Facing the Facts…

YOUNG PEOPLE and the 'MORNING-AFTER PILL'

The 'morning-after pill' (MAP), more properly known as the emergency contraceptive pill, has been surrounded by controversy since it was first approved for use in the UK during the 1980s. At that time, the then Department of Health and Social Security offered reassurances that it would be used only in exceptional circumstances, and that it would remain as a prescription-only drug under the control of doctors.

However, in a series of unparalleled moves, the MAP became available for general, rather than exceptional, use. It became available off-prescription; it was sold over-the-counter by pharmacists; and it was made available in schools to girls under the legal age of consent to sexual intercourse. Provision of the MAP in schools violates the government's own guidelines on the provision of drugs within schools; it violates the guidelines given by the Law Lords in the 'Gillick' ruling; and it violates parents' hard-won rights to know and approve the kind of sexual instruction and advice which their children are receiving in school.

The Government's Strategy

The government is committed to making the MAP more widely available to teenage girls as part of its efforts to halve the number of conceptions among under-18s by 2010. Health Minister Jacqui Smith stated: *'Improving teenagers' access to contraceptive advice, including emergency contraception, is a key strand of the government's teenage pregnancy strategy.'*[1] This strategy includes making the MAP easily available to those under the legal age of consent to sexual intercourse.

Availability to under-16s

Despite the fact that no clinical trials have been conducted with girls under 16, the MAP has been licensed without an age limit. During 1999, it was prescribed to girls under the age of 16 on 23,100 occasions in family planning clinics in England alone, representing 10% of the total prescriptions in that setting.[2]

This figure does not include girls who received treatment from a GP or a hospital accident and emergency department. Bearing in mind that 1999 was before Patient Group Directions (PGD) came into force (see below) and before the introduction of the progestogen-only MAP, Levonelle-2, which is claimed to have fewer side-effects and to be safer and more effective, these figures are likely to rise over the next few years.

In March 2000, the Committee on Safety of Medicines admitted that providing the MAP to girls under the age of 16 presented special risk management issues and concluded that, 'because of the likelihood of these possible indirect dangers to health in those under 16 years of age', it should be supplied to that age group under medical supervision.[3] However, this advice has not been followed in practice.

Patient Group Directions

Under Patient Group Directions (PGD), in many parts of the country the MAP is now widely available to under-age girls without a doctor's prescription. The terms of PGDs vary from region to region but, in some areas, the MAP is available to girls of any age. For example, in a magazine distributed to all households in its area, East Surrey Health Authority advises residents that the local hospital offers 'an "all day, every day service" where emergency contraception can be obtained confidentially and free of charge *by girls of any age*' (emphasis added).[4]

Girls as young as 12 can obtain the MAP at the Magic Roundabout in Kingston-upon-Thames. This self-referral, confidential sexual health advice service targeted at young people aged 12-20 is commended by the government's report on Teenage Pregnancy as a 'promising approach'.[5] Similar projects are operating in other parts of the United Kingdom.

Family Education Trust, Jubilee House, 19-21 High Street, Whitton, Twickenham TW2 7LB
Tel: 020 8894 2525 Fax: 020 8894 3535 email: fyc@ukfamily.org.uk Website: www.famyouth.org.uk

In practice, it is fairly straightforward for under-16s to obtain the MAP. The Royal Pharmaceutical Society insists that girls under 16 are entitled to a sympathetic and confidential consultation. In the absence of a PGD permitting pharmacy supply to under-age girls, the Society encourages pharmacists to assist them to obtain the MAP from another source.[6]

Schools

Under a PGD, school nurses may also supply the MAP to girls under the age of 16 at the discretion of school governing bodies, in consultation with parents and the school community.[7] Health ministers have stated that in the event of medical complications arising as a result of its supply by school staff, potential liability would be covered by the arrangements of the NHS body operating the PGD under which it was being dispensed.[8]

The availability of the MAP in schools runs counter to the government's good practice guide with regard to the supply of any other medical treatment in schools.

