funded in part by the Department of Health and Human Services, and serves as a designated technical assistance provider for the Office on Violence Against Women of the U.S. Department of Justice. In an effort to promote safety and justice for women and their children, the BWJP works at state, national and international levels to engage court systems in methods of accurately assessing the effects of intimate partner violence on women and children and to fashion safe outcomes that hold batterers accountable.

The Black Women's Health Imperative in Washington, D.C. is a national organization dedicated to promoting optimum health for Black women across the life span – physically, mentally and spiritually. The Imperative chose its name to reinforce the fact that it is imperative to move beyond documenting the enormous health disparities that exist for Black women, and focus on actionable steps to eliminate them. To ensure that happens, the Imperative works at the national and local levels to bring the perspectives and often missing voices of African American women to ongoing health policy debates, and partners with health coalitions and organizations to develop community-based strategies to effect change. The Imperative works through engagement in health policymaking, public education, research, knowledge and leadership development, and communication to save and extend the lives of Black women.

The California Coalition Against Sexual Assault provides the unifying vision and voice to all Californians speaking out against sexual violence. Founded in 1980, CALCASA serves the largest population of sexual assault programs in the nation. CALCASA's leadership at both the state and national level brings support, justice, and hope to survivors of sexual assault, and to those who work to eradicate sexual violence in our communities. The needs of sexual violence survivors as well as the prevention approaches designed to stop sexual assault, guide CALCASA as it works to impact public policy, educate the public, and provide resources to all

those working to end sexual violence. CALCASA has a significant interest in ensuring that sexual assault survivors, including those from communities that have been traditionally underserved, have access to all resources available to assist in their healing, including emergency contraception to prevent pregnancy.

The California Partnership to End Domestic Violence is the federally recognized state domestic violence coalition for California. Like other domestic violence coalitions throughout the U.S. and territories, the Partnership is rooted in the battered women's movement and the values that define this movement, including working toward social justice, self-determination and ending the oppression of all persons. The Partnership has a 30-year history of providing statewide leadership, and has successfully passed over 100 pieces of legislation to ensure safety and justice for domestic violence survivors and their children. We believe that by sharing expertise, advocates and legislators can end domestic violence. The Partnership's mission and work are focused on protecting the safety of domestic violence victims and their children and holding batterers accountable. Abusers utilize a wide range of tactics to intimidate and control their victims. One such tactic, reproductive coercion, may include interfering with the victim's access to contraception. These tactics may lead to unplanned pregnancy and being coerced into having a child. Access to emergency contraception may be critical for a victim's safety and ability to leave the abusive relationship.

Consejo Counseling and Referral Service provides a continuum of behavioral health services to individuals and families across Washington State through its mental health, substance abuse, and domestic violence programs. Founded in 1978, Consejo's Domestic Violence Advocacy Program provides advocacy-based counseling, safety planning, legal advocacy and support groups for Latino survivors of domestic violence and sexual assault, with over twenty years of experience of service provision to this marginalized and underserved population. The majority of Consejo's clients face barriers to receiving adequate care following a physical or sexual assault, including isolation, fear of law enforcement, and lack of financial resources to pay for medical care. Consejo's Domestic Violence Program is strongly committed to ensuring that the safety and protections afforded to survivors remain intact.

CounterQuo is a national nonprofit organization dedicated to creating lasting social and legal change for survivors of sexual assault. Created to foster new alliances and information sharing between anti-violence leaders from the worlds of advocacy, law, media, public health and the academy, CounterQuo encourages the development of fresh ideas and honest dialogue, and considers best practices from other social, legal and public health movements. CounterQuo convened a leadership summit in 2008 to review the state of the law and the culture regarding sexual violence, and developed a results-oriented strategic plan for

moving the issue of sexual violence out of the shadows and onto the public stage. CounterQuo pursues this plan, including a multi-media public awareness campaign, a series of white papers and a national speakers bureau, to help change the way law and culture respond to sexual violence.

