Emergency Contraception: The Ongoing Debate

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The first ever UK advertisement for the morning-after pill caused controversy recently when it was announced that it would be watched by Irish viewers of channels such as Channel 4 and Sky.

The ad shows a woman waking up next to her partner, before going to a pharmacy and asking for Levonelle One Step.

The advert was welcomed by many, but criticised by many more.

The ProLife Alliance in the UK were particularly vocal, stating that the morning-after pill is “advertised inaccurately” as emergency contraception.

“In fact its major function is to cause the abortion of an embryo that has already been conceived, not as suggested by the name to prevent conception,” said this organisation. “Young girls will be particularly susceptible to this advertising campaign, and it is foolish to imagine they do not watch TV after the 9pm watershed.”

However, the morning-after pill works by preventing fertilisation and implantation (and therefore conception). It is the “abortion pill”, mifepristone, that terminates an established pregnancy.

Which is why the advert is important. The point of it is to raise awareness of the morning-after pill, especially among young girls, so it is taken in time to prevent pregnancy in those women who do not want to become pregnant (statistics show that a typical woman spends only a few years of her life trying to become or being pregnant, but about three decades trying to avoid pregnancy).

Calls for wider availability of emergency contraception are not new in Ireland. But we now lag even further behind than we used to.

Last week Spanish health minister Trinidad Jimenez announced the morning-after pill will be available over the counter in Spanish pharmacies without prescription within three months.

Ms Jimenez said the pill will be sold with no age restrictions, and that it “does not constitute a means of aborting pregnancies but should not be regarded as a routine method of contraception”. The health minister also pointed out that statistics in countries that have made the pill available over the counter, such as the US and France, show it has helped reduce the number of abortions significantly.

Similar steps have been taken in the US, where the Food and Drug Administration (FDA) has announced that it will allow 17-year-olds to purchase the emergency contraceptive method “Plan B” without a prescription.

The FDA’s announcement followed a US District Court decision in March 2009, which stated that the FDA had “bowed to political pressure” from the Bush administration in its 2006 decision to limit access to emergency contraception without prescription to women aged 18 and older. The court ordered reconsideration of all age restrictions, “which never had any scientific basis and were ideologically driven”.

“There is no good medical reason why emergency contraception shouldn’t be more available,” says Dr Caitriona Henchion, Medical Director of the Irish Family Planning Association (IFPA), who spoke to IMN. “It is safer than a lot of other OTC medications. The pill we have now is different to what was available 10 years ago; being progesterone-only makes it more safe.”

Dr Henchion also points out that — despite claims by pro-Life organisations — emergency contraception does not in any way disrupt an established pregnancy. A good thing about the advert, she says, is that it will hopefully increase awareness and understanding of this form of contraception. “There is also no good argument that says it shouldn’t be available OTC,” says Dr Henchion.

“Increasing availability is important, especially since there are some doctors who do not supply the pill. Which is their right, but I believe they should state this in their clinic, so patients are aware, and then refer her on to a doctor who will supply it. I saw a patient recently who had queued for hours in an out-of-hours clinic for the pill only to be eventually told by the doctor in question that it was not prescribed there.”

Another issue surrounding prescribing the morning-after pill is consent, when the patient is underage. Dr Henchion believes doctors should act in these cases with the patient’s care as their first priority.

“The issue is not straightforward in Ireland, as it is in the UK, unfortunately,” she says. “All a GP can do is ask the under-16 year-old would she be willing to involve or tell her parents. If she says no, the GP should perhaps treat it like an emergency case – ask, does the patient need treatment, and will they be harmed if they do not get it? It is also important that the whole process should be documented carefully.

“We can’t stop them having sex at this point – they have already done it – but what we can do is try prevent pregnancy and then from there start discussion about safe sex and contraception.”
Dr Henchion says there is no way to tell if a doctor could be liable for prescribing emergency contraception to a minor without parental consent as it hasn't yet happened in Ireland. If the pill was available in pharmacies these issues would still be relevant but it would remove barriers to access.

Fears that the morning-after pill distributed by pharmacists will lead to huge numbers of girls using it regularly are not backed up by the evidence. The most widely cited research on the issue came from the BMJ in 2005. The authors, from London, found that after emergency contraception was made available over the counter in the UK, levels of use of different types of contraception by women aged 16-49 remained similar.

They found that no significant change occurred in the proportion of women using emergency contraception (8.4 per cent in 2000, 7.9 per cent in 2001, 7.2 per cent in 2002) or having unprotected sex.

A change did, however, occur in where women obtained emergency contraception; a smaller proportion of women obtained emergency contraception from physicians and a greater proportion bought it over the counter. No significant change occurred in the proportion of women using more reliable methods of contraception, such as the oral contraceptive pill, or in the proportion of women using emergency contraception more than once during a year. "In the US and elsewhere, debate about making emergency hormonal contraception (EHC) available over the counter has centred not on the safety of the drug itself – its safety is well documented – but on the harmful effects some people claim it will have on women’s behaviour," wrote the authors. "In particular, opponents say that over the counter availability will encourage unprotected sex, increase “abuse” of EHC, undermine the use of more reliable methods of contraception, and lead to increased promiscuity and pregnancy among teenagers…. This debate, although heated, has been based largely on speculation."

The authors conclude that a number of lessons can be learned from the British experience with OTC emergency contraception: "Firstly, many women seem to prefer obtaining EHC this way rather than from a physician: uptake has been high, with corresponding savings in time and resources for the health service.

"Secondly, cost seems to be an important barrier to buying EHC over the counter – lowering the cost might increase uptake from this source, particularly in lower income groups. Thirdly, lifting the ban in the UK did not lead to any increase in the proportion of women using EHC, nor did it raise the proportion of women using EHC more than once during a year. Finally, no fall occurred in the use of more reliable methods of contraception."