The morning after pill
Promoting Promiscuity

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The morning after pill shake-up

The morning after pill is being made available as never before. This is the result of two Government initiatives: the first involves the over-the-counter sale of the drug at chemists; the second involves free distribution programmes in schools and other places.

Over-the-counter sale in Chemists

As a result of a Ministerial Order[1] introduced in December 2000, the morning after pill (MAP) has been available over-the-counter from pharmacists since January 1st 2001 to women aged over 16. A vote in the House of Lords on 29th January 2001 will confirm or overturn this move.

The initial cost has been set at £20, but this is very likely to fall. Some private clinics are already selling it at £10.[2]

Free distribution programmes

In a completely separate move involving another Ministerial Order[3] the Government has made it possible for the MAP to be distributed free by school nurses and other health professionals.

Under this Ministerial Order it is also possible for chemists to dispense the drug for free to girls aged under 16 where the local health authority have made an appropriate "Patient group direction".

In a recent highly publicised case, a 15 year old girl, open about her age, was able to obtain the morning after pill from six chemists[4]. In fact The Royal Pharmaceutical Society has pointed out that the chemists were acting lawfully under one of the Government's new *Patient Group Directions(PGDs)* and not under the over-the-counter scheme.[5] The Direction in this case is operated by Lambeth, Southwark and Lewisham Health Authority. A total of 33 chemists have been given power to give out the pills to girls. The Direction is quite specific that there is no lower age limit.

PGDs were originally introduced in August 2000 to ease pressure on GPs by enabling other health professionals to carry out large scale

prescription of drugs such as the "flu-jab", Relenza.

But these delegation powers are now being used to enable school nurses to distribute the morning after pill without charge and without parental consent. One newspaper article alone reports that 18 schools are involved in such programmes.[6] Whilst school nurses cannot legally prescribe paracetamol, they will be able to prescribe the morning after pill where a patient group direction is in force.[7]

The Government has refused to intervene in the free distribution schemes saying they are a matter for local health authorities. This is disingenuous since the health authorities are clearly following Government policy.[8]

The existing policy

The morning after pill has been available on prescription for several years. Various forms of the pill have been developed, but it is a new drug *Levonelle-2* which is supplanting previous products.

The involvement of the GP necessarily involves doctors making clinical assessments based on complete knowledge of the patient. Details of any prescriptions are added to the medical record.

Doctors in all family planning clinics and in many accident and emergency departments are also able to prescribe the MAP.

The Government's new policy

The Government wants to make it more convenient for women to have access to the MAP. It wants health authorities to take action to reduce the present high levels of teenage pregnancies.

The Government's White Paper on *Teenage Pregnancy* aims to halve the rate of conceptions amongst the under 18s by 2010.[9]

Praise for the Government's new morning after pill policy has come from what constitutes the 'sex education establishment' which, broadly speaking, has promoted the 'safer-sex' message with the emphasis on

increasingly explicit sex education at ever decreasing ages.

Whilst the ‘safer sex’ policies have been almost universally adopted for many years in schools and elsewhere, the promised reductions in teenage pregnancies and sexually transmitted diseases(STDs) have not materialised.

In fact the teenage pregnancy rate has not fallen, whilst the prevalence of STDs has rocketed.

This Government’s policy is reckless because it

- promotes teenage promiscuity
- encourages unsafe sex
- will therefore increase the incidence of STDs
- risks the health and, in certain cases, the lives of young girls
- has virtually no safeguards
- undermines the role of parents

Rather than improving the situation the Government’s policy will make matters worse.

The “morning after pill” is taken to prevent pregnancy in a 72 hour period following intercourse. The pill acts as a contraceptive, but if conception has already occurred, it prevents the embryo implanting into the lining of the womb. This last mode of action was deemed not to constitute abortion under the 1967 Abortion Act by the Attorney General in 1983.[10]

Christians holding to the sanctity of life from conception disagree and say that preventing embryo implantation is a form of abortion.

Promoting promiscuity

Availability of sex education and contraception

Sex education has been the norm in secondary schools for twenty years. In 1991 mandatory content was laid down for all state schools.[11]

Condoms can be bought by anyone - no matter what their age - from most supermarkets and petrol stations. Dispensing machines are widely accessible.

The morning after pill (MAP) has been available through GPs since 1985[12]. Even before this inter-uterine devices (IUDs) were used as an "emergency contraceptive" particularly for older women.

All women can obtain contraception, including the MAP, on the NHS without any prescription charge through their GP.

In addition to the local GP, there are over 1,300 family planning clinics spread throughout the country from where the same contraceptives are available for free. An increasing number of accident and emergency units also make the morning after pill available.

These contraceptives are also available to girls under 16 even without parental consent. This follows the ruling in the *Gillick* case in 1985.[13] Following this case it has become commonplace for under 16 year old girls to seek contraceptive advice through their GP or a family planning clinic.

It has not worked : under age sex

The age of first intercourse has been steadily declining. Only 1% of girls born in 1931 had had intercourse before the age of 16. For those born in the 1950s it was 5%. For those born in 1974 it was 24%.[14]

As the White Paper notes, the number of young people sexually active by 16 doubled between 1965 and 1991, with the rise most striking for girls (see Figure 1).[15]

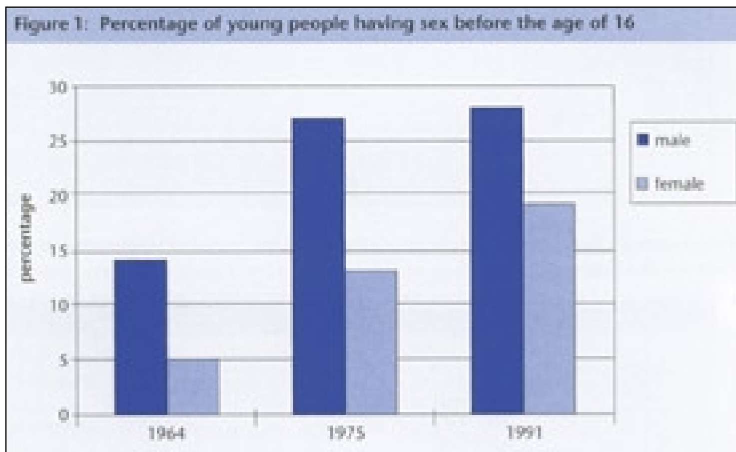

Figure 1: Percentage of young people having sex before the age of 16

It has not worked : teenage pregnancies

The teenage pregnancy rate has changed very little over the past 25 years (Figure 2). The crucial difference is marriage and consequently the costs to the State. If teenagers were marrying in their droves and having children there would be little or no public concern. Many would be delighted. This was the case in the 1970s and for most of that century.