Official guidance states that:

- 'Parents or guardians have prime responsibility for their child's health and should provide schools with information about their child's medical condition.'
- 'Parents' cultural and religious views should always be respected.'
- There should be 'prior written agreement from parents or guardians for any medication, prescribed or non-prescription, to be given to a child'.
- 'School staff should generally not give non-prescribed medication to pupils [e.g. aspirin and paracetamol]. They may not know whether the pupil has taken a previous dose, or whether the medication may react with other medication being taken.'
- 'No pupil under the age of 16 should be given medication without his or her parent's written consent.'[9]

This guidance is completely overlooked in connection with the supply of the MAP in the school context.

What is the MAP and how does it work?

The MAP is designed to prevent an unwanted pregnancy after intercourse has taken place. The manufacturers of Levonelle-2 put it like this: *'If you have sex without using contraception or if your contraception might have failed, you can get pregnant. Emergency contraception can prevent pregnancy after you have had unprotected sex.'*[10]

Before the year 2000, the only form of MAP available in the UK was a combined pill, so called because it contained oestrogen and progestogen, the two hormones commonly found in the contraceptive pill. However, in the Autumn of 1999, a new progestogen-only MAP (Levonelle-2) was licensed for use in the UK and became available on prescription from February 2000. It was claimed that the lack of an oestrogen component in Levonelle-2 would make oral emergency contraception accessible to those women for whom the earlier pill was not advised.[11] Health experts throughout the world heralded the progestogen-only pill as safer, more effective and carrying with it fewer side-effects.

It is not known precisely how the MAP works. The manufacturers state that Levonelle-2 is thought to work by:

- stopping or delaying the ovaries from releasing an egg;
- preventing sperm from fertilising an egg already released; or
- stopping a fertilised egg from attaching itself to the womb lining.[12]

This corresponds to the way in which the oral contraceptive pill (OCP) is believed to work. However, while the OCP is taken to prevent *conception* and operates principally to suppress ovulation and prevent fertilisation, the MAP is taken with the intention of preventing *implantation* after conception has taken place.

How effective is it?

Measuring the effectiveness of the MAP is extremely complex for the simple reason that, when it is taken, there is no way of ascertaining whether conception has taken place. Women who take the MAP do so as a precautionary measure rather than on the basis of any sure knowledge of a developing pregnancy.

A World Health Organisation study (Table 1) which estimated the number of anticipated pregnancies, taking into account the menstrual and sexual histories of participating women, and then comparing them with the actual numbers of pregnancies occurring after treatment, found that the progestogen-only pill is more effective than the combined pill and that the effectiveness of both pills varies depending on how soon after intercourse they are taken.[13]

Table 1: Relative effectiveness of the progestogen-only and combined emergency contraceptive pill

Interval between intercourse and treatment	Progestogen-only pill	Combined pill
24 hours or less	95%	77%
25-48 hours	85%	36%
49-72 hours	58%	31%

Source: *Lancet* 1998; 352:428-433

THE MAP AND UNDER-AGE GIRLS

The government's strategy to reduce the rate of teenage conceptions is based on the assumption that young people lack accurate knowledge about contraception.[14] Hence the emphasis on sex education, information services and increased availability of contraception. But there is growing evidence that this approach does not address the real issues and may prove counter-productive.

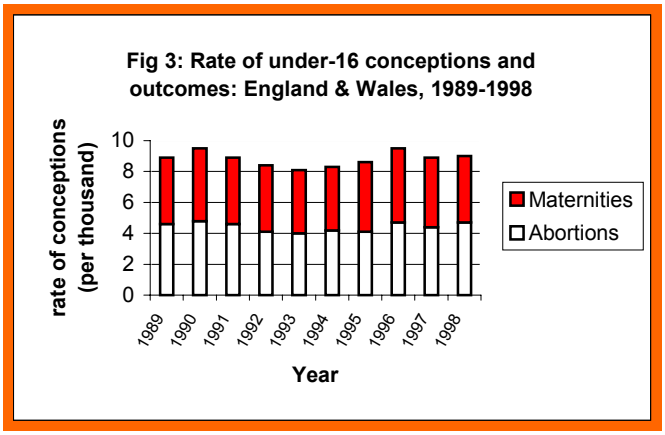
Ignorance is not the problem

Over the past decade there has been an expansion of sex education programmes in schools, promoting a 'safer sex' message. There has also been a considerable rise in the number of young people attending family planning clinics in England. The number of attendances by girls under the age of 16 rose from 18,000 to 68,000 between 1989 and 1999, while attendances by women overall remained the same.[15]

During 1999-2000, it is estimated that over seven per cent of resident females aged 13-15 attended family planning clinics.[16]

Throughout the 1990s, prescriptions for the MAP to girls under the age of 16 in family planning clinics in England increased dramatically and, by 1999/00, represented 10% of prescriptions in that setting (figures 1 and 2).