Domestic Violence Legal Empowerment and Appeals Project (DV LEAP), founded in 2003 by one of the nation's leading domestic violence lawyers and scholars, is a partnership of the George Washington University Law School and a network of participating law firms. DV LEAP provides a stronger voice for justice by fighting to overturn unjust trial court outcomes, advancing legal protections for victims and their children through expert appellate advocacy, training lawyers, psychologists and judges on best practices, and spearheading domestic violence litigation in the Supreme Court. DV LEAP is committed to ensuring that federal and state courts understand the realities of domestic violence and the law when deciding cases with significant implications for domestic violence litigants. DV LEAP has co-authored amicus briefs in numerous state courts and to the United States Supreme Court in *Town of Castle Rock, Colo. v. Gonzalez; Davis v. Washington; Hammon v. Indiana; Giles v. California; United States v. Hayes; and Abbott v. Abbott.* DV LEAP is aware that one major area for coercion and intimidation in abusive relationships is reproductive choice and

behavior. It is critical that courts avoid rulings that further empower abusive individuals in controlling and harming their partners.

The Domestic Violence Report is a multi-disciplinary newsletter distributed throughout the nation to 2,000 domestic violence programs and advocates, judges, lawyers, therapists, doctors, clergy, academics, police, probation officers and others interested in ending domestic violence. Edited by national domestic violence expert Joan Zorza, *DVR* assists keeps these professionals up to date with new developments in research, law, and treatment with the aim of keeping battered women and their children safe. The newsletter contributors and advisory board include lawyers, psychologists, doctors, nurses and other healthcare providers, criminologists, police, academics, researchers and battered women's advocates, all of whom work with and train policymakers throughout the nation. *DVR* has published regularly every two months since October of 1995. *DVR* recognizes how difficult it is for victims of domestic and sexual violence to obtain health care because their abusers often deny them access to medical coverage; to money to pay for health care needs; to transportation to obtain access to doctors, hospitals, pharmacies, therapists and other health care providers; and often destroy what medications they have, with the result that any further impediments to obtaining health services act to empower their abusers and makes it harder for them to leave and become safe.

End Violence Against Women International was founded in 2003 by Sgt. Joanne Archambault (Retired, San Diego Police Department). EVAWI is a nonprofit organization dedicated to inspiring and educating those who respond to gender-based violence, equipping them with the knowledge and tools they need to support victims and hold perpetrators accountable. EVAWI promotes victim-centered, multidisciplinary collaboration, strengthening the response of the criminal justice system, other professionals, allies, and the general public, and making communities safer. EVAWI joins this brief because of this case's potential impact on victims of intimate partner violence and sexual assault who need access to emergency contraception. Abusive partners often perpetrate physical and sexual assault on victims, as well as emotional abuse, financial abuse, and reproductive coercion, which may include unwanted sexual activity as well as denied access to contraception. EVAWI believes that all survivors of sexual assault and intimate partner violence should have access to emergency contraception without delay or harassment to ensure their safety, privacy, and self-determination.

Futures Without Violence (formerly Family Violence Prevention Fund) is a national nonprofit organization that has worked for over thirty years to prevent and end violence against women and children around the world. Futures Without Violence mobilizes concerned individuals, children's groups, allied professionals, women's rights, civil rights, and other social justice organizations to join the

campaign to end violence through public education/prevention campaigns, policy reform, training and advocacy programs, and organizing. Futures Without Violence has a particular interest in ensuring the health and safety of victims of domestic and sexual violence. For several years, Futures Without Violence has worked closely with survivors of intimate partner and sexual violence and their health care providers to assess the risk of, and take steps to address, reproductive coercion. Futures Without Violence believes that all survivors of sexual assault and intimate partner violence should have timely and appropriate access to emergency contraception without delay or harassment to ensure their safety and privacy.

INCITE! Women and Transpeople of Color Against Violence is a national activist organization that works to advance a movement to end violence against women of color, transpeople of color, and communities through direct action, critical dialogue, and grassroots organizing. Founded in 2000, INCITE! has grown to become one of the largest multiracial, grassroots, feminist organization in the United States, with chapters, affiliates, and individual members in more than twenty cities. INCITE! members work to address both personal and state violence, acknowledging the ways that oppressions intersect in the lives of women and transpeople of color. By supporting grassroots organizing, INCITE! advances a national movement to nurture the health and wellbeing of communities of color.