The heart of the problem is that now these teenage mothers are unmarried and as a consequence are dependent on the State for their living costs, including housing (See Figure 3). In 1999 the BBC reported that teenage pregnancies cost the taxpayer some £10 billion per year.[16]

Twenty years ago 60% of teenage pregnancies took place within marriage, today the figure is only 10%.[17]

Joint registrations, where the father is much more likely to be cohabiting with the mother and supporting the family, have changed very little in the past few decades. It is births registered solely to single teenage mothers that have dramatically increased.

The under 18 conception rate has been increasing since 1994. It has risen from 42 conceptions per 1000 women per year to 47 per 1000 in 1998.[18]

It has not worked : abortion

There can be no doubt that contraception can be easily obtained and that the quantity and explicitness of sex education has dramatically increased over the past 25 years.

Despite all this, and the provision of the morning after pill which was first licensed and manufactured in 1985[19], the teenage abortion rates are much higher now than they were 25 years ago.

Age	1975[20]	1999[21]	% rise
Under 15	2.3	3.3	**43 %**
15	7.5	8.2	**9 %**
16-19	17.4	26.0	**50 %**

Rates of abortions per 1,000 women per year, *Residents* of England and Wales. Source : *Abortion Statistics Series AB nos.24 and 26*, ONS

The percentage of all pregnancies terminated by abortion has increased every year since 1993.[22]

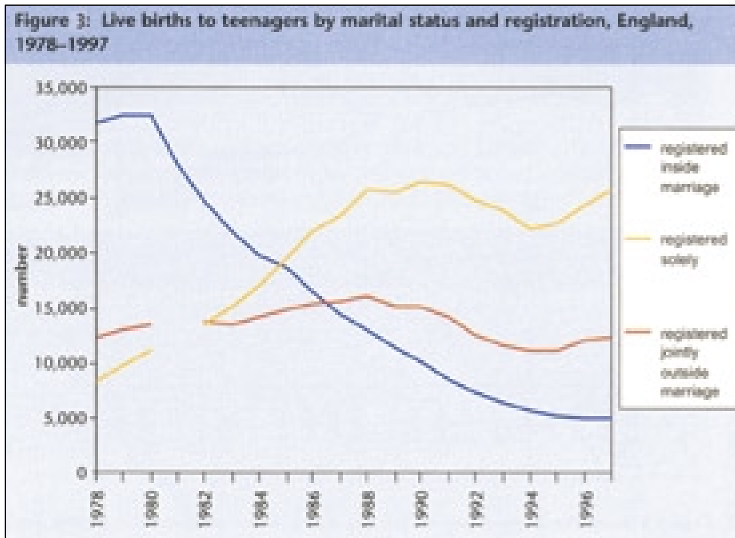

Figure 3: Live births to teenagers by marital status and registration, England, 1978–1997

It has not worked : STDs

The Department of Health have admitted that the UK is in a state of "poor sexual health" :

"Virtually all the sexually transmitted infections (STIs) are increasing. The number of attendances at departments of genitourinary medicine/ sexually transmitted diseases now totals 1 million per year, a doubling over the last decade. The commonest conditions are genital warts (some types of which can be associated with the subsequent development of carcinoma of the cervix), chlamydia and gonorrhoea, which if untreated can result in ectopic pregnancy and infertility. Chlamydial infection seen in clinics has risen by 21% between 1996 and 1997, and a further 13% from 1997 to 1998 (latest figures). Population surveys have reported rates of chlamydia as high as 20%, particularly in young women.
There has been no reduction in the annual number of new diagnoses of HIV made and the latest annual figures (1999) saw the highest number of new HIV diagnoses ever recorded."[23]

The myth of safe sex

In the 1980s much was said about 'safe sex', that is, sex using a condom. In the 1990s the term was changed to 'safer sex'. This change protected condom manufacturers from litigation, but the distinction will be lost on young people. 'Safer sex' materials rarely tell young people of the *typical* condom failure rate.

Medical journals report condoms having a *typical* failure rate of 14%. This means that with typical use 14% of women will become pregnant over the course of a year.[24] This is much higher than the often quoted 'perfect use' rate of 2% of women per year.[25]

Typical failure rate of condoms : % of women falling pregnant per year

15.7% *Family Planning Perspectives*, Alan Guttmacher Institute, 1989 (21) No 3, p103

14% *Contraceptive Efficacy*, Trussell J in Hatcher RA, *Contraceptive Technology*, BMJ Publishing, 1998, page 800

It is common sense to expect that the failure rate amongst teenagers will be higher. One family planning clinic in Manchester found that 52% of those who obtained a condom from the clinic had one or more either burst or slip off in the previous three months.[26]

A failure rate for pregnancy will always be lower than the failure rate for sexually transmitted diseases since women have 23 non-fertile days where condom failure does not result in pregnancy.

Condom failure can result in infection by an STD on any day of the month.

Promoting promiscuity

Given all the objective facts about the rates of teenage pregnancies, abortions and STD infections, it is reasonable to question whether the present policy of safer sex is in fact achieving the many claims made for it.

The sex education establishment which has promoted safer-sex is the same establishment now promoting the use of the morning after pill.

