

# Breaking The Impasse: Emergency contraception and the abortion debate

*Tara Shochet, MPH and Wendy Chavkin, MD, MPH*

We are all well aware of the long term political storm centering on abortion. One would think that contraception could offer a potential way out of this impasse. However, many of those opposing abortion rights have not embraced this route. Consequently, we are missing a major chance to significantly decrease the need for abortion. If both sides of the abortion debate focused their energies on what should be common ground – increasing access, availability and knowledge of contraception, we could dramatically lower the incidence of unwanted pregnancy.

## **Emergency Contraception Has Great Potential for Decreasing Unwanted Pregnancy**

Emergency contraception (EC) offers a second chance at preventing pregnancy

when other contraception either fails or is not used. Depending on the regimen, EC is 75-89% effective.<sup>1,2</sup> This means that many unintended pregnancies could be avoided, which in turn would reduce the need for abortion. It has been estimated that widespread access to EC could halve the current rate of unintended pregnancy.<sup>3</sup> Even in 2000, when only 2% of women used this method, it was estimated that 51,000 abortions were averted in the United States due to the use of EC.<sup>4,5</sup> With universal access, EC could clearly have an enormous impact.

Some of the opponents of EC argue that it is an abortifacient. This is not correct, as emergency contraception will not interrupt an established pregnancy.<sup>6,7</sup> While it is not entirely known how EC works, the data indicate that the primary mechanism of action is preventing or delaying ovulation.<sup>8</sup> However, its high efficacy suggests that something other than interference with ovulation must be occurring,

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*Tara Shochet, a doctoral student in the School of Public Health, University of Michigan, is the Executive Director of the American Society for Emergency Contraception. Wendy Chavkin is Professor of Clinical Public Health and Obstetrics-Gynecology at the Mailman School of Public Health and College of Physicians and Surgeons at Columbia University. She is Chair of the Board of Physicians for Reproductive Choice and Health.*

although there is no solid evidence that EC directly interferes with fertilization or implantation.<sup>8</sup> EC containing only levonorgestrel has also been shown to interfere with luteal function.<sup>8</sup> EC may work by affecting ovulation, fertilization or implantation; the same is true for several commonly used methods of contraception, including oral contraceptives and breastfeeding.<sup>8,9</sup>

Emergency contraceptive pills are effective in preventing pregnancy up to 5 days following unprotected intercourse.<sup>10,11</sup> A large World Health Organization (WHO) study found that they are more effective the sooner they are taken.<sup>2,12</sup> Given the time sensitivity, easy access is essential. However, there are a host of structural barriers that interfere with access and that impede a woman's ability to take EC when it is needed.

### **Health Insurance Coverage**

Because emergency contraception is expensive, averaging \$20-\$25 per set of pills,<sup>13</sup> some women may find cost to be a significant barrier. Health insurance coverage of contraceptives would alleviate this. However, only 21 states currently have laws that require plans that offer prescription drugs to include contraceptive coverage.<sup>14</sup> Plans in these states are significantly more likely to cover oral contraceptives.<sup>15</sup> The Equity in Prescription Insurance and Contraceptive Coverage Act (EPICCA) would mandate contraceptive coverage in health plans nationwide. While this bill has been introduced into congress several times, it has yet to be passed. Moreover, twenty percent of women of reproductive age have no health insurance coverage at all.<sup>16</sup>

Assuring coverage is the first step. There are also procedures within the insurance system that burden the process of obtaining emergency contraception. There are health plans, for example, that cover contraceptives through mail order only, which is clearly nonsensical for a medication that must be taken within a narrow window of time.<sup>17,18</sup> Publicly funded insurance, Medicaid, does not reimburse for Plan B, the only dedicated EC product on the US market, in at least 25% of states. Accessing Medicaid coverage information is often quite difficult and may be prohibitive for women seeking reimbursement.<sup>19</sup>