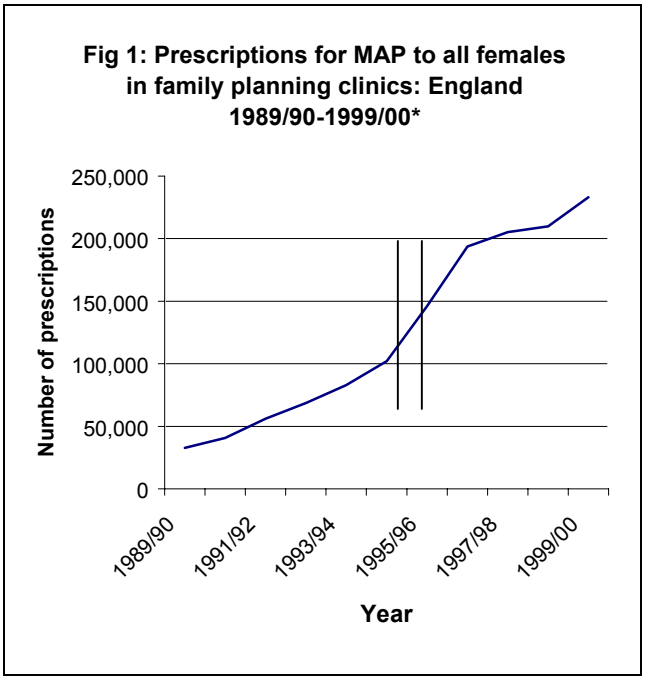
Increased access to sexual health advice and contraception, including provision of the MAP, has made no appreciable difference to the recorded conception rates among under-age girls, leading either to maternities or to abortions during the 1990s (figure 3).[17]

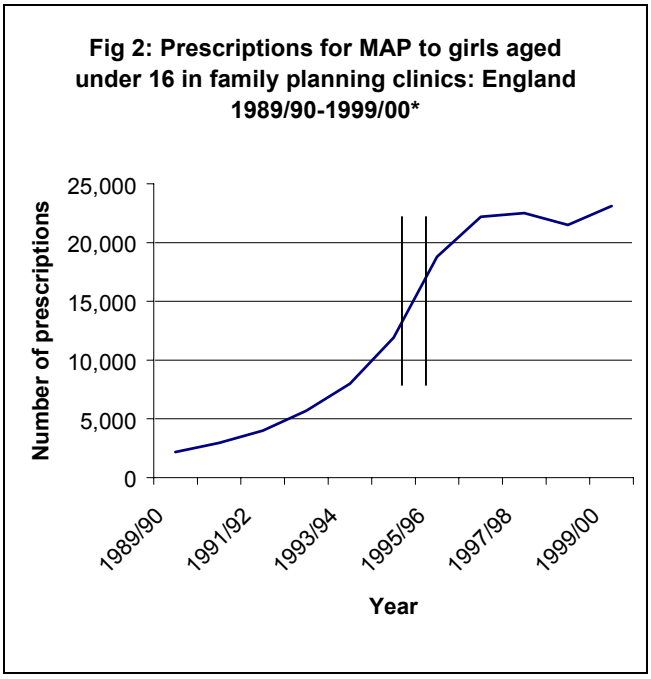


Source: *Birth Statistics 1999*

For example, a recent study of 240 teenagers who became pregnant found that 93% had seen a health professional at least once during the previous year, and 71% had discussed contraception. The researchers concluded that:

- 'Most teenagers who become pregnant do access general practice in the year before pregnancy, suggesting that potential barriers to care are less than often supposed.
- 'Teenagers who become pregnant have higher consultation rates than their age-matched peers, and most of the difference is owing to consultation for contraception.
- 'Teenagers whose pregnancies end in termination are more likely to have received emergency contraception.'[18]





(Source: Department of Health Statistical Bulletins)

(* Prior to 1995/96, not all Brook Clinic data was included in the published statistics. The annual totals were subsequently revised by 8-13%, but the original figures are used in these graphs for ease of comparison.)