The availability of the morning after pill further fosters the belief amongst girls that they can have sex without consequences. Unlike the regular contraceptive pill, they do not have to take one every day. Unlike the condom neither they nor their sexual partner have to remember to take one with them. Nor is there the problem of persuading their sexual partner to use one.

For all these reasons the morning after pill is an easy alternative to condoms. That is why use of the MAP is linked to reduced use of condoms.

If the Government goes ahead with all its morning after pill schemes the message will not be lost on young people. Everyone from GPs to health authorities, school nurses to headteachers, from youth workers to the Prime Minister will be going out of their way to make the morning after pill available to them.

It gives the green light to sleeping around. A message which will probably have a much more powerful impact in the statistics than the drug itself.

The journalist Jeannette Kupfermann commented :
'An over-the-counter sale will do nothing to address the underlying behaviour that leads to the woman needing emergency contraception in the first place. It gives her permission to continue in the same old irresponsible way.' [27]

Pressure on girls

Could the MAP become a usual method of contraception for some young women?

The General Household Survey has found that 5% of women aged 16 – 17 and 6% of women aged 18-19 had used the morning after pill more than once in a two year period.[28] This is at the levels of availability in 1998.

A woman who regularly used the MAP would be at risk of any number of sexually transmitted diseases. Because pharmacists are forbidden to contact the GP, no one other than the young woman concerned would know how frequently she used the MAP. She would be free to go to any number of chemists. The only limit would be the cost.

Men prefer not to wear a condom because of the loss of sensation during intercourse. Durex, the leading condom manufacturer state that this, along with the smell of latex, are the two main reasons why many men do not like using condoms.[29]

The Government's Teenage Pregnancy White Paper quotes one boy as saying:
"I have used a condom, but I don't like it, it puts you off. What's the use of having sex if you don't enjoy it?"[30]

Girls would come under more pressure to have unsafe sex from men who prefer, and may even be glad to pay for, the MAP. Moreover one morning after pill treatment covers a whole weekend. Many young men will consider £20 well spent if it means a 2 day period during which they can have unprotected sex as often as they like. It has already been noted that some clinics sell the pill for £10. The price is bound to fall in chemists.

Sadly there are many young people who think nothing of spending £40 or £50 on drugs or drink at the weekend. So £20 to fund a weekend of hedonism is not out of their price range.

If the sex education industry is so committed to 'safer-sex', it should oppose the widespread use of the morning after pill since it will have such a catastrophic effect on young people's willingness to use a condom.

Unsafe sex linked to MAP

The Government cannot avoid the charge of promoting unsafe sex.

Many women believe that use of the morning after pill lessens the likelihood that a condom will be used. This would therefore lead to an increase in unsafe sex and the likelihood of catching sexually transmitted diseases.

572 women who sought emergency contraception in family planning clinics in North and East Devon were asked:
'Do you think it would be a good idea to make MAP available directly from the chemist?'

Half of the women said 'No' because amongst other things 'Women would take more risks; condoms would be less likely to be used; MAP would be used frequently; it would encourage less responsibility for contraception.' [31]

The risks from a single occasion

The Government's own White Paper warns that in a single act of unprotected sex with an infected partner, teenage women have a

- 1 % chance of acquiring HIV,
- 30 % risk of getting genital herpes and
- 50 % chance of contracting gonorrhoea.[32]

Sexually Transmitted Diseases

The medical dangers of STDs

There are several general principles associated with STDs:

1) Often a patient with one disease is more likely to get another, for example gonorrhoea with genital warts. Chlamydia increases the likelihood of contracting HIV between 3.6 and 5-fold.[33]
2) Several of the important sexually transmitted diseases cause extremely mild or usually no symptoms in women. Indeed the first time that a woman may be aware that she has become infected is when she has developed a complication of the infection.
3) These diseases cause a range of complications which are often serious, for example cancer and meningitis, and which are not exclusively restricted to the genital region.
4) Young girls and women are particularly vulnerable because
   a) Physically the genital tract is immature and is subject to trauma or tearing during the sexual act.
   b) The epithelium, or skin, of the vagina in the prepubescent or pubescent girl is very thin, 2-3 cell layers thick, in contrast to 80 cell layers thick skin of the mature woman which does not normally tear during the sexual act. The very thin skin tears very easily allowing bacteria or viruses (from the sexual partner) to enter the girl's body tissues.
   c) Specific defence mechanisms against infection are not fully developed.
   d) Frequently the sexual partner of a young girl is an experienced, and potentially infected, older teenager or man.[34]
5) The use of condoms cannot fully protect a woman from sexually transmitted disease because of condom failures and because there are certain conditions such as genital warts and genital herpes which are transferred by skin-to-skin contact. Moreover the use of condoms amongst teenagers drops over time. According to a study by the research firm Child Trends, 63% of females, ages 15-19 reported condoms use at first sex, only 28% reported condom use at most recent sex.[35]
6) Some sexually transmitted diseases are developing into superstrains which have become resistant to current antibiotic treatment.[36]

Serious risks to health

Sexually transmitted diseases such as chlamydia may cause many unpleasant complications, the most notable being ectopic pregnancy,[37] and cancer of the cervix[38].

Cancer of the cervix may also be caused by having unprotected sex under the age of 16. Susan Blunt, a consultant obstetrician and gynaecologist, has written:
"If a girl has sexual intercourse before she is 16, when the cervix is rapidly growing and dividing, she significantly increases her cancer risk. The more partners, the greater the risk."[39]

The most common STDs

The most common sexually transmitted diseases are

- Gonorrhoea
- Chlamydia
- Syphilis
- Genital Warts
- Hepatitis B and C
- HIV
- Genital Herpes[40]

Trichomona and thrush are common STDs, they have some unpleasant symptoms but they do not have significant consequences.

Selective preaching

Don't preach on sex...

There are many subjects on which Governments have views which they are keen to promote. From serious subjects such as racism and smoking, to what we should eat and how to choose a nanny, Government ministers are happy to preach.