### **Access To Services**

#### **FDA**

One way to simplify access would be to make EC available over the counter. This would remove the steps required in obtaining a prescription, including a visit or phone call to a clinician, and thus would shorten the time it takes to get the pills. Both the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) support this regulatory change.<sup>20,21</sup> In 2003, the US Food and Drug Administration (FDA) received an application from Barr Laboratories requesting such a switch for Plan B. After several postponements, and a favorable 23 to 4 vote by their Advisory Committees, they denied the application, citing concerns around use by young teens. Recent studies have shown that easy access to EC does not increase sexual activity by teens, and such concerns are

therefore unwarranted.<sup>22,23</sup> However, Barr submitted a revised petition that offered to compromise with the FDA by requesting a dual label: nonprescription for women age 16 and older and prescription-only for those under the age of 16. Nevertheless, in January 2005, acting FDA Commissioner Lester Crawford announced an indefinite delay in responding to the revised application. Subsequently, the Center for Reproductive Rights filed a lawsuit arguing that by failing to follow their own procedures and in denying women of all ages over the counter access to Plan B, the FDA violated both the Administrative Procedures Act and the US Constitution.<sup>24</sup> Non-scientific motivation and sexual discrimination are among the grounds of the suit.

Recently, several Senators have held up the vote on Crawford's nomination as permanent FDA Commissioner because of his stall on the decision about OTC status for Plan B. During the Senate confirmation hearing in March 2005, several Senators focused their questions on the Plan B application and Crawford's refusal to provide a decision date. The vote on his confirmation has now been officially postponed as the delay regarding Plan B has raised questions about the FDA's decision-making process in general.

The struggle for easier access to EC in the US contrasts with the situation in much of the world. There are now 37 countries where EC is available directly from the pharmacist without the need for a prescription.<sup>25</sup> Two countries (Norway and Sweden) have EC available over the counter.<sup>25</sup> In France, EC is available to teens free of charge at pharmacies and at school clinics.<sup>26</sup>

## Pharmacies

Indeed, a significant barrier can take place at the pharmacy level as some pharmacists are citing religious objection and refusing to fill prescriptions for EC.<sup>27</sup> Many who refuse to fill the prescriptions are also refusing to transfer customers to other pharmacies or to offer any referrals.<sup>27</sup> These refusals disproportionately affect low-income women and women in rural communities who may be less able to travel to another pharmacy.<sup>28</sup> So called "refusal-laws" that allow pharmacists to refuse to fill prescriptions based on religious beliefs have been passed in three states and have been introduced in twenty others.<sup>27</sup> Some have suggested the compromise of allowing refusals as long as there are mandatory referrals, although the delay involved would pose a serious problem for a time sensitive method.<sup>29</sup> In response to these refusal trends, lawmakers introduced The Access to Legal Pharmaceuticals Act in both the House and Senate in April 2005. Under this law, pharmacies would be required to fill all prescriptions even if an individual pharmacist refuses for religious or moral reasons.<sup>30</sup> The law would also ban transfer refusals and other attempts at deterring patients from filling their prescriptions.<sup>30</sup>

A flurry of legal activity surrounding pharmacy access to contraceptives has also developed at the state level and has become a major area of contention throughout the country. Illinois Governor Blagojevich recently issued an emergency rule requiring pharmacies to fill all contraceptive prescriptions without delays or hassles. He also created a hotline for reporting refusals. Two pharmacists subsequently filed a lawsuit against this rule claiming viola-

tions to the Illinois Health Care Right of Conscience Act. Other recent state-level actions include Arizona Governor Napolitano vetoing a pharmacist refusal bill, and the Wisconsin Pharmacy Examining Board disciplining a pharmacist for refusing to fill a contraceptive prescription.

### Hospitals

Some emergency rooms physicians are declining to supply EC or to provide information about the method or referrals to other providers. This is particularly true in Catholic-affiliated hospitals. A survey of all US Catholic hospitals conducted in 2002 found that only five percent of their emergency rooms supplied EC when it was requested, and only 28% supplied EC to victims of sexual assault.<sup>31</sup> Only half of those not providing EC gave a referral, two-thirds of which led the investigators to dead ends.<sup>31</sup> As with pharmacies, rural and low-income women are likely to be more affected by such policies, as they may have significant difficulty accessing EC from another location in the necessary timeframe. The American College of Obstetricians and Gynecologists (ACOG) recommends that all victims of sexual assault be offered EC, and four states have mandates requiring all emergency rooms to provide EC to victims of sexual assault.<sup>32,33</sup>

In September 2004, the Department of Justice (DOJ) released the first national protocol on the treatment of sexual assault victims, "A National Protocol for Sexual Assault Medical Forensic Examination," and failed to mention EC.<sup>34</sup> Over 200 medical and advocacy organizations signed a response letter to the DOJ urging that the protocol be revised to include informa-

tion on EC.