Jewish Family Service, Project DVORA (Domestic Violence Outreach, Response & Advocacy) in Seattle, Washington, facilitates a Jewish communal response to domestic violence. For over 115 years, Jewish Family Service has provided services for refugees, low-income families and elderly members of the community. Created in 1999, Project DVORA's vision is to create the conditions in the Jewish community to support loving, safe and respectful relationships; and to build the capacity in the community to respond to domestic abuse. Collaborating with other local Jewish organizations, synagogues, domestic violence programs and others, this internationally-recognized program provides consultation and training to Seattle's Jewish Community on domestic violence prevention, and serves survivors of domestic violence through counseling, safety planning, Jewish healing rituals for survivors of abuse and support groups for Jewish women suffering from intimate partner violence. Project DVORA believes all survivors of domestic and sexual violence need support and nonjudgmental help, including immediate access to emergency contraception.

King County Coalition Against Domestic Violence works to end domestic violence by facilitating collective action for social change. The organization works in King County, Washington, with a diverse population of just under two million people. In countywide public policy and education efforts, KCCADV provides leadership on behalf of more than thirty-five community-based victim service

agencies and their allies. KCCADV works to support and expand the choices available to victims and survivors of domestic violence, including reproductive choice. KCCADV believes that lack of access to emergency contraception undermines survivors' self-determination and threatens their healing process.

Founded in 1976 as King County Rape Relief, **King County Sexual Assault Resource Center** has grown to be the largest sexual assault victim's service organization in Washington State. KCSARC's purpose is to alleviate, as much as possible, the trauma of sexual assault for victims and their families. This nonprofit organization's mission is to give voice to victims, their families, and the community; create change in beliefs, attitudes, and behaviors about violence; and instill courage for people to speak out about sexual assault. KCSARC's comprehensive Victim Services (in English & Spanish) include 24-hour crisis support, advocacy, individual therapy, parent education, and Parent Child Interaction Therapy. KCSARC delivers an array of Sexual Assault Prevention workshops and programs, including groundbreaking work with communities coping with returning sex offenders. In 2011, KCSARC's staff served over 2,900 victims and an additional 4,500 individuals through prevention and community advocacy. Over 60% of victims served are under the age of 18. KCSARC believes that impeding access to emergency contraception for victims of sexual assault undermines their healing process.

The National Asian Pacific American Women's Forum is the only national, multi-issue Asian and Pacific Islander (API) women's organization in the country, with offices in Washington D.C., New York, and Oakland, and eleven chapters throughout the United States. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls. Since its founding, NAPAWF has supported and advocated for public policies that advance civil rights, economic opportunity, educational access, health and reproductive justice, immigrant and refugee rights, and efforts to end violence against women and girls. For API women, sexual and reproductive justice includes the fundamental human right to access affordable and linguistically and culturally competent health care services that support their overall health and wellbeing, including emergency contraception. NAPAWF supports policies that reduce the barriers that hinder many API women from accessing the drug in a timely manner.

The National Association of Women Lawyers, founded in 1899, is the oldest women's bar association in the country. NAWL is a national voluntary organization with members in all fifty states. NAWL is devoted to the interests of women lawyers, as well as all women. Through its members, committees and the Women's Law Journal, it provides a collective voice in the bar, courts and congress on women's rights. NAWL has a particular interest in protecting the rights of all women to obtain contraception. Further, the organization has a long

history of supporting rights for women who are abused. For this reason, NAWL joins as *amici* to this brief that makes a compelling case for the need for access to contraception in arguing: "Emergency contraception is a critical medication for any woman at risk for unintended pregnancy; for survivors of rape and victims of reproductive coercion, it is a lifeline."

The National Coalition Against Domestic Violence was formed in 1978 to provide support, technical assistance and information to domestic violence programs located in the United States, as well as growing the number of programs to assist victims available in communities. There were approximately 200 programs in 1978, and NCADV has helped that number grow to over 2,000 today. NCADV organizes for collective power by advancing transformative work, thinking, and leadership for communities and individuals working to end violence. Tactics used by abusers against their victims are coercive, controlling behaviors that include physical and sexual assault, emotional abuse, financial abuse, and interference in reproductive health decisions. Women who are victims of domestic violence consistently report their abusers denying them access to birth control, refusing to use condoms, and forcing sexual interactions. Unplanned pregnancies increase the risk of physical violence for women, and homicide is a leading cause of death for pregnant women. Access to emergency contraception in a timely manner may dramatically increase the safety of a victim of domestic violence.

