Emergency contraception in the UK

Summary
As part of our campaign to reduce the number of unwanted pregnancies in the UK, we examine the importance of emergency contraception (EC). This briefing reviews and compares ECs available, and notes the dual purpose of intrauterine devices (IUDs) as an EC and as a long-acting method of contraception. Despite legislation to make EC more available, price and stigma remain significant barriers to use. To reduce unwanted pregnancies an integrated and comprehensive reproductive health service should be championed, with EHC as a vital component.

Introduction
To reduce the number of unwanted pregnancies, it is necessary to consider a range of contraceptive methods, and methods to be used when those contraceptives fail. A study in the US found that 65 per cent of women using emergency hormonal contraceptives (EHC) were also using a form of contraception, 40 per cent of whom had been using condoms, which have a high rate of user failure. The same study found that for every pregnancy that occurred after the use of an EHC, three pregnancies were prevented, demonstrating the importance of EHC but also the need to improve its provision.

Research in the UK has found that increasing the availability of emergency contraception does not reduce the use of regular contraception, or increase rates of unprotected sex. Improving the accessibility of emergency contraception is an important contributor to reduce unintended pregnancies.

Currently, there are three options for emergency contraception available: the emergency intrauterine device (IUD) and two varieties of emergency hormonal contraceptives (EHCs).

Intrauterine Device
The Intrauterine Device (IUD), also known as the coil, is typically used as a form of long-acting reversible contraception (LARC) but can be implanted up to five days after unprotected sex to provide emergency contraception, and left in place to serve as a LARC thereafter. The IUD is highly effective as emergency contraception, as 99.91 per cent of users did not become pregnant. It remains a less popular option, however, as a study in the USA found that most women seeking emergency contraception were not offered the IUD and only 10 per cent asked for it.

Research has focused on the effectiveness of IUDs but has neglected the development of an understanding of how easily IUDs are available to women following unprotected sex and how aware women are of this option. The IUD can be fitted in sexual health clinics, a contraceptive clinic, some genitourinary medicine (GUM) clinics and certain general practitioner (GP) surgeries. An advantage of the requirement to see a medical practitioner is that it is provided for free by the National Health Service (NHS) in the UK. However, the intimate process of having an IUD fitted, or

1 https://www.guttmacher.org/pubs/journals/3429402.html
2 http://www.bmj.com/content/331/7511/271?linkType=FULL&ck=nck&resid=331/7511/271&journalCode=bmj
3 http://www.nhs.uk/news/2012/05may/Pages/emergency-contraception-pill-or-IUD-coil.aspx
Emergency contraception in the UK

the time constraints of clinic opening hours may dissuade some women. To address discomfort, confidential care is essential, where patients feel safe and can build a rapport with the medical professionals.

A limit in the number of professionals trained in IUD insertion can also affect accessibility. The pressure to limit waiting times may also discourage the fitting of an IUD which is more time consuming than prescribing the oral contraceptive pill. In the long-term, however, IUDs are a much more cost-effective option for the NHS as after the initial cost of the device and insertion, IUDs require only occasional check-ups and eventually, after five to ten years, removal.

Emergency hormonal contraceptives
While Emergency hormonal contraceptives (EHC) pills are less effective than the IUD, they are more commonly used and prevent up to 85% of pregnancies. According to National Health Service guidance, ellaOne is more effective than Levonelle, though both decrease in efficacy as time since intercourse passes. Unlike IUDs, which must be fitted by a trained medical professional, EHC are more easily accessible and widen choice for emergency contraception, particularly during holiday periods when core medical services can be closed for several days.

Availability
The terminology surrounding EHC perpetuates several common myths, which may affect perceptions of availability. EHC are popularly referred to as the “morning after pill” which not only disguises the differences between the options, but also causes confusion, as many believe that it must be taken within 24 hours of sex. In fact, the two EHC options vary with regard to the number of days after sexual intercourse that they are effective and the number of times they can be used during a menstrual cycle. Health workers should take care to avoid the use of this phrase to reduce confusion.

Over the counter (OTC) sales of EHC were legalised in 2001 in the UK. The uptake has been high, which has resulted in savings in time and resources for health services. While there has been little increase in the overall use of emergency contraception, it is believed that OTC availability will increase the effectiveness of use, as women may obtain it more quickly and EHC are more effective the closer to the time of sex. While evidence is limited, academics tend to recommend OTC remedies given the absence of negative consequences and the possible positive consequences for unwanted pregnancies and reducing the burden on the health system.

As a result of advocacy from the scientific community, ellaOne became available without a prescription in April 2015. This change in legislation has not been widely publicised, as pharmacists await adequate training on asking open ended and non-judgemental questions.

While being made available without prescription is welcome, the £34.95 cost of purchasing ellaOne may be prohibitive to some women unable to reach a free clinic or a doctor’s surgery within the recommended time limit. The price is considerably higher than in France where emergency contraceptive pills can be purchased for

______________________________

5 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960101-8/abstract

Emergency contraception in the UK

Around €7 or £5.60. In Italy, ellaOne is almost a third of the UK price at €16.38, around £12, and Denmark at half the price, or approximately £17.25. An audit in 2012 found that health services, covering 3.2 million women of reproductive age were providing a comprehensive contraceptive service, creating a postcode lottery for affordable availability.