However, when it comes to teenage sex, the Government believes that no-one should moralise or be seen to tell young people that they should be abstaining from sexual activity.

The assumption is that young people will be sexually active, whatever anyone says to them, and that the best that can be done is to help them limit the damage they will suffer as a result.

This *harm reduction* approach to sex education is almost universal amongst local education authorities, NHS health promotion trusts and groups like the Family Planning Association, Brook and others who together comprise the sex education industry.

The harm reduction approach advocates that young people are simply to be given information to help them make informed choices. Directive advice is out. Even telling young people that they must obey the law on the age of consent is said to be pointless and counter-productive.

The Government has adopted this approach in its White Paper on Teenage Pregnancy. The White Paper comments that there are 90,000 teenagers in England who become pregnant each year. It goes on, "They include 8,000 who are under 16. Some of these teenagers, and some of their children, live happy and fulfilled lives. But far too many do not".[42]

Yet despite this admission that there are 8,000 children involved in illegal sexual activity, telling them that it is wrong, is most definitely out:

"Preaching is rarely effective. Whether the Government likes it or not, young people decide what they're going to do about sex and

contraception. Keeping them in the dark or preaching at them makes it *less* likely they'll make the right decision."[43]

...do preach on smoking

The Government's approach on teenage pregnancies stands in stark contrast to its attitude to teenage smoking.

Even the title of the Department of Health White Paper - 'Smoking Kills' - indicates a very different approach to this subject. This White Paper states that a key aim of its strategy on smoking is to "protect young people both by making it less likely that they will begin to smoke and by helping them to stop". In line with this approach it proposes, for instance, "minimal tobacco advertising in shops" and "tough enforcement on under age sales".[44]

The Government's policy is to stop teenagers from smoking in the first place and for those that have started, it wants to see them give up. This is clearly preaching.

Such preaching was pursued in this area by previous Governments. The significant falls in the prevalence of smoking show that it has been very successful:

Prevalence of cigarette smoking,[45] percentage of persons aged over 16

	1974	1998
Men	51	28
Women	41	26

Smoking is addictive and therefore the physical impulse to smoke is hard to restrain. Nonetheless, the Government has sensibly decided that the best way to prevent smoking-related diseases is to encourage people to stop smoking.

It is notable that the Government does not take a harm reduction approach in this area. It does not suggest that young people should be told how to smoke more safely. It does not propose that young smokers should be issued with free filters, available in schools, clinics and youth

clubs, to give some protection from smoking related diseases. It does not even suggest treating smoking as a controversial issue where a teacher might say, for example, that, on the one hand, many people smoke and say it is relaxing and beneficial to their mental health, while, on the other hand, medical experts say it is linked to serious diseases such as lung cancer.

The Government has decided that teenagers should be told that smoking is a bad thing and that young smokers should be helped to stop.

Another Government preaching initiative: alcohol

Alcohol affects the brain: it slows reflexes and impairs judgement. It is, however, legal and it used to be thought that it was safe to drive after drinking alcohol as long as consumption was below a certain level. However, although consuming a small amount of alcohol before driving is still legal, successive Governments have told the public: “Don’t drink and drive”.

The present Government has continued this sensible policy using the slogan ‘Have none for the road’.[46]

The success of abstinence education

On teenage pregnancy, the Government of the USA has adopted a very different approach to that pursued by the Prime Minister’s Teenage Pregnancy Unit. The main aims of the respective strategies pursued by Tony Blair and Bill Clinton are in stark contrast.

Two aims contrasted

President Clinton	Prime Minister Blair
A National Strategy to Prevent Teen Pregnancy, US Department of Health and Human Services	Teenage Pregnancy Report, The Social Exclusion Unit
1. Parents and other adult mentors must play key roles in encouraging young adults to avoid early pregnancy and to stay in school.	1. Reducing the rate of teenage conceptions, with the specific aim of halving the rate of conceptions among under 18s by 2010.
2. Abstinence and personal responsibility must be the primary messages of prevention programs.	2. Getting more teenage parents into education, training or employment, to reduce their risk long term exclusion.

The USA has had an even greater problem of teenage pregnancies than the UK:
"Beginning in the 1960s and 1970s, various statistical measures confirmed a dramatic increase in sexual activity by adolescents as reflected in the consequences.

- The birth rate among unmarried females aged 15 to 19 years increased by 90% from 22.4 per 1,000 in 1970 to 42.5 per 1,000 in 1990.
- The abortion rate among females aged 10 to 19 years rose 94% from 9.7 per 1,000 in 1972 to 18.8 in 1990."[47]

After many years of failing with safer sex education programmes, the US response in many states has been to turn to abstinence-based sex education: teaching young people to say 'no' to sex before marriage. Some 23% of secondary school teachers in the USA teach abstinence education.[48] There are many other teachers who teach "abstinence plus" which promotes sex as being intended for marriage, but also covers contraception.

Each year the US Government gives at least $50 million to support abstinence education.[49] Additional funding from state sources takes the total up to almost $100 million. Funding for safer-sex programmes was less than a third of this amount. [50]

The 1999-2000 Annual Report of the National Strategy to Prevent Teen Pregnancy, reported "a record low US birth rate for teens aged 15-17"; the "lowest rate in three decades' for girls aged 10-14". The report states: "Trends throughout the 1990s have shown a steady reduction in teen birth rates that is now significant for all 50 states. Rates have declined for all adolescent age groups, for all racial and ethnic groups, and for both first and second births to teens. Clearly we are reaping the benefits of this Administration's strong commitment to our National Strategy and renewed efforts by states, localities, private organizations, parents, and youth."[51]

Abstinence-based sex education has not just reduced the teenage illegitimacy rate. Between 1991 and 1999 the prevalence of sexual experience among adolescents decreased by 8%.[52]

Hillary Rodham Clinton, despite her liberal credentials, has been preaching the abstinence message:

"After many years of working with and listening to American adolescents, I don't believe they are ready for sex or its potential consequences – parenthood, abortion, sexually transmitted diseases – and I think we need to do everything in our power to discourage sexual activity and encourage abstinence".[53]

Here in the UK, researchers have begun to consider the importance of developing school sex education programmes that will lead to a decrease in sexual activity.[54] Delaying first sexual intercourse and reducing sexual activity is now considered a worthwhile thing to do.