The National Latina Institute for Reproductive Health works to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization and policy advocacy. Founded in 1994, NLIRH is the only national Latina health and reproductive rights organization representing an increasingly diverse and growing Latina population. Latinas face a unique array of reproductive health and rights issues that are exacerbated by poverty, gender, racial and ethnic discrimination and xenophobia. Latinas also experience significant risk of sexual and domestic violence, but may have greater difficulty accessing domestic violence services and health care – including pharmacy care – because of language barriers and the lack of culturally competent services. Refusing to dispense emergency contraception or referring a Latina rape survivor to another pharmacy creates additional barriers. NLIRH is committed to providing all Latinas access to quality, safe and affordable contraceptive options, including emergency contraception.

The National Network to End Domestic Violence is dedicated to creating a social, political and economic environment in which violence against women no longer exists. NNEDV is a membership and advocacy organization representing 56 member-state and territorial coalitions, their nearly 2,300 programs, and the millions of victims they serve. NNEDV serves as the national voice of battered women and their children and those who provide direct services to them. Along

with local, state and national leaders in domestic violence, NNEDV continues to formulate new approaches and innovative legal solutions to ending domestic violence. NNEDV is working on the current reauthorization of the Violence Against Women Act and, since 1994, has been instrumental in the enactment and reauthorization of that legislation. Through its longtime experience in domestic violence, NNEDV is well aware that "reproductive coercion" is a tool of power and control used by abusive partners, and survivors say that an unplanned pregnancy makes it harder for them to leave an abusive relationship. Leaving an abusive relationship is a complicated process and preventing access to emergency contraception may mean the difference between safety and the risk of continued abuse for many women.

Started by Columbia University students in 2000, **Students Active for Ending Rape, Inc. (SAFER)** supports college students in building a safer campus community by empowering them to strengthen their schools' sexual assault policies. SAFER facilitates student organizing through a comprehensive training manual; in-person workshops and trainings; free follow-up mentoring; our Campus Sexual Assault Policies Database, and a growing online resource library and network for student organizers. As college students, our constituents face enormous barriers to reporting and medical care following an assault, including but not limited to inadequate sexual assault policies; fear of law enforcement; lack of

emotional, physical and financial support; and reproductive coercion. SAFER is committed to fighting sexual violence and rape culture in campus communities and believes that denying access to emergency contraception is harmful to survivors and their healing process.

The Sargent Shriver National Center on Poverty Law provides national leadership to promote justice and improve the lives and opportunities of people with low income. Access to affordable, comprehensive health coverage and health care is vital to the wellbeing and upward mobility of people with low income. The Shriver Center's Women's Law and Policy Project works for justice for women and girls, including those who are survivors of domestic and sexual violence, with respect to fair and adequate treatment by the health care system – this includes access to emergency contraception for women who have been raped or experienced reproductive coercion. Domestic and sexual violence is epidemic. It not only negatively impacts survivors' immediate and long-term physical and psychological wellbeing, but also their economic wellbeing – all of which are at stake in the case before this Court.

The Sexual Violence Law Center is a nonprofit organization based in Seattle that serves the 38% of Washington women who will be sexual assaulted in their lifetimes. The mission of SVLC is to help these survivors rebuild their lives by protecting their privacy, safety, and civil rights, and by securing other legal

remedies through direct representation, advocacy, and education. Since 2010, SVLC's Sexual Assault Legal Services and Assistance (SALSA) program has provided direct legal representation to more than one hundred survivors of sexual assault in King County, and to more than one hundred other survivors across the state though a legal information and referral Help Line. Many sexual assault victims do not have the choice of using preventative birth control during an attack and risk unplanned pregnancies if they are denied access to emergency contraception. Both the fear of becoming pregnant due to rape and the actual consequences of such a pregnancy are profoundly traumatic to victims of sexual assault. It is SVLC's experience that prompt, easily accessible, nonjudgmental access to emergency birth control is absolutely necessary for survivors of sexual assault to prevent unplanned pregnancies and ensure their emotional recovery.

Surge Northwest is a new nonprofit organization based in Seattle, Washington, that works to advance racial and reproductive justice through community mobilization, education, and policy advocacy. Increasing access to quality, culturally proficient health care – including reproductive health care – is one of Surge Northwest's top priorities. Access to health care is critical for all communities, and is essential for survivors of sexual assault and intimate partner violence. Surge Northwest supports public policies that promote timely access to health care, including emergency contraception.

