PCAR
PENNSYLVANIA COALITION AGAINST RAPE

Help • Hope • Healing

Pennsylvania Coalition Against Rape's Testimony before the Pennsylvania House Health Committee
Public hearing on pro-life/abortion, Part III—Down Syndrome
Presented by Donna Greco, policy director; and Barbara Sheaffer, medical advocacy coordinator
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Thank you Chairwoman Rapp, Chairman Frankel, and members of the House Health Committee for inviting the Pennsylvania Coalition Against Rape (PCAR) to join today's hearing. My name is Donna Greco, and I am the policy director at PCAR. I am joined by my colleague, Barbara Sheaffer, medical advocacy coordinator at PCAR. We have both worked as advocates for survivors of sexual violence for over 25 years. We are grateful for the opportunity to share PCAR's views with you on this important issue.

ABOUT PCAR

PCAR was established in 1975 with a mission to eliminate all forms of sexual violence and to advocate for the rights and needs of all victims of sexual assault. That mission is mobilized in partnership with our network of rape crisis centers, which serve all 67 counties of the Commonwealth. These centers provide both crisis-response and long-term support to approximately 33,000 victims per year, with approximately 3,500 children and their families. Rape crisis centers also engage community members in efforts to prevent future assaults, using public health practices to uproot the risk factors that contribute to sexual violence.

We are grateful to be here today because we feel conversations about reproductive health care must be informed by the perspectives of rape crisis centers and the survivors they serve.

Our testimony today focuses on the intersections between sexual violence, reproductive coercion, and pregnancy and abortion-seeking behaviors among victims. We share as much data from the research as possible, with the caveat that this area of sexual violence is under-studied. We recognize that this hearing is much broader, but given PCAR's scope and mission, we hope the information that we share today can be helpful as this Committee further discusses policies and protocols related to the needs of Pennsylvanians seeking reproductive healthcare.

PCAR strongly supports a full range of reproductive health care options for victims of rape and incest, including abortion services. This policy position guides our legislative stances and programmatic standards.

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We believe victims should be afforded unbiased information about their rights and available services when faced with a rape-related pregnancy.

ABOUT SEXUAL VIOLENCE

Sexual violence remains a pervasive and traumatic public health problem affecting Pennsylvanians, the nation, and world. According to the National Intimate Partner and Sexual Violence Study (NISVS), nearly one in five women and one in 38 men have experienced rape or attempted rape during their lifetimes. NISVS concludes that sexual violence starts early, with one in three female victims experiencing rape between the ages of 11 and 17 and one in four male victims experiencing rape before the age of 10. The overwhelming majority of sexual assaults are committed by people known by victims.

ABOUT RAPE-RELATED PREGNANCY AND REPRODUCTIVE COERCION

As staggering and unnerving as these statistics are, they're only the tip of the iceberg. Sexual violence is among the most underreported crimes in the U.S. As a result, knowledge about rape-related pregnancies is also limited.

Reproductive coercion is sadly a common experience for many adults and teens seeking abortion services. Reproductive coercion includes acts and threats that coerce a partner into having sex, trying to get a partner pregnant without their consent, refusing to use or removing contraception during sex, and blocking a partner's access to contraception or birth control. NISVS found that of women who were raped by an intimate partner, 30% had experienced reproductive coercion by that partner. More specifically, 20% of victims stated their partner tried to get them pregnant when they did not want to, or blocked their access to birth control; 23% of victims reported their partner refused to use a condom.

The shame and stigma intertwined with many survivors' experiences of both sexual violence and abortion drive many victims into the margins of our communities. Many do not come forward due to justified fears that their safety or privacy will be dangerously invaded if they openly share their stories. These barriers may be compounded for victims of color, immigrant victims, and children, because these individuals are also victims of systemic oppression or power imbalances in broader society.

While research is limited, we do know, from NISVS, that approximately three million women in the U.S. have become pregnant as a result of rape at some point in their lives. These victims cross all racial and ethnic boundaries.

Studies also show that early sexual abuse is associated with unwanted pregnancies and abortion-seeking among teens and adult women.

The United States has higher rates of adolescent pregnancy than many other industrialized countries, with over 700,000 teen pregnancies annually (United Nations, 2012).

A study of 1,900 women between the ages of 18 and 22 found that 36% had been sexually abused and 26% became pregnant before the age of 18 (Kenney & Reinholtz, 1997). Sexual abuse and sexual coercion were associated with unwanted pregnancies.