Getting the MAP off prescription

Spring 2000 - The manufacturers submitted an application for the removal of the prescription-only status of Levonelle-2, the new, progestogen-only MAP.[19] It was originally envisaged that the change in classification would require ratification by parliament after approval by health ministers, but, in the event, the government introduced two measures without parliamentary debate which had the effect of making Levonelle-2 available without a doctor's prescription.

August 2000 - Patient Group Directions (PGD) were introduced in various parts of the UK to allow nurses, pharmacists and other health workers to administer or supply prescription-only medicines, as specified by local health authorities, without a doctor's prescription.[20] This provision made it possible for family planning clinics and health workers, including school nurses, to supply the MAP to women and girls of all ages, and pilot schemes offering emergency contraception over-the-counter, free of charge, were operated by pharmacies in areas with high unwanted pregnancy rates.[21]

December 2000 - The government laid a second Order before Parliament, which permitted the progestogen-only MAP to be sold over-the-counter at pharmacies to women aged 16 and over. By-passing the convention that 40 days should be allowed for parliamentary scrutiny and debate, the government chose to bring the measure into force on 1 January 2001 without public consultation or parliamentary debate.[22]

'Emergency' contraception – not just for emergencies

Already there are signs that the boundaries may be pushed back still further. While the manufacturers emphasise that the MAP is designed to be used only as a back-up and not as a regular method of long-term contraception, the Royal Pharmaceutical Society guidance to pharmacists states that: 'Supply of emergency hormonal contraception (EHC) via the pharmacy in advance of need is not *currently* recommended. Clients requesting advance supplies should be advised that some, but not all, doctors and family planning services may prescribe EHC for advance situations. Pharmacists should ensure that they know if and where this is provided locally so that the information can be offered to clients' (emphasis added).[23]

The Family Planning Association is even more positive. In response to the question, 'Can I get emergency pills in advance?' the Association confidently answers, 'Yes, if you are going on holiday or are worried about your contraceptive method failing. Ask your doctor or family planning clinic about this.'[24]

LEGAL AND ETHICAL ISSUES

Both the manufacturers and the government are insistent that the MAP does not produce an abortion and that 'it does not work if you are already pregnant'. To make the point crystal clear, the Committee on Safety of Medicines recommended that 'the Patient Information Leaflet should be amended to highlight the fact Levonorgestrel 0.75mg is not an abortifacient'.[25]

However, these oft-repeated assurances mask a very real ethical issue. The only way in which it can be claimed that the MAP is incapable of acting as an abortifacient is by redefining the meaning of conception.

The word 'conception' refers to the point at which the sperm meets the egg and fertilises it. *Contra*ception works to prevent this, whether by physical or chemical means. Where the MAP operates to stop or delay the ovaries from releasing an egg, or to prevent sperm from fertilising an egg, it is acting as a contraceptive. However, where the pill functions to stop a fertilised egg from attaching itself to the womb lining, it is not serving as a contraceptive because conception has already taken place.

In 1983, the Attorney-General ruled that the MAP did not constitute a criminal offence under the Offences Against the Person Act 1861, which forbids any action which has the intent of procuring a miscarriage.[26] He considered that prior to the implantation of the embryo in the lining of the womb, five or six days after conception, 'carriage' cannot have occurred, and that the use of a pill which operated prior to implantation could not be deemed to procure a 'miscarriage' under the terms of the 1861 Act.

It is on the basis of this advice that successive governments have taken the view that 'a pregnancy begins at implantation' (rather than at conception) and can refer to this as 'the accepted legal and medical view'.[27] It also cleared the way to licence the emergency pill as a 'contraceptive'.