Clearly it is possible for young people to embrace an abstinence message, even if they have been sexually active in the past. The BMJ have recently reprinted one of the major US textbooks on contraception that endorses abstinence in the following way:

"Secondary abstinence, or celibacy, is the choice of many sexually experienced adolescents and adults. It is not an extremist position in the age of viral sexually transmitted infections."[55]

But despite all this, the current approach of the Government is still: "don't preach". Instead, it adopts the prevailing philosophy that naively says that young people must simply be given as much information as possible about sex and this will lead them to make good decisions.

The fact is, it is not *how much* sex education children get that is important, but the nature of it. One lesson could seriously undermine a child's belief in good moral values, taught by its parents, if a respected teacher promotes the view that most young people are sexually active and that there is nothing wrong with that.

The UK's sex education industry is scathing about abstinence-based sex education. An article published by the Sex Education Forum, probably the most influential grouping of organisations involved in sex education, referred to the "fear-based abstinence programmes."[56]

The industry is also very defensive about the accusation that more sex education leads to an increase in sexual activity. For example, five pages in the back of the Teenage Pregnancy report are taken up with summarising studies, many of which are said to show that sex education does not increase sexual activity rates. [57] This hardly seems to be the right emphasis.

There clearly needs to be a re-examination of the sex education industry and the 'non-judgmental' approach it advocates. Its policies have been in the ascendancy during a period when teenage abortion rates and STDs have increased substantially.

The inconsistency of approach

The Prime Minister does not "believe young people should have sex" but is resigned to the fact "that no matter how much we disapprove, some do".[58]

The statement "no matter how much we disapprove, some do" could be applied to anything of which society disapproves and which has not been completely eliminated. It certainly applies to people who commit crime. It applies to drink driving, smoking and drug taking.

The Government *is committed* to making "the misuse of drugs less culturally acceptable to young people"[59], but does not seem to believe that the same is possible or even desirable for underage sexual activity.

The great irony is that a single act of unprotected intercourse can be much more dangerous than a single cigarette. As the Teenage Pregnancy White Paper warns a single act of unprotected sex with an infected partner, teenage women have a

- 1 % chance of acquiring HIV,
- 30 % risk of getting genital herpes and
- 50 % chance of contracting gonorrhoea.'[60]

Yet, whilst cigarettes are very unhealthy and prolonged use results in many serious and often fatal illnesses, no one would ever argue that such consequences could follow from a single act of smoking.

The strong impression is given that drivers can be persuaded not to give in to the pressure to drink at a social gathering, that smokers and drug users can be helped to overcome addictions, but that teenagers can not be expected to control their sexual desires.

In the US, they know differently. A 1999 report from the Consortium of State Physicians and Resource Council found:
"The evidence points to sexual abstinence, not increased contraceptive use, as the primary reason for the decline in teen pregnancy and birth rates throughout the 1990s. It appears possible that programs aimed at producing abstinent behaviour have been more successful than programs aimed at increasing safer-sex practices in reducing unintended birth to adolescents. Douglas Kirby, a noted sex education researcher, was prophetic in 1991 when he noted that "it may actually be easier to delay the onset of intercourse than to increase contraceptive practice."[61]

Over-the-counter from chemists

The pressure of waiting customers

The pharmacists who are expected to dispense the morning after pill face considerable difficulties. They are providing a controversial drug to clients who may well be in an agitated and highly embarrassed state. In many chemists there is frequently a queue at the pharmacists counter, each person awaiting advice on their personal medical problems.

In the middle of this, pharmacists are expected to elicit detailed information from female clients anxiously seeking the morning after pill and then to make a judgment as to whether or not she should receive it. The pressure of waiting customers, on top of the seriousness of the request itself, may well result in many pharmacists simply giving the client what she asks in order to defuse the tension. To insist on a lengthy consultation going into all the relevant details might create further embarassment. Actually concluding that the request should be denied may cause the woman to become acutely distressed there and then in the middle of the shop.

A particular source of pressure on chemists will be the knowledge that the woman in front of them may well blame them if they have an unwanted baby as a result of not getting the morning after pill.

Even the basic question of whether the female is over 16 may fall foul to these pressures.

In theory, chemists are meant to have facilities for confidential consultations. In practice, few chemists have room for this kind of facility and a lone pharmacist would be unable to leave a queue of customers to hold a one-to-one consultation.

Not best for patients

Selling the morning after pill without prescription from chemists has many disadvantages for female patients. The main problems stem from the fact that the Pharmacist and GP cannot know what each other is up to. Under the rules on confidentiality they are not permitted to

communicate with each other (see inset). Even if there were no such rules, it would be impossible on a practical level to arrange it.

This means that the chemist cannot be certain there are not good reasons why he should decline to give the pill to a particular patient. He only has her word (and her memory) in response to the questions he asks.

Important information that the GP needs to know about his patient in order to properly assess any future problems she may have will not be on her record. It may be unlikely that the patient will advise the GP about her purchase of the morning after pill, since going to the pharmacist and paying for it instead of having it prescribed by the GP may indicate that she wishes to keep the matter secret. Even if she is not embarassed to tell her GP, the accuracy of her record depends on whether she gets around to informing him and how accurately she recalls each occasion.

Dr George Rae, chairman of the British Medical Association's prescribing committee warned there was a risk of 'fragmentation' of girls' medical records, with the risk of serious prescribing errors or complications. He said: "...unless you have a central electronic record and the pharmacist and school nurse share this information with the GP, there is a serious risk of fragmentation"[62]

The restrictions of 'confidentiality'.

