

Emergency contraception in the UK: stigma as a key ingredient of a fundamental women's healthcare product

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Introduction

Although combinations of contraceptive pills had been used in Britain as a method of post-coital back-up since the 1960s, it was not until 1982 that Schering PC4, a combined oestrogen-progestogen product, was specifically licenced for emergency post-coital contraception. It was another 20 years again before emergency contraceptive pills in their progestogen-only form were made available to buy from behind the counter in pharmacies, following a consultation with a pharmacist. Today women in the UK can obtain emergency contraception through a number of routes: via a prescription from their General Practitioner (GP) or a sexual health clinic, by purchasing it from a pharmacy, and sometimes through an NHS scheme run through their local pharmacy, in which case it can be obtained free of charge.

Emergency hormonal contraception (EHC) is a safe and effective way to protect against unplanned pregnancy when contraception has not been used or has failed. In the UK today, condoms and pills remain the most popular methods of contraception. This is despite sustained attempts to promote long-acting reversible contraceptives (LARCs) such as the intrauterine device (IUD) and intrauterine system (IUS), or the implant, Nexplanon. While these may suit many women perfectly, others suffer side-effects or simply feel they are not having sex frequently enough to take on a long-acting form. In this context, swift access to emergency contraception should be seen as essential back-up to women's existing method, which women should be encouraged to make use of when they need it.

While EHC will never be a silver bullet for unintended pregnancy, it remains a significantly

under-utilised resource.¹ Only a third of women in the UK report using EHC after an episode of unprotected sex.² EHC is extremely safe, even when used repeatedly and within the same cycle. Repeat use of EHC is classified as Level 1 in the World Health Organization's Medical Eligibility Criteria, indicating there should be no restriction on use.³ However, EHC was never embraced in the way it should have been, nor its safety profile emphasised. Indeed the narrative around EHC as a manifestation of moral malaise, and a marker of irresponsible female sexuality that needs regulating, has paved the way for the framework which places considerable barriers in women's path when seeking to obtain it in a timely fashion, and contributes to women's perception that this is a risky product that should rarely be used.⁴

Twenty years ago, the WHO made clear that "repeated use [of EHC] poses no health risks and should never be cited as a reason for denying women access to treatment".⁵ Despite this, health professionals are expected to discourage women from use of EHC, not least by quick starting them on "regular" options. EHC is not supposed to replace routine hormonal contraception as the lower dose daily pill is more effective at preventing pregnancy on an ongoing basis, although this raises questions as to why women should not be "allowed" to choose a slightly less effective method if they prefer it. However, the concern raised around "abuse" of EHC means that it is not promoted as a contraceptive option that women can access easily when they need it.⁶

The price of the non-prescription retail product was also deliberately set high to discourage women from regular use. Despite a successful campaign by

the British Pregnancy Advisory Service (BPAS) in 2017 to reduce the cost of the progestogen pill from as much as £30 to between £12 and £16 when sold in pharmacies, the price women pay still remains extremely high in relation to the actual cost of the pill and it is still only available after consultation with a pharmacist. The product remains behind the shelf, often out of eye-line, with no in-store advertising of its availability. While it is increasingly available online, the price for timely delivery of a time-sensitive product is extremely high. Although the pill is available for free through prescription, if women do not meet the criteria for the NHS-funded scheme in a pharmacy this will require booking an appointment with a GP or a clinic, which may have unusual opening hours, or waiting at a walk-in service. As time is of the essence with this product, these barriers cause delay which puts women at greater risk of unwanted pregnancy. Below, we share our perspective on the development of the narrative around EHC in Britain and consider future paths for a product that has been shamefully exceptionalised and stigmatised.