A 2014 report by the National Institute for Health and Care Excellence recommended that GPs should offer a small supply of EHC in advance of perceived need to young women who rely on condoms or the contraceptive pill, both of which have relatively high rates of user failure. Although greeted with alarm in the press, due to fears of teenagers ‘stocking up’, NICE believes this would reduce the number of unwanted pregnancies in the under-25s. Indeed, there is no reason to believe that the benefits would be limited to the young, as older women can experience issues in accessing health services outside of working hours. NICE recommends that when being asked to prescribe an advanced supply GPs should take the opportunity to discuss wider sexual health issues and recommend other more reliable alternatives such as LARCS.

Barriers to use

As legislation changes, confusion remains among health service providers and potential service users over what can be accessed and for what price. A survey of women aged between 16 and 54 years carried out by the Family Planning Association found that 43 per cent did not know where they could obtain emergency contraception. Several widespread myths surrounding access and information emerged from this survey including that a third of respondents who believed a prescription is required (it is not), and that almost two-thirds of respondents believed that repeat use would cause infertility, (it won’t).

While reducing teenage pregnancies has been an important focus in recent family planning debates, there is a danger that older women are being neglected. There has been a 20 per cent rise in abortion rates among 25 to 29 year olds over the past 10 years, while rates for under-18s have dropped. Brooks clinics provide an important service to the under-25s but the gap of services after this age has not been adequately filled.

One significant issue that surrounds the topic of contraception, and particularly emergency contraception, is the social context, which all too often becomes muddled with medical advice. In the USA, the Food and Drug Administration requires a label on emergency contraception packaging saying ‘for ages 17 and up’, even though no proof of age is required at purchase. This label is not based on scientific research but on societal norms about teenage sexual activity. This labelling is misleading for both customers and practitioners, as some pharmacy staff have rejected those under the age of 17 who are seeking to buy emergency contraception. A secret shopper study found that pharmacists are misinforming potential users, with potentially detrimental impacts for those

7 http://www.theguardian.com/commentisfree/2014/jun/13/women-having-abortions-20s-baby-contraception
9 http://www.guidelinesinpractice.co.uk/jan_13_connolly_contraception_jan13#.VeYNDVNvIkg
10 http://www.nice.org.uk/guidance/PH51
12 http://www.theguardian.com/commentisfree/2014/jun/13/women-having-abortions-20s-baby-contraception
trying to buy emergency contraception, and rates of unintended pregnancies.\(^\text{13}\)

**Conclusion**

Health service providers risk being trapped in a short-term mind-set, resulting in increasing contraceptive costs over time. While the IUD offers both emergency contraception and a long term solution, it is being undermined by cuts in the funding of family planning services, and in a survey carried out by the Faculty of Sexual & Reproductive Healthcare in 2010, 16 per cent of lead clinicians in England reported restricting the provision of LARCs over the past 18 months.\(^\text{14}\)

While IUDs and EHC vary in cost and ease of access, which can alter individual’s use, a sense of shame and of being linked to negative behaviour continues to surround the use of all emergency contraception. This can reduce the likelihood of people accessing emergency contraception, particularly younger women.

Studies of different groups of young people have found that embarrassment inhibits them from using contraceptive services. It is, therefore, crucial to tackle the environment in which contraception is provided, as well as the service itself.\(^\text{15}\) Before being given emergency contraception, women are required to discuss their current contraceptive use with the service provider. While this is an opportunity to improve women’s choices, all too often it leaves women feeling “lectured, told off and humiliated”\(^\text{16}\)

The head of advocacy at The British Pregnancy Advisory Service, Abigail Fitzgibbon, welcomed measures to make emergency contraception more accessible but said that “in order to make a real difference, we need to stop stigmatising the women who take it, and it needs to be regulated in exactly the same way as any other method of contraception: not priced out of reach or a symbol of shame”\(^\text{17}\)

A secret shopper study revealed negative perceptions held by service providers that easy access to EHC has a negative impact on sexual behaviour, which leads to negative perceptions of young people requesting, especially repeat requesting, EHC.\(^\text{18}\) Evidence, however, does not seem to support these fears as increased access to emergency contraception has not increased the rate of use, though it has increased the speed of use, thus making it a more effective method.

Trust in local services is a vital aspect of service accessibility and in allowing young people to feel confident and in control when using them. This can be especially important in rural areas in relation to confidentiality where medical staff may know service users’ families. Increased training for service providers on the importance of non-judgemental conversations should reduce the psychological barriers to emergency contraception.

\(^{13}\) [http://rhrealitycheck.org/article/2014/05/01/inequality-misinformation-generic-emergency-contraception-still-inaccessible-many/](http://rhrealitycheck.org/article/2014/05/01/inequality-misinformation-generic-emergency-contraception-still-inaccessible-many/)


\(^{15}\) [http://www.nice.org.uk/guidance/ph51/evidence/contraceptive-services-with-a-focus-on-young-people-up-the-age-of-25-review-3-views-review2](http://www.nice.org.uk/guidance/ph51/evidence/contraceptive-services-with-a-focus-on-young-people-up-the-age-of-25-review-3-views-review2)


It is clear that no single initiative to reduce unwanted pregnancies will succeed. Instead, an integrated and comprehensive service must be championed, with emergency contraceptives taking a vital place in this system. The network of services must be coordinated and, importantly, publicised. Common myths surrounding contraception remain a significant barrier to use and efficacy, and this should be an important target of health providers.