The debate continues, however. In November 2001, the Advertising Standards Authority ruled that an advertisement placed in several newspapers by the Society for the Protection of Unborn Children (SPUC) was 'misleading' because it went against 'the accepted legal and medical view' when it claimed that the MAP was 'abortion inducing'. SPUC were advised that if they persisted with the advertisement, they could be referred to the Office of Fair Trading and face penalties.[28]

However, it is a simple matter of fact that the embryo is contained within the womb and 'carried' around irrespective of whether implantation has taken place, and, in the opinion of Gerard Wright QC, the meaning of the word 'miscarriage' did include the expulsion of an unimplanted embryo when the 1861 Act was framed.[29]

Dr John Ling, formerly of the Institute of Biological Sciences at Aberystwyth University, refers to the government's position as a 'new biology' whereby, contrary to centuries of biological scholarship, conception has been separated from fertilisation. It is, he says, an example of lexical engineering preceding social engineering.[30]

Feminist author Germaine Greer also recognises the abortifacient nature of the MAP and considers that to conceal this fact is deceptive, and undermines the dignity of women:

> *'These days, contraception is abortion because...pills cannot be shown to prevent sperm fertilising an ovum... Whether you feel that the creation and wastage of so many embryos is an important issue or not, you must see that the cynical deception of women by selling abortifacients as if they were contraceptives is incompatible with the respect due to women as human beings.'*[31]

SOCIAL CONSEQUENCES

The rise of sexually transmitted infections

Although the government's report on Teenage Pregnancy warns that a single act of unprotected sex with an infected partner exposes teenage women to a risk of acquiring HIV (1%), genital herpes (30%), or gonorrhoea (50%),[32] the wider availability of the MAP will not address the alarming increase in the incidence of sexually transmitted infections (STIs). Indeed, there are concerns that the ready availability of the MAP may lead to an increase in promiscuous behaviour among young people and contribute to a further rise in the incidence of STIs.

An article published in *The Lancet* notes that the introduction of a safety device is frequently accompanied by an increase in risk-taking which may cancel out the intended benefit. In some cases, the risk may be transferred from one group of people to another. So, for example, legislation requiring the use of seat-belts in cars was followed by a rise in the rate of deaths among pedestrians, cyclists and rear-seat passengers not wearing a seat-belt, as drivers had been lulled into a false sense of complacency. The authors argue that there is a parallel to be drawn between the use of seat-belts and the more recent rise in the use of condoms to reduce the risk of HIV infection. They refer to evidence that suggests that increased condom usage has been accompanied by a rise in promiscuous behaviour, carrying a high risk of infection.[33]

There is also emerging evidence which suggests that the development of drug therapies to prolong the lives of men infected with HIV has led to increased risk-taking among homosexuals.[34]

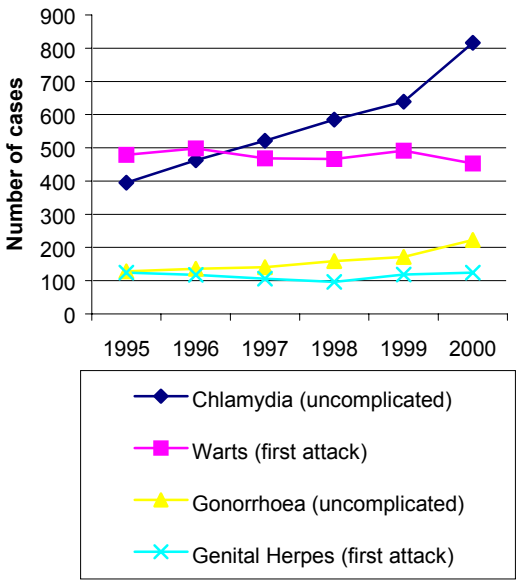
A similar trend may be anticipated as a result of the wider availability and promotion of the MAP. While it may reduce the 'risk' of an unwanted pregnancy, it will encourage a more casual attitude to sex and expose young people to increased risk of STIs.

During the 1990s, new episodes of STIs seen at genitourinary medicine (GUM) clinics in the UK almost doubled from 624,000 at the beginning of the decade to almost 1,170,000 in 1999. The rise in diagnoses of acute STIs was particularly marked between 1995 and 1999, with an increase of 76% for genital chlamydial infection, 55% for gonorrhoea, 54% for infectious syphilis and 20% for genital warts. The highest rates and increases in STI diagnoses were found in the 16-24 age group, with the rises in acute STIs being highest among teenagers.[35]

In the year 2000 GUM clinics in England, Wales and Northern Ireland saw further substantial increases in new episodes of STIs over the 1999 figures. In that single year diagnoses of uncomplicated gonorrhoea rose by 29%, genital chlamydial infection by 18%, and infectious syphilis by 57%.[36]

STI statistics suggest that the problem is rapidly going down the age range. In England, Wales and Northern Ireland, there was a 74% increase in cases of gonorrhoea in girls under 16 between 1995 and 2000, and a 107% rise in diagnoses of chlamydia in under-age girls over the same period (figure 4).[37] The peak age for women to be diagnosed with chlamydia is between 16 and 19.[38] Chlamydia is the biggest cause of ectopic pregnancy and can lead to infertility and cervical cancer.