The Victim Rights Law Center is a nonprofit organization based in Boston, Massachusetts and Portland, Oregon. Rape and sexual assault often devastate a life, shattering a victim's social, economic, and emotional wellbeing for years, even decades, to come. The mission of VRLC is to provide individual legal representation to prevent such harm and help victims stabilize their lives in the aftermath of an assault, thereby promoting healing and long-term social and economic security. Its vision is to build a national cadre of pro bono and legal services attorneys committed to seeking justice for every sexual assault victim in the United States. The VRLC meets its mission through direct representation of victims in education, immigration, privacy, employment, housing, physical safety, and other matters, and through national legal advocacy, training and education regarding civil remedies for victims of sexual assault. The VRLC believes that all victims deserve and should have access to immediate and appropriate medical care following a sexual assault.

The Voices and Faces Project is a national documentary project created to give voice and face to survivors of sexual violence, offering a sense of solidarity to those who have lived through rape and abuse while raising awareness of how this human rights and public health issue impacts victims, families, and communities. The Voices and Faces Project was created for, and is largely funded and staffed by, survivors who have rejected the shame, invisibility and silence thrust upon them by

the broader culture. Through its permanent archive, the organization is building a valuable resource for advocates, policymakers, and all who seek to better understand the long-term impact of sexual violence.

The Washington Coalition of Sexual Assault Programs is a nonprofit organization that links 41 community sexual assault programs throughout Washington State. Since 1979, WCSAP has supported local sexual assault programs through training, publications, annual conferences and public policy advocacy. WCSAP engages in legislative and systems advocacy to improve the legal response to sexual assault survivors, and is committed to fostering a culture of respect and autonomy for all individuals, and healing and justice for victims of sexual violence. Toward that end, WCSAP was at the forefront of advocating for Washington State's law requiring hospital emergency rooms to provide emergency contraception to rape survivors, and testified to the Washington State Board of Pharmacy about the importance of pharmacies providing immediate and compassionate access to emergency contraception.

The Washington State Coalition Against Domestic Violence, founded in 1990, is a statewide membership organization comprised of organizations and individuals committed to ending domestic violence. The mission of WSCADV is to end domestic violence through advocacy and action for social change. Member programs include domestic violence shelters and other advocacy organizations

throughout Washington State. Women in these shelters describe abusive relationships where their partners hide, discard, or withhold their birth control, often resulting in unintended pregnancy and being coerced into having a child. WSCADV's collective experience demonstrates that if a domestic violence survivor is trying to prevent pregnancy, she may be doing so for reasons directly related to the violence perpetrated by the abuser. In some circumstances, a pregnancy can put a woman's life in great jeopardy. Timely access to emergency contraception may be critical for a domestic violence victim's safety and freedom from abuse.

The Washington State Native American Coalition Against Domestic Violence & Sexual Assault serves 29 federally recognized Tribes in Washington State, promoting the safety and rights of Native women who are victims of domestic violence, sexual assault, stalking, and dating violence. Recognizing that one of every three American Indian and Alaska Native women will be raped in their lifetime, that more than six of ten will be physically assaulted, and that Indian women are stalked at more than twice the rate of any other population of women, the organization works to eliminate violence against Native women and promote the wellbeing of native families and communities. The Coalition works by seeking opportunities to collaborate to increase direct service effectiveness, developing mentoring and networking capacity for further development of Native Women's

leadership proficiency, and promoting discussion, policy setting, and resource building that are relevant to Tribal communities. The Coalition also strives to improve services and systems response for Native victims living on reservation and off reservation by federal, state, tribal, and local authorities.

Law Professors and Other Experts[1]

Michelle J. Anderson, the Dean at CUNY School of Law, is an expert and leading scholar on sexual violence and rape law. Her work has been published widely, reprinted in casebooks, and referenced by courts and legislators. Her article redefining rape was selected as a core text in *Criminal Law Conversations*, published by Oxford University Press in 2009. Dean Anderson is the former Policy Chair for the National Alliance to End Sexual Violence. and recipient of the Sue Rosenberg Zalk Award from the Feminist Press.

Caroline Bettinger-Lopez teaches international human rights law and directs the Human Rights Clinic (HRC) at the University of Miami School of Law. Her scholarship, advocacy, and teaching focus on international human rights law and advocacy, including the implementation of human rights norms at the domestic level. Her main regional focus is the United States and Latin America, and her principal areas of interest include violence against women, gender and race discrimination, immigrants' rights, and clinical legal education. She regularly

[1] Law school affiliations are listed for identification purposes only. Each law professor joins this brief as an individual, not on behalf of an institution.

litigates and engages in other forms of advocacy in the Inter-American Human Rights system, federal and state courts and legislative bodies, and the United Nations.