Pharmacists cannot tell a patient's GP if she purchases the morning after pill. This means that:

1. Doctors will not know if their patients have taken the morning-after pill and how many times they have taken it.

2. Doctors will not have the information they need in order to assess other medical treatments they may be giving. In the event of any complications arising from the pill, such as bleeding, he will not be aware of the cause. The patient may not even remember how many times she has taken the morning after pill.

3. Chemists will be limited to the information about medication and medical history that their clients give them. A young client, in particular, may not know.

4. Chemists are advised to encourage the client to attend a GP surgery or family planning clinic within the month. There is no way of ensuring that this will happen.

The under 16s
The Ministerial Order allowing over the counter sale stipulates that it is only for over 16s. GPs know the age of their patients from their official records but pharmacists only have the say so of the customer before them. It is not uncommon for teenage girls to lie about their age, usually to get into licensed premises. Teen magazines regularly contain adverts for fake ID cards on which girls can falsify their age. There is every prospect that under 16s will have little difficulty in getting hold of the MAP.

It will be a simple matter to discover which chemists sell the morning after pill with the least fuss and to go there rather than to a chemist who is thorough.

Unlike a shopkeeper who sells cigarettes to under 16s, there is little realistic prospect that a chemist would get into trouble for selling the pill under-age to girls. Although the Medicines Control Agency could, in theory, bring a prosecution, it is unlikely that there would be the political will for it given that the same pill is available to girls under 16 through clinics and school nurses as well as GPs.

Record keeping
It will be difficult to assess how chemists are going about dispensing the MAP from their own records. Chemists say privately that record-keeping for over-the-counter drugs is often cursory. The Royal Pharmaceutical Society guidelines state that the record-keeping for the MAP should not be any different to that for other non-prescribed medicines, such as paracetamol.[63] A pharmacist wanting to know what

his obligations are will go to the General Legal Requirements which state that ‘Protocols for the sale of non-prescribed medicines from pharmacies should comply with Standard 12 of the Appendix to the Code of Ethics”.[64] Standard 12 of the Appendix to the Code of Ethics make no mention of record keeping for over-the-counter medicines.[65]

Pressure to sell

The NHS buys Levonelle-2 at £5, however chemists can only buy it in at £10.[66] The drug manufacturers therefore get an extra £5 when they sell the pill to chemists.

The chemist sells Levonelle-2 for £19.99, making £9.99 on every sale. This represents a considerable financial incentive to sell more Levonelle-2.

It is very likely that in the long-term there will be pressure to reduce the price of Levonelle-2. The disparity between the price to the NHS and the price to pharmacists may pull the cost down. Pressure will also come from supporters of the pill who will no doubt claim that the price is off-putting to women.

Pharmacies currently sell drugs under a retail price maintenance system. Many believe that this system is unsustainable in view of competition law. If the price fixing system is abolished this will exert considerable downward pressure on the price of the morning after pill.

Free distribution programmes

Patient group directions (PGD)

There have long been local arrangements enabling nurses to supply and/or administer prescription only medicines. This may take place on a hospital ward or, in the case of large scale vaccination programmes, in other venues such as schools.

However, in August 2000, using a Ministerial Order,[67] these comparatively limited arrangements were extended to many more health professionals. The new system of Patient Group Directions allow them to administer drugs in a wide range of situations. This is done in accordance with a binding protocol (see inset box).

In effect the new Ministerial Order permits health authorities to issue ‘blanket’ prescriptions to a group of patients using healthcare staff other than doctors. An example of the use of a PGD is to grant nurses the power to give the flu-jab, Relenza.

PGDs have the potential for great usefulness. However the Government’s White Paper on Teenage Pregnancy has encouraged several health authorities to use the Directions to allow school nurses to give the morning after pill to girls under 16 without parental consent.

It is also possible for a PGD to be used to enable chemists to dispense the MAP for free to girls aged under 16. This is done on an entirely separate legal basis from the over the counter sale of the MAP.

How a Patient Group Direction (PGD) works

To establish a Patient Group Direction a protocol has to be drawn up which specifies which prescription-only drugs are involved and which health professionals are to supply the drug.

The protocol has to be signed by a doctor and a pharmacist authorised by the health authority.[68] This document then allows named health professionals to supply the specified drug to patients within the terms of the protocol without the need for an individual prescription from a doctor.

The range of qualified health professionals who are now entitled to supply or administer medicines under a Patient Group Direction includes nurses (including school nurses), midwives, health visitors, optometrists, pharmacists, chiropodists, radiographers, orthoptists, physiotherapists, and ambulance paramedics.[69]

Health action zones (HAZs)

In 1998 &1999, the Government created a total of twenty-six 'health action zones' throughout the United Kingdom in areas of deprivation and poor health. Their purpose was to tackle health inequalities and modernise services through local innovation.[70] HAZs vary in size and include a total of 34 health authorities and 73 local authorities. The zones are intended to encourage close co-operation between the various statutory authorities and agencies.

In 1999, the Government White Paper on Teenage Pregnancy advocated reducing the number of teenage pregnancies through better access to contraception.[71] This is an area that several HAZs have targeted in their individual health action plans.

Through the introduction of Patient Group Directions, teenagers can now be approached with the morning after pill by health professionals other than doctors, and in familiar surroundings such as a school, a youth club or in a chemist's shop.

Free distribution in schools

Whilst school nurses cannot normally even give a pupil paracetamol, where an appropriate Patient Group Direction is in force they can prescribe the morning after pill.[72]

According to press reports, Patient Group Directions giving *carte blanche* for school nurses to hand out the morning after pill without parental consent have been made in east Kent, Oxfordshire, Derbyshire and South Yorkshire.[73] Only a minority of schools in each local education authority appear to be involved.