Fig 4: New episodes of selected diagnoses of STIs in girls aged under 16: England, Wales and Northern Ireland 1995-2000



Source: PHLS, *Data on STIs in the United Kingdom (1995-2000)*

According to the Alan Guttmacher Institute, there are biological factors which heighten the risk of STIs for young women in their teens: 'Young women contract [STIs] more easily than adults because they have fewer protective antibodies and the immaturity of their cervix facilitates the transmission of an infection.'[39] Younger sexually active people are also more likely to have more than one partner.[40]

The increased availability of the MAP is contributing to a culture which will have a number of further damaging consequences. Several powerful messages are being conveyed:

1. *There is nothing wrong with engaging in sex at any age.*

Provided a condom is used to minimise the risk of pregnancy and/or STIs, the impression is given that there is no real objection to teenage sex outside of marriage. The protective principles underlying the statutory age of consent are being undermined.

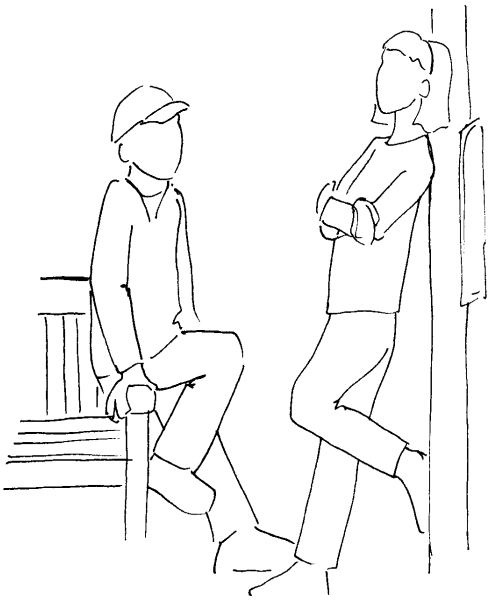
2. *Actions need not have lasting consequences.*

While 'safer sex' is encouraged, it is acknowledged that not all will practise it, and among those who do, it may fail. Enter the MAP... All is not lost, because a couple of pills are now readily available which, if taken within 72 hours, will more than likely put an end to any resulting pregnancy.

3. *There is a drug to deal with every eventuality.*

According to much current thinking, the only thing 'wrong' with teenage sex is that it may leave girls with an unwanted child who may blight their future education and career prospects. Rather than encouraging them to control their own behaviour, they are being directed to a drug which will help control the unwanted consequences of that behaviour.

The ready availability of the MAP will further promote a casual approach to sexual relationships. It will also serve to give the green light to men and boys wishing to exert pressure on young women and girls who are reluctant to enter a sexual relationship. In response to the female's fears of contraceptive failure, the male can assure her that emergency contraception is available to deal with that eventuality.



THE UNDERMINING OF PARENTS

In 1985, the House of Lords overturned a ruling in the Court of Appeal to the effect that under no circumstances should contraception be supplied to girls under the age of 16 without the knowledge and consent of their parents. However, in delivering their judgment, the law lords were insistent that under all normal circumstances the child's parents should be informed and in agreement with the supply of contraceptive treatment to an under-age girl:

'...a doctor is only in exceptional circumstances to prescribe contraception to a young person under the age of 16 without the knowledge and consent of a parent... Only in exceptional cases does the guidance contemplate [a doctor] exercising his clinical judgement without the parents' knowledge and consent.' (Lord Scarman)[41]

'Nobody doubts, certainly I do not doubt, that in the overwhelming majority of cases the best judges of a child's welfare are his or her parents. Nor do I doubt that any important medical treatment of a child under 16 would normally only be carried out with the parents' approval. That is why it would and should be most unusual for a doctor to advise a child without the knowledge and consent of parents on contraceptive matters.' (Lord Fraser)

Many health professionals appeal to the 'Fraser criteria' to defend the supply of contraception to a girl under the age of consent: (i) that she will understand the advice given; (ii) that she cannot be persuaded to tell her parents; (iii) that she is likely to begin or continue in a sexual relationship; (iv) that her physical or mental health may suffer if contraceptive treatment is denied her; and (v) that it is in her best interests. However, few are aware that Lord Fraser added that these criteria:

'ought not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would, in my opinion, be failing to discharge his professional responsibilities, and I would expect him to be disciplined by his own professional body accordingly.'