Need, not choice

Today's framing of "in emergencies only" is quite different from the original intentions of those involved in the post-coital pill development. Early developments indicate manufacturers envisaged EHC would be made available to women by choice and would become a suitable addition to their arsenal of contraceptive options.⁷ The first EHC pill products were developed in the early 1970s. Following the success and popularity of the pill, testing for alternative hormonal contraceptive options continued. One of the objectives of post-coital pill development was to reduce drug exposure for women: growing fears of thrombosis linked to the pill meant doctors hoped to offer safer options for women who were having sex less frequently. This may appear as an outlandish construct given the EHC we recognise today. Commonly we distinguish EHC as a "back-up only" method. However, historically EHC was developed as an additional method for women having sporadic sex to take as a matter of choice rather than need.

In fact, early manufacturers sought to provide women with more than one dose to have at home with a view to this being an ongoing method for women having sex once a week or less.

Although never offered in the UK, Hungarian pharmaceutical company Gedeon Richter initially marketed a blister packet of 10 pills each containing 0.75 mg. Women were instructed to take two per episode of unprotected sex, but this multiple-use package came with the warning not to use them more than four times per month.⁸ The number of pills made available to women was gradually changed, apparently over concerns from the medical community that women were using it more than four times per month.⁹ In 1994, the company changed the presentation to a two-dose box, then in 1998 to a one-time use package. Offering a post-coital option for women to keep at home and use when they choose to, differs drastically from the framing around EHC today.

In the UK context, a number of debates have surfaced in relation to EHC that indicate it has been a contentious area of policy. Because of its post-coital use, EHC has at times been positioned as an abortion, adding to its stigma, with some religious groups arguing it should be subject to the controls of the 1861 Offences Against the Person Act for procuring a miscarriage. At the same time, there were also concerns among some feminists in the 1970s that EHC might undermine the call for abortion on demand, and family planning clinics were reluctant to advertise its availability "for fear that the publicity would lead to a stream of women thinking they could use it as a regular contraceptive".¹⁰ These arguments often overlapped with more socially conservative concerns that EHC enabled sex without consequences; it has been this aspect of the EHC debate, with the pill symptomatic of recklessness and fecklessness, which has largely dominated the tenor of media coverage, at least until recently.

Despite this contentious history, there was significant public outrage when the UK's leading pharmacy chain, Boots, refused to reduce the price of EHC in 2017 on the grounds that women might "misuse" the product if it were more affordable. The company was eventually forced to back down after intervention from MPs and a cascade of negative media coverage.¹¹ This indicates that perceptions of EHC are starting to change, particularly in a climate more sensitive to manifestations of sexism and where women's needs and perspectives are given more attention. Nevertheless, the continuing restrictions on access to EHC products, including high cost and consultation, create a vicious circle where the product appears irregular and to require supervision, which in turn impacts

upon the approach and attitudes of both health-care professionals and women.

The early years of EHC in the UK set the tone for the pill and meant the product was never presented as simply a further contraceptive option for women. In the UK, even when a dedicated product was developed, EHC marketing was risk-averse to satisfy the growing concerns of policymakers around an after-sex pill, rather than the needs of women. This meant post-coital options were isolated as “abnormal” and not positioned as an option for women to choose, but as a pill they could avail themselves of only when in need – with the clear message that they should never in fact need to use it. This takes us to the space we occupy today.

Changing the EHC record

Enabling emergency contraception to be sold directly from the shelf without mandatory consultation, as it is in Europe where comparable drug classifications exist (e.g. Sweden, Netherlands and Norway) and in North America, would be a key step forward in normalising this product in the UK. This would require a change in the classification, from a Pharmacy medicine (P) to a General Sales List (GSL) medication, which can be sold in a variety of locations. Products in this category in the UK include a wide variety of painkillers, such as paracetamol and ibuprofen, Nicotine Replacement Therapies (NRTs) and strong indigestion remedies such as esomeprazole, under the brand name Nexium. All these products have considerably riskier safety profiles than emergency contraception.¹² In the case of NRTs, the UK’s medicines licencing authority, the MHRA, deemed that any risk posed by increasing public access to these drugs (they are theoretically toxic to small children if consumed in large quantities) was offset by the huge public health benefits of enabling more people to quit smoking. There are no risks posed to any parties by emergency contraception, and the health benefits for that individual woman of being able to avoid an unwanted pregnancy are significant.