Sarah Buel, who NBC has called one of the five most inspiring women in America, is Clinical Professor of Law at Arizona State University School of Law, and a leading scholar and advocate in the field of domestic violence law. Professor Buel, a survivor of domestic violence herself, has worked for more than 30 years with battered women and children. She graduated cum laude from Harvard Law School, where she founded the Harvard Battered Women's Advocacy Project, the Harvard Women in Prison Project, and the Harvard Children and Family Rights Project. She was a prosecutor for six years in Boston and Quincy, Mass., and for 14 years was a clinical professor at the University of Texas School of Law, where she founded and co-directed their Domestic Violence Clinic, co-founded the University of Texas Institute on Domestic Violence and Sexual Assault, and served as special counsel for the Texas District and County Attorneys Association.

Ann Cammett is a Professor of Law at the William S. Boyd School of Law, University of Nevada Las Vegas. She teaches Civil Procedure and co-directs the Family Justice Clinic, a live-client clinical program with a particular focus on the low-income families of prisoners, and those affected by the child welfare system and other forms of state intervention. Her scholarly work examines the

intersections of race, gender, poverty, family law and incarceration. Prior to joining the faculty at Boyd School of Law, Professor Cammett taught in Georgetown University Law Center's Domestic Violence Clinic and served as a Women's Law and Public Policy Fellow. She was previously awarded a Skadden Fellowship to provide civil legal services to formerly incarcerated women at the Legal Aid Society of New York, many of whom are survivors of domestic violence and sexual assault.

Donna K. Coker is a Professor of Law at the University of Miami School of Law, and a nationally recognized expert in domestic violence law and policy. One of her major areas of research concerns the connection between economic vulnerability and domestic violence. She is a leading critic of the disproportionate focus on criminal justice responses that characterizes U.S. domestic violence policy. Her widely cited research illustrates the negative impact of this focus on battered women marginalized as a function of race, poverty, or immigration status. Before attending law school, Professor Coker worked in the domestic violence field for 10 years, beginning in 1978 when she was the sole staff person for newly opened battered women's shelter in Little Rock, Arkansas. She has trained religious professionals, military police, shelter staff, attorneys and judges in responding to domestic violence.

Sarah Deer is Assistant Professor of Law at William Mitchell College of Law. She is a Citizen of the Muscogee (Creek) Nation. She focuses her legal work on violent crime on Indian reservations. Professor Deer has co-authored two textbooks on tribal law and several academic articles on Native American women. She is the author of Amnesty International's "Maze of Injustice" report, and the U.S. Department of Justice's report "Sexual Assault in Public Law 280 States." She is a Board Member of the American Bar Association's Commission on Domestic Violence as well as the National Alliance to End Sexual Violence.

Margaret Drew is a domestic violence lawyer, trainer and consultant based in Cincinnati. Ms. Drew trains and advises lawyers and judges on all aspects of intimate partner violence, particularly on how the parties who have experienced this violence interact with the legal system. In addition, Ms. Drew advises individuals who have experienced intimate partner violence and who also have involvement with either the civil or criminal legal system. Prior to establishing her consulting business, Ms. Drew was a professor of clinical law at the University of Cincinnati College of Law and was a visiting professor of clinical instruction at the University of Alabama School of Law. She is recognized as a national expert in the field of violence against women and intimate partner abuse. Ms. Drew recognizes the frequency with which rape and other forms of sexual abuse are used to control targets of intimate partner violence. Those who are in abusive intimate

relationships typically have no control over when and how they have sexual intercourse. Conception prevention of any sort is often out of their control. Plan B is a critical element of recovery for those who have been raped and otherwise subjected to forced sex. To limit Plan B's availability re-traumatizes victims of sexual violence and could forever tie them to their rapists through conception.

Deborah Epstein is a Professor of Law at Georgetown University Law Center, and a national and international expert in domestic violence law and policy. Much of her scholarship focuses on access to justice for economically vulnerable victims of domestic violence, and the importance of developing more individualized solutions responsive to the concerns of individual survivors. She was an early and influential critic of the ways in which the U.S. justice system has focused so heavily on criminal justice responses to the problem. Professor Epstein has represented over 600 indigent women on civil protection order cases in the District of Columbia, and has conducted trainings on the issue for lay advocates, attorneys, shelter workers, social workers, police, and judges.