In 1985, it was not widely envisaged that, by the turn of the century, contraception and the MAP would be available to children in clinics operating in schools. Yet that is the situation which prevails in a growing number of schools. For example, at John Port School in Etwall, Derbyshire, the MAP is supplied on average to two pupils each week, the majority of whom are aged 15. As at December 2001, Bodyzone health clinics were operating in 18 secondary schools in Oxfordshire, catering for 17,500 pupils. The project pack explains that the family planning nurse can '...issue condoms, emergency contraception and repeat supplies of the pill and injectables without a doctor present'.[42]

Children attending a Bodyzone clinic are issued with a welcome form which assures them that 'this is a completely CONFIDENTIAL service...your school/college are not allowed to ask why you are attending Bodyzone'. The first option on the form is for children to ask for 'The Sexual Health Nurse (for contraception, pregnancy tests, supplies and advice)'. During the first year the scheme operated in Oxfordshire schools, around 140 teenage girls were given the MAP without their parents' prior knowledge.[43]

The guidance of the former Department for Education and Employment (DfEE) on sex and relationship education emphasises that parents are the key people in teaching their children about sex and relationships and that '[s]chools should always work in partnership with parents, consulting them regularly on the content of sex and relationship education programmes'.[44]

However, in some parts of the country, the guidance on sex and relationships education with its emphasis on parental responsibility is being by-passed by projects operated by health authorities in the context of the local school. Education legislation is similarly being circumvented. Under the Education Act 1993, parents have an unconditional right to withdraw their children from any sex education in school with the exception of 'biological aspects' required by the National Curriculum. However, since Bodyzone, for example, operates outside the school curriculum as a service of the health authority, it is not subject to primary education law or covered by the DfEE guidance.

With regard to the availability of the MAP in a school setting, the government's position is that: 'where a school nurse provides emergency contraception she works within the same legal framework and government guidance as other health professionals providing contraception to under 16s. They must always encourage the young person to involve her parents, but the nurses' professional code states that, if the girl refuses, confidentiality must be maintained unless there are serious child protection issues.'[45]

Increasingly, girls under the age of 16 are being supplied with contraceptives, including the MAP, without the knowledge or consent of their parents. The exception has become the norm, and the availability of the MAP in schools looks set to expand. Parents are being excluded from decisions that vitally affect their children's lives. The Director of Communications for the British Pregnancy Advisory Service writes:

'[F]or emergency contraception to be used effectively by teenagers, it needs to be provided conveniently, confidentially and cheaply (preferably free of charge altogether)...Teenagers are more likely to benefit from projects that take free contraceptive services into their schools...'[46]

TOWARDS A BETTER WAY…

Everyone is in agreement that the current rate of teenage pregnancy in the United Kingdom is a problem that needs to be addressed. However, all the available evidence suggests that the government's policy of improving teenagers' access to contraceptive advice, including emergency contraception, is destined to fail. The government's strategy is based on the flawed premise that teenagers will continue to engage in sexual activity irrespective of anything parents and teachers say to them. The truth is, however, that the vast majority of young people under the age of 16 are not engaged in sexual relationships. A national survey of 2,250 students aged 13-15 found that only 17% claimed to be sexually active.[47]

There is a need to support and affirm the majority in their abstinence, and to demonstrate to the minority the physical, emotional and psychological benefits of delaying sexual activity until marriage, where it serves as an expression of the total self-giving of the one to the other which lies at the heart of a lifelong commitment.

Over the past decade there has been a huge expansion of abstinence-based sex education programmes in the United States. There is evidence to suggest that these have had some success in discouraging early sexual intercourse and in reducing the teenage pregnancy rate.[48] In the United Kingdom, there has been a surprising resistance to such programmes among professionals in the field. But until we overcome our current phobia about abstinence and our obsession with sexual expression, we are unlikely to make any positive progress.

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