A study of 13,310 American women and girls (aged 18 to 44 years), from 2011 to 2017 through a cross-sectional analysis of the National Survey of Family Growth, found that 6.5% of participants were forced to have sex as their first sexual experience (Hawks, Woolhandler & Himmelstein, 2019). The mean age of sexual coercion was 15 and the mean age of the coercive partner was 6 or years older. Thirty percent of participants had an unwanted pregnancy as a result of this coercion and 24% sought abortions.

A study of 535 young women in Washington state found that two thirds who had become pregnant were sexually abused (Boyer & Fine, 1992). Five percent were molested, 42% experienced attempted rape, and 44% were raped. These experiences were linked with having sex earlier, lack of contraception use, drug and alcohol problems, homelessness, engaging in survival sex for a place to stay, and physical or domestic violence.

Another study found over 60% of teen mothers had coercive sexual experiences and 23% of them became pregnant by the perpetrator (Gershenson et al., 1989). Perpetrators were most often (30%) family members. Other perpetrators were boyfriends, dates, and friends.

ABOUT CONSENT AND AGE DISPARITY

Not all children and teens seeking abortions in Pennsylvania are considered victims of sexual violence, according to the legal age of consent and Child Protective Services Law.

Age of Consent: In Pennsylvania, children aged 12 and under cannot legally consent to sexual activity in Pennsylvania. Teenagers between the ages of 13 and 15 can consent to sex with peers who are not more than 4 years older than them. Teenagers who are 16 and older can consent to sexual activity. However, we know age disparities within intimate relationships can create power imbalances and risk factors for reproductive coercion, sexual violence, unwanted pregnancies, and abortion-seeking behaviors.

The National Survey of Family Growth (Abma et al., 2002) found the majority of adolescent female subjects had a partner who was 1 to 3 years older, and those younger than 14 years were also more likely than those aged between 15 and 19 years to have partners who were 4 or more years older.

It is vital that children who are reasonably suspected to be victims of sexual abuse should be referred to the systems designed to respond to abuse as well as comprehensive support services, as they heal from the trauma of sexual violence and the difficult decisions that follow the crime when rape results in pregnancy. Such servcies include counseling and advocacy provided by rape crisis centers and other victim service agencies in the community.

At the same time, it is important to move upstream and invest in prevention and health education for young people. The Centers for Disease Control and Prevention points to several prevention strategies as promising, such as healthy relationships and sexuality, consent and body autonomy, engaging boys and men in prevention, leadership opportunities for girls, access to contraception, and many other programs to address risk factors for reproductive coercion and sexual violence.

ABOUT TRAUMA AND CARE FOR VICTIMS

Sexual violence is a traumatic event. Rape-related pregnancies can also be traumatic. The choices victims must face in these situations may not feel like choices at all—rather, they are realities that victims are forced to navigate where none of the outcomes are ideal. Some survivors may choose to carry a pregnancy to term and then decide to either keep the child or pursue adoption. Other victims choose to terminate pregnancies that were an outcome of rape. Trauma encompasses all of these steps a victim might have to take. This painful situation can be further exacerbated for child- and teen victims, due to their developmental stages and limited power and understanding of complex choices and social systems.

Sexual abuse and rape-related pregnancy can undermine a child's health, well-being, and stability for the rest of their lives. One rape crisis center described to us their experience helping a child who became

pregnant through rape by their uncle. They shared how traumatic this child's experience was, and told us that this child's ability to access abortion care was a critical component of their healing.

Victims do not have to carry these burdens alone. Rape crisis centers and other victim service providers are open across the Commonwealth to help victims navigate their options. But these centers cannot do the work alone. We must support their efforts by expanding victims' choices and preventing sexual abuse from happening in the first place.

RECOMMENDATIONS

To summarize and conclude, we offer recommendations for further consideration:

- Expand medical care for victims of sexual violence, including pediatric examiners.
- Maintain access to reproductive health care options for victims of sexual violence.
- Support victim-centered collaborations among victim service providers, law enforcement, medical providers, and others working in Sexual Assault Response Teams.
- Ensure mandated reporter training is provided across reproductive healthcare and other healthcare services.
- Invest in sexual violence prevention and sex education.

Thank you for your time and consideration today.

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