Julie Goldscheid is a Professor of Law at CUNY School of Law, where she teaches courses on gender equality as well as contracts and lawyering. She writes and speaks widely about gender equality, with a particular focus on gender-based violence and economic equality. Before joining the CUNY faculty, she held positions including senior staff attorney and acting legal director at Legal

Momentum (formerly NOW Legal Defense and Education Fund). She spearheaded that organization's legal work to end violence against women, which included defending the constitutionality of the civil rights remedy of the 1994 Violence Against Women Act in courts nationwide, and before the U.S. Supreme Court in *United States v. Morrison.* She continues to be involved in advocacy to end domestic and sexual violence and to advance gender equality.

Leigh Goodmark is a Professor of Law at the University of Baltimore School of Law, where she directs the Family Law Clinic and teaches Family Law. Professor Goodmark is the author of numerous articles on domestic violence; her book, *A Troubled Marriage: Domestic Violence and the Legal System,* was published by New York University Press in 2012. In that book, Professor Goodmark discusses the problems of reproductive abuse and the links between reproductive health and domestic violence. Professor Goodmark's students in the Family Law Clinic regularly litigate domestic violence protective order matters and custody and divorce cases involving intimate partner abuse, and her clients have been subjected to rape and reproductive abuse; access to Plan B and other contraceptives is essential for them to live lives free of abuse.

Cheryl Hanna is a Professor of Law at Vermont Law School. She is an expert in constitutional law and gender equity. She has written extensively on issues of violence against women and is the co-author of the casebook *Domestic*

Violence and the Law: Theory and Practice (Foundation Press). She consults with domestic violence organizations in Vermont and across the United States, and her work has been cited extensively, including by the United States Supreme Court. Prior to becoming an academic, she prosecuted cases in one of the country's first specialized domestic violence units.

Nancy K. D. Lemon has taught Domestic Violence Law at UC Berkeley School of Law (Boalt Hall) since 1988 and wrote the textbook, *Domestic Violence Law*, now in its third edition with West Publishers. She has also taught the Domestic Violence Practicum at Boalt since 1990. She has published extensively and has worked on hundreds of cases as an expert witness: interviewing survivors of domestic violence, writing reports, and testifying. Many of these cases involve overlapping issues of reproductive justice and domestic violence.

Elizabeth L. MacDowell is a Professor of Law at the William S. Boyd School of Law, University of Nevada Las Vegas. She teaches Civil Procedure and Gender and the Law, and co-directs the Family Justice Clinic, a live-client clinical program focused on low-income families of prisoners, and those affected by the child welfare system and other forms of state intervention. Many of her clients are survivors of domestic and sexual violence. She previously taught at Chapman University School of Law, where she developed a domestic violence clinical course and taught courses on family law and domestic violence law and policy.

She also practiced law in Los Angeles, California, where she specialized in family law and domestic violence law and policy. Her scholarship focuses on intersectional issues of gender, race, class and culture, domestic violence, and access to justice. She has published articles on the construction of media representations of domestic violence, and how court systems and cultures impact access to justice in domestic violence cases.

Kris Miccio is a Professor of Law at the University of Denver Sturm College of Law. Professor Miccio is also an ordained Rabbi. She teaches criminal law and procedure, jurisprudence and a seminar on the Holocaust. Professor Miccio was a Fulbright Scholar to the Republic of Ireland where she conducted research on male intimate violence in a traditional Catholic country. She has received numerous awards for her scholarship on state accountability and male intimate violence including the Marie Curie Transfer of Knowledge Award, Erasmus Mundus, and a Fulbright Senior Specialist. Prior to entering the legal academy, Professor Miccio was a prosecutor in New York City and the founding director of Sanctuary for Families Center for Battered Women's Legal Services.

Robin R. Runge is an Assistant Professor of Law at the University of North Dakota School of Law, where she teaches Domestic Violence Law and the Employment and Housing Law Clinic. The former director of the Commission on Domestic Violence at the American Bar Association, Professor Runge is a

nationally recognized expert on the legal response to domestic violence. She developed and provided national and regional trainings for judges and attorneys on violence against women in China, and has received a Fulbright for the 2012-2013 academic year to study China's emerging legal response to domestic violence. Professor Runge's scholarship and advocacy interests focus on the regulation of the work and family lives of women and low-wage workers and the impact of that regulation on class and gender equity in the workplace and in family law.