### Abstinence-only Education

Limited knowledge about contraception effectively creates yet another barrier to access. Abstinence-only programs have become the standard in many classrooms. As early as 1999, over one third of school districts with a sex education policy either prohibited or severely limited discussion of contraceptives and only 14% had policies requiring comprehensive education both about abstinence and about contraception.<sup>35</sup> These abstinence only curricula often exclude any information on contraception and safe sex practices, and many contain inaccurate or misleading statements about reproductive health.<sup>36</sup> Inaccuracies include grossly inflated failure rates for condoms, false links between abortion and both sterility and ectopic pregnancy, and false claims that HIV can be transmitted through tears and sweat.<sup>36</sup>

While there is no credible evidence that abstinence-only programs delay onset of sexual activity or reduce teen pregnancy rates, there are rigorously obtained data demonstrating that comprehensive programs that include both abstinence and contraceptive education are highly effective.<sup>37</sup> Data reveal that virginity pledge programs (where teens take a pledge to refrain from sex until marriage) have mixed outcomes; while those taking the pledge do delay initiation of intercourse, the delay only lasts an average of 18 months.<sup>38</sup> Moreover, these teens are more likely than non-pledgers to participate in other sexual high-risk behaviors such as oral or anal

sex.<sup>39</sup> They then use lower rates of contraception at first intercourse than do non-pledgers and as young adults have equally high rates of sexually transmitted infection.<sup>38, 40</sup> These findings indicate that the teens in these programs come away with a very limited literal understanding of what “sex” is (vaginal intercourse), and so they neither keep to the spirit of abstinence nor to its protective goals.

Yet, in 2005, the federal government is planning to spend \$167 million on abstinence-only programs and has proposed zero funding dedicated to comprehensive sex education (“abstinence-plus”) programs.<sup>36,41</sup> States accepting federal dollars through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“welfare reform”) for programs geared towards reducing teen pregnancy must follow a strict federal definition of abstinence education and must contribute three state dollars for every four federal dollars.<sup>42</sup> United States international support is also tied to abstinence education. For example, one third of the HIV-prevention funds in the Global AIDS Bill have been allocated to abstinence-only programming.<sup>43</sup>

## Is Progress Possible?

Clearly, the current approaches are not working. Americans contracept poorly and consequently have high rates of both unintended pregnancy and abortion. Almost half of all American women of reproductive age have experienced an unintended pregnancy, and approximately half of all pregnancies each year in the US are unintended.<sup>44</sup> Younger women and wom-

en with lower incomes are more likely to report that a pregnancy was unintended.<sup>44</sup> As demonstrated above, these women may also be more likely to face barriers in accessing contraception. Furthermore, the United States has a higher rate of teen pregnancy than most other developed countries: the United States rate is twice the rate of Canada or Great Britain, for example, and more than four times the rate of France or Sweden.<sup>45</sup> One reason may be the lower rates of contraception reported at first or most recent intercourse.<sup>45</sup> Rather than take steps to improve these outcomes, resources are being used to blockade any possible advances.

This suggests that the prime concern of those who oppose abortion is not in fact the moral status of the embryo. Rather, they appear to be anti-sex in general as they insist on abstinence and impede efforts to promote contraception.

The Prevention First Act, introduced in the Senate this past January, aims to reduce unintended pregnancy by increasing spending on family planning, ensuring equity in prescription drug coverage, endorsing EC and providing accurate contraceptive information to our youth.<sup>46</sup> While the political storms over these issues are such that this is unlikely to pass, it would offer a commonsense way out of the abortion morass. Let’s break the impasse and move forward. 🙏

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