Resistance to reclassification has been put forward by the Royal Pharmaceutical Society, which wants to preserve the mandatory consultation on the basis that it provides an important opportunity to ensure women are taking the pill within the correct time frame, to discuss other methods of contraception, risk of sexual infections and address any safeguarding concerns. Research shows, however, that most women presenting for emergency

contraception do so within the first 24 hours, as awareness that it should be taken as soon as possible is high;² while a mystery shopper exercise conducted by BPAS in 2018 discovered that few pharmacies provided information about other forms of contraception, or STI testing. As many consultations took place in an open shop rather than a private room, the likelihood of a woman divulging issues relating to her safety was in any event diminished.¹³ Regardless of whether this assistance is provided by pharmacies, the positioning of a woman seeking emergency contraception as being in need of information about “regular” methods or being particularly at risk is a manifestation of the stigmatisation of this product. No such questioning is required when women purchase condoms, sexual lubricants, or pregnancy tests. The reclassification of emergency contraception so it can be sold in the same way as these products is now a matter of urgency.

Greater attention must also be paid within NHS-funded services to combating the stigma associated with this product. Service providers are aware of women’s concerns around “judgment”, the safety of this method, and the need to explain why they require EHC. Therefore, changes should be made in service settings to pro-actively offer and encourage this as a back-up option for women choosing user-dependent methods, emphasising its safety, and reducing the stigma attached to use.

In the longer term, licencing arrangements for EHC should be changed so that the product could be specifically prescribed for women who have less frequent sex, as it was originally conceived, as their first-line contraceptive. We believe there would be widespread interest in this; concerns thus far expressed mainly centre on the effectiveness as a regular method for irregular sex. Nevertheless, women are currently able to make their choice from a range of options that vary in efficacy – from implants to diaphragms – so a pill that is less effective than its daily counterpart should not be discounted on that basis.

This change in approach would dramatically alter the framing of and stigma attached to the product, and allow it to take the place it deserves on the menu of legitimate contraceptive options that women can freely choose.

Disclosure statement

No potential conflict of interest was reported by the authors.

References

1. Trussel J. Emergency contraception: hopes and realities. In: Foster A, Wynn LL, editors. *Emergency contraception*. New York, NY: Palgrave Macmillan; 2012. p. 19–35.
2. Nappi R. Use of and attitudes towards emergency contraception: a survey of women in five European countries. *Eur J Contracep Reproductive Health Care*. 2013;19(2):93–101.
3. World Health Organization. *Medical eligibility criteria for contraceptive use*. 5th ed. Geneva: World Health Organization; 2015.
4. Barrett G, Harper R. Health professionals' attitudes to the deregulation of emergency contraception (or the problem of female sexuality). *Sociol Health Illn*. 2000;22(2):197–216.
5. World Health Organization. *Emergency contraception: a guide on service delivery*. Geneva: World Health Organization; 1998.
6. Abuabara K, et al. As often as needed: appropriate use of emergency contraceptive pills. *Contraception*. 2004;69:339–342.
7. Prasad M. Post-coital agents and menses inducing drugs. *J Biosci*. 1984;6(2):107–119.
8. Ellerston C. History and efficacy of emergency contraception: beyond Coca-Cola. *Fam Plann Perspect*. 1996;28(4):4–10.
9. Camp S. Postinor – the unique method of emergency contraception developed in Hungary.
10. Mackie H. *The Guardian*. 1976 Apr 21; p12.
11. Khomami N. Boots apologises over morning after pill pricing row. *The Guardian*. 2017 Jul 22. Available from: <https://www.theguardian.com/business/2017/jul/21/labour-mps-tell-boots-of-concern-over-emergency-contraception-cost>
12. Office for National Statistics. *Number of deaths from drug poisoning by paracetamol in England and Wales from 1993 to 2017*. London: Office for National Statistics; 2018.
13. Soppelsa A, Murphy C. *Pharmacy provision of emergency contraception: a mystery shopper study*. London: British Pregnancy Advisory Service; 2018.