The Oxfordshire BodyZone Project:

School Nurses in Oxfordshire are distributing the morning after pill in seven schools.[74] Another five schools are preparing to follow suit.[75] Under the Practice Group Direction for the project only girls over the age of 14 can be given the morning after pill and they cannot be given it more than 8 times a year.[76]

Parents are not entitled to know that their daughter has been given the morning after pill, only whether the school allows the practice in principle. Oxford Community NHS Trust has given a blanket prescription to all its family planning nurses working in schools enabling them to give out this pill. The Trust's director of family planning, Dr. Elizabeth Greenhall, has said: 'It is important that young girls who have had sex get easy access to emergency contraception'. [77]

- This action is being carried out under the 'BodyZone' scheme, a drop-in service which provides health advice covering contraception, bullying, diet, smoking, drugs and stress. It is provided in clinics known as 'BodyZones'.[78]
- These clinics are held mostly in secondary schools, though they are also held outside school premises, e.g. youth clubs.[79]
- The organisers are encouraging pupils to attend the outside clinics and would like schools to develop passes so that pupils can be absent during school hours. The project praises a scheme which uses sixth-formers to administer the passes.[80]
- A welcome form is given to all children on arrival at a clinic. The

form states: 'Please note - this is a completely CONFIDENTIAL service… your school/college are not allowed to ask you why you are attending BodyZone.'[81]

- The *first option* given by the form is to see 'The Sexual Health Nurse (For contraception, pregnancy tests, supplies and advice).'[82]
- The family planning nurse can '…issue condoms, emergency contraception and *repeat* supplies of the pill and injectables without a doctor present'.[83]
- 'Young people requiring condoms, emergency contraception, repeat supplies of the pill or injection are generally given these by the nurse. They see a doctor every two years as a routine'.[84]
- Schools are encouraged to promote the 'BodyZone' scheme on noticeboards, in assemblies, or even by group visits: 'The new year 7's [11 year olds] are given a guided tour of the facility…This appears to have had the effect of empowering the new pupils to utilise the project- especially the boys!'[85]
- A survey carried out at one school where the project is being run revealed that almost half of 14-16 year old girls had used the service.[86]

Free distribution in chemists and youth groups

In a recent highly publicised case, a 15 year old girl, open about her age, was able to obtain the morning after pill from six chemists[87]. In fact The Royal Pharmaceutical Society has pointed out that the chemists were acting lawfully under one of the Government's new *Patient Group Directions* and not under the more recent over-the-counter scheme.[88] The Direction in this case is operated by Lambeth, Southwark and Lewisham Health Authority. A total of 33 chemists have been given power to give out the pills to girls. The Direction is quite specific that there is no lower age limit.

Examples of other local projects to reduce 'unintended young pregnancy'[89] include

1) In Walsall, West Midlands, a project was started in July 2000 where designated pharmacists have received training and designation under a patient group direction to supply emergency contraception. This scheme was started after concern was raised by members of

the HAZ Steering Group regarding unwanted pregnancies including teenage pregnancies.[90]

2) Lambeth, Southwark and Lewisham is running a similar scheme. The funding for this project was £56,000 for 1998/1999 and £66,550 for 2000/2001. Again one of its aims was to reduce the rates of unwanted teenage pregnancy.[91]
3) In Plymouth, six youth health drop-ins called 'First Steps' were developed for young people aged 13-25. They are staffed by qualified youth and health workers and will offer confidential services including emotional development and relationship advice, free contraceptive advice and supplies.

The role of the Government

The Government has responded to criticism of the free distribution schemes by saying they are a matter for local health authorities. This is disingenuous since the health authorities concerned are clearly following government policy.[92]

According to a letter from some of the local health chiefs responsible for the Oxfordshire BodyZone scheme, the project receives "money from the Department of Health targeted for the prevention of teenage pregnancy".[93]

The Teenage Pregnancy White Paper explains that in 1999, £0.6 million of Department of Health money was set aside for a Local Implementation Fund[94]. Health Action Zones and areas with high rates of teenage pregnancy were invited to apply for some of this money by submitting plans to the Department of Health. It was specifically envisaged that supplying contraception would be included in such plans.[95]

The Government has changed the role of the school nurse

Before Patient Group Directions were established, "Nurse Protocols" governed the ways in which nurses administered drugs to patients.

In a 1996 Government review of support for pupils with medical needs, the limited role of the school nurse was made clear :
"The school nurse or doctor may help schools draw up individual health

care plans for pupils with medical needs, and may be able to supplement information already provided by parents and the child's GP. The nurse or doctor may also be able to advise on training for school staff willing to administer medication, or take responsibility for other aspects of support."[96]

School nurses had an advisory or training role to help teachers who gave medication to pupils. Officially school nurses did not give the medication themselves.

In a 1998 review article on the administration of medicines in schools, Dr Bannon, a consultant paediatritian, deplored the fact that nurses did not adminster drugs in school. He stated that "the school health service has been preventive rather than therapeutic in its focus."[97]

Two major reviews of the role of school nurses therefore seem to indicate that they have not officially been permitted to give out any drugs at all, let alone the morning after pill. Technically health authorities could have established Nurse Protocols to allow school nurses to administer drugs, but they seem not to have done this.

This situation has changed completely since the Teenage Pregnancy White Paper and the setting up of Health Action Zones. Instead of merely advising on contraception, the school nurse now dispenses it.

The Oxfordshire BodyZone scheme uses Nurse Protocols established in March 2000 - nine months after the White Paper.

What is the lower age limit?

The press has reported that girls as young as eleven will be given the morning after pill in the schemes involving free distribution in schools.[98]

In the Gillick court case (which established that doctors could legally give contraception to girls under 16) one of the judges countenanced a ten year old receiving contraceptive advice from doctor.[99] Rather than setting a lower age limit, the court ruled that the key factor in any decision whether to give contraception to a child was that "in the

doctor's judgement she had sufficient maturity and intelligence to understand the nature and implications of the proposed treatment." [100]

This factor is, of course, entirely a matter of subjective judgement. There does not seem to be any reason following the logic of the Gillick case as to why a girl *under* the age of 10 could not be given contraceptive advice. It will be argued that new research has shown that one in six girls start puberty at the age of 8.[101]

The result is that the law does not protect the rights of parents from intervention by the State in fundamental areas of family life. The *Gillick* case has left the law unclear as to what treatments and advice a school nurse may give to a child and at what age. As a consequence, it is unclear how far the rights of parents to bring up their own children have been eroded.