Emily J. Sack is Distinguished Research Professor of Law at Roger Williams University School of Law, where she teaches in the areas of Criminal Law, Domestic Violence Law, Family Law, and Juvenile Justice. She is the author of several articles related to domestic violence, including *Battered Women and the State: The Struggle for the Future of Domestic Violence Policy* (2004 WISC. L. REV. 1657), which was quoted and cited extensively in Justice Stevens' dissenting opinion in *Castle Rock v. Gonzales* (U.S. 2005). She is co-author of the third edition of the casebook, *Domestic Violence and the Law: Theory and Practice* (Foundation Press, 3rd ed., forthcoming 2013). Her work includes an examination of intimate partner rape as a form of domestic violence. Prior to joining the RWU Law School faculty, Professor Sack was responsible for developing and implementing domestic violence courts throughout New York State, and she has

worked intensively with several jurisdictions around the country on improving their justice system response to domestic violence.

Elizabeth Schneider, Rose L. Hoffer Professor of Law at Brooklyn Law School, is a national expert in the fields of federal civil litigation, procedure, gender, law and domestic violence, and a frequent commentator for print and broadcast media. She teaches Women and the Law and Domestic Violence and the Law, among other courses. She is the author of the prize-winning book, *Battered Women and Feminist Lawmaking* (Yale University Press, 2000) and co-author of a law school casebook, *Domestic Violence and the Law: Theory and Practice* (3d. ed. forthcoming 2013) (with Cheryl Hanna, Judith G. Greenberg and Emily J. Sack). Professor Schneider has also written numerous law review articles and book chapters on civil rights, civil procedure, women's rights, and domestic violence. She has lectured around the world and participated in trainings of lawyers and judges in countries such as China, Vietnam, South Africa and Turkey. She was a consultant for the Secretary-General's Report on All Forms of Violence Against Women, submitted to the General Assembly of the United Nations in Fall 2006. Professor Schneider has also been a Visiting Professor at Harvard and Columbia Law Schools.

Jane Stoever is Professor of Law and directs the Domestic Violence Clinic and teaches Family Law and Domestic Violence Law & Lawyering at Seattle

University School of Law. Prior to joining the faculty at Seattle University, Professor Stoever was the Director of the Domestic Violence Clinic at American University, Washington College of Law, where she also taught Family Law, Domestic Violence Law, and a clinical seminar on lawyering skills and values. She previously taught in Georgetown University Law Center's Domestic Violence Clinic as a Women's Law and Public Policy Fellow and was awarded the Kaufman Public Interest Fellowship. She has published multiple articles on domestic violence law and lawyering.

Deborah Tuerkheimer is a Professor of Law at DePaul University College of Law, where teaches Criminal Law, Domestic Violence, and Feminist Jurisprudence. She is a co-author of West's *Feminist Jurisprudence* casebook. Much of her scholarship has focused on domestic violence and the criminal justice system's inadequate response to ongoing patterns of control. She has also published an article specifically treating the problem of violence during pregnancy. Before entering academia, she served as an Assistant District Attorney in the New York County District Attorney's Office, where she specialized in domestic violence prosecution.

Merle H. Weiner is the Philip H. Knight Professor of Law at the University of Oregon School of Law. She teaches courses in Domestic Abuse Law, Family Law, Torts, and International and Comparative Family Law. Her scholarship often

examines the way in which various legal issues impact victims of domestic violence and sexual assault, including custody, child abduction, and torts. Professor Weiner helped start the Domestic Violence Clinic at the University of Oregon, a live-client clinic that represents victims of sexual assault, stalking, and domestic violence, and is very involved with its oversight. She is a co-author of the first U.S. casebook on comparative and international family law and wrote the chapter on Domestic Violence.

D. Kelly Weisberg is Professor of Law at Hastings College of the Law, University of California. She teaches and writes in the areas of family law, children and the law, and domestic violence. Her casebook, *Domestic Violence: Legal and Social Reality*, was published by Aspen Publishers in 2012.

Deborah M. Weissman is the Reef C. Ivey II Distinguished Professor of Law at the School of Law at the University of North Carolina at Chapel Hill. She teaches, researches and writes, and has practiced in the realm of gender-related human rights, and has worked with coalitions of groups and individuals to promote gender equality.