Medical facts and ethical issues

How it is used

Levonelle-2 is a 'progestogen only' drug. It avoids the medical complications that have arisen from the combined oestrogen and progestogen morning after pill.

Each treatment involves taking one Levonelle-2 tablet and then another 12 hours later. The treatment can be taken up to 72 hours after intercourse, although its effectiveness is prone to decline with time after intercourse (see inset).

The effectiveness of the morning after pill

It has been estimated that Levonelle-2 prevents 85% of expected pregnancies.

Effectiveness at preventing pregnancy

95% if taken within 24 hours
85% if taken between 24-48 hours
58% if taken between 49 and 72 hours

The effectiveness after 72 hours is unknown.[102]

How safe is MAP compared to the oral contraceptive pill?

There are two types of oral contraceptive pill: the progestogen only pill and the combined pill which contains both oestrogen and progestogen. Unlike the morning after pill, the oral contraceptive pill has to be taken daily.

The morning after pill is a powerful drug. A single Levonelle-2 tablet contains the hormone equivalent of five combined oral contraceptive pills[103] or 25 progestogen only contraceptive pills.[104]

There can be no doubt that Levonelle-2 is much safer than the oral contraceptive pill. It is also safer that the previous MAP which contained oestrogen.

But as Jeannette Kupfermann has commented
"It has taken over 30 years for the problems associated with taking the contraceptive pill to emerge". [105]

The absence of long-term trials
There have been no long-term trials clinical trials of Levonelle-2. The effect of repeated use over the long term has therefore not been measured. Most of the studies that have been done to date have looked at one off use and not repeated prescriptions.

With the MAP it is possible that a young girl may take several packets at once to make sure that it works and that she does not get pregnant.

It is also possible that a young girl may use Levonelle-2 frequently as a form of contraception. This could have major implications for other medication that can be prescribed and for the long-term health of the girl herself.

The Government says that the wide availability of emergency contraception is 'to help reduce the number of unwanted pregnancies amongst all age groups'[106], this would include adolescents but the studies on this drug to date have not concentrated on the use of Levonelle-2 on teenage girls.

The Government is laying plans for the widespread distribution of the morning after pill. The key issue for any long term side-effects is the level at which the pill is repeatedly used.

Clearly the Government does not believe that the MAP will be used as a routine form of contraception. The manufacturers of Levonelle are clear that it should not be used in this way, but what if it is?

The contention of this publication is that if chemists are permitted to sell the drug this is precisely what will happen.

Known side-effects
Advocates of Levonelle-2 say that it has very few side effects and that these are mild.

Undesirable side effects
Nausea occurs in about 25% of women taking Levonelle-2
Vomiting occurs in about 5% of women taking Levonelle-2[107]

Other side effects include (% of women affected)
Abdominal pain in 17.6%
Fatigue in 16.9%
Heavier menstrual bleeding in 13.8%
Lighter menstrual bleeding in 12.5%
Dizziness in 11.2%
Breast tenderness in 10.7%
Diarrhoea in 5.0%[108]

How the morning after pill works

The morning after pill (MAP) works in four ways[109]:

1. It prevents the release of an egg from the ovary (if that has not occurred)
2. It slows down the speed at which an egg passes along the fallopian tubes
3. It slows down the speed at which sperm travels along the fallopian tubes
4. Where conception has occurred, it prevents the implantation of the embryo in the wall of the womb.

A form of abortion

The term ‘emergency contraception’ is a misnomer if conception has already occurred.

In 1983 the Attorney General deemed that preventing the implantation of an embryo was not an abortion for the purposes of the 1967 Abortion Act.[110]

Whilst this has never been tested in the courts, it seems safe to assume that the Attorney General's opinion would be upheld.

Almost all GPs take the same view. Very many GPs who consider themselves 'pro-life' and who would not sign forms for an abortion take the view that the pre-implanted embryo is not a human person that falls to be protected by the law.

The pregnancy is said to begin at implantation rather than conception. But Christians who believe that human life begins at conception do not accept this based on the teaching of the Bible.

Biblical teaching on why life begins at conception

For Christians the main sources of teaching that life begins at conception are the Biblical accounts of the incarnation of Jesus Christ. The gospels clearly teach that Jesus became a man at his conception. Matthew 1:20 states: '…that which is conceived in her is of the Holy Ghost.' The belief that God knows people from conception is confirmed in Isaiah 44:2. Jeremiah (in 1:5) maintains this consistent view and from conception King David reminds us all that we need a Saviour (Psalm 51:5). The Biblical principle at stake here is expounded at length in Psalm 139 vv13-16: the unborn child, even with 'an unformed body', is seen by God.

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Summary

The Government's plans to make the morning after pill widely available in chemists, schools and youth groups must be firmly resisted.

It is difficult to think of a policy which more fundamentally undermines the role of parents than the free distribution of the morning after pill to girls without their parents' consent. The decision to engage in sexual activity can profoundly alter the course of a girl's life. It is wrong to deny parents the right to know what their children are doing in this area and to prevent parents from guiding them in the right direction.

Not only is the State undermining the values of the home, it is also putting the health of young girls at risk. They will take the morning after pill to prevent pregnancy and, at the same time, expose themselves to sexually transmitted diseases.

A pregnancy which results in birth may cost the State much more than treating a teenage girl for STDs. But the cure offered by the morning after pill will be worse than the disease.

If the Government goes ahead with all its morning after pill schemes the message will not be lost on young people. Everyone from GPs to health authorities, school nurses to headteachers, from youth workers to the Prime Minister will be endorsing making the morning after pill available to them.

It gives the green light to sleeping around. A message which will probably have a much more powerful impact in the statistics than the drug itself.

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