Case Study Analysis of Emergency Contraception Can Reveal Characteristics of Society as a Whole

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The condom broke. I was sexually assaulted on my way home from a late night studying at the library. My boyfriend came to town unexpectedly after I missed a pill earlier this week. I couldn't just insert my diaphragm in front of him!

A number of circumstances in a woman's life may result in unprotected sexual intercourse. In such an event, although the probability of becoming pregnant peaks at 17% upon ovulation, if a woman takes no preventative measure, an unplanned pregnancy may result. Emergency contraception (EC) comes in two forms: hormonal pills or a copper-T Intra-Uterine Device (IUD)[1]. Oral EC imparts either a high dose of progestin or both estrogen and progestin in combined hormone pills with an average 88% success rate of preventing pregnancy when used within at least 72 hours and up to 120 hours after unprotected intercourse[2]. The American College of Obstetricians and Gynecologists (ACOG) defines the start of pregnancy as the point of implantation of the blastocyst – a fertilized egg that has begun developing into an embryo – into the uterine lining. After the introduction of sperm into the female reproductive tract, but before blastocyst implantation, EC operates to prevent pregnancy in a variety of ways based on a woman's position in her menstrual cycle. Beyond successful implantation, EC has no effect on the pending pregnancy and therefore does not induce abortion (Kane- Low, 2004).

Because of its function, EC provides an opportunity for women who prefer to decrease the risk of becoming pregnant to exercise reproductive agency after unprotected intercourse. Of the three million unplanned pregnancies that occur annually in the United States, up to half end in abortion, but in 2000, "as many as 51,000 abortions were averted with the use of [EC]" (Kane-Low, 2004; Steinberg, 2327). Case study analysis of arguments for and against EC, the differential access to EC that women experience, and the political approach to EC use for

[1] This paper will focus on the former.
[2] A 2003 study on extending the time effectiveness of EC finds that "Differences between [EC effectiveness for the control group that took EC within 1-3 days and for] the days 4-5 group are not statistically significant" (Ellertson, et. al., 1170).

survivors of sexual assault reveal that the personal is routinely made political with decreased female agency and limited sexuality as a result, that racial, ethnic, and classist subjectivity within the health care system leads to restricted and disproportionate access to health care services, and the directions in which political efforts are made. When these revealed characteristics are extrapolated to society as a whole, they construct a model of the health care system and the society it services.

In addition to reporting research findings on the medicinal use of EC, academic writers contribute unique perspectives to the debate over EC availability and the struggle for federally approved OTC status. Current investigations center on the effectiveness of a one pill form of EC versus the conventional two pill prescription as well as on the effectiveness of anti-emetic drugs like meclizine for reducing the side-effects of EC (Robinson, 2004). Much of the academic discussion following the May 2004 FDA decision to deny OTC status for Plan B centers on consequences for political dynamics between health care professionals, scientists who work to manufacture pharmaceuticals, pro-life and religious representatives, and government entities who introduce legislation relevant to reproductive health. While "Fundamentalist Christian groups such as the Family Research Council and Concerned Women for America applauded the decision," feminist writers, the Planned Parenthood Federation of America, Inc. and ACOG criticize the FDA decision: not only does this "morally repugnant" act hinder the availability of EC, but it also provides support for "recent criticisms that political interference is hampering scientific review within federal agencies" (Robinson, 2004; "Ob/gyn," 29). For example, scholars consider the authority and autonomy of pharmacists and patients respectively and legislature mandating that all hospitals – even those supported by the Roman Catholic Church provide EC to rape victims (Cantor, 2004; Cooper, 2002). That scholars now dissect relationships between the church, science, and state provides evidence that the personal is

increasingly political, with the female body and her reproductive choice the battleground through which cleats tear when the church and scientists tug-of-war with government entities.

"There is a public health imperative in this country to increase access to EC. Accidents and coercion happen, and post-coital contraception must be made readily available to reduce unintended pregnancy and abortion rates. ACOG and other organizations have estimated that greater access to [EC] could significantly reduce the U.S. abortion rate" ("Ob/gyn," 2004). Women who do not choose to terminate unplanned pregnancies will require costly pre- and post-natal care, and will undergo radical bodily changes that could endanger their health. In an extreme example, pregnancy could be fatal for a woman with Eisenmenger's Syndrome, and for such a patient, access to contraception is of vital importance (Cantor, 2010). "The serious and growing phenomenon of sexual violence against women and girls is another dramatic global reality that not only can result in increased transmission of STIs, but can also lead to unwanted pregnancy… primary care services that include [EC] have provided an invaluable resource" to alleviate the health consequences suffered by rape victims ("Ensuring," 2003).

In addition, EC availability represents a female's ability to act as an agent of her personal reproductive health, as EC is essentially the last opportunity a woman has to prevent a pregnancy from happening when other forms of contraception are not used or fail. In the event of sexual assault, EC represents one of the few personal ways in which a woman can independently retaliate against her attacker by refusing pregnancy for her body at a time following unprotected intercourse. Because of its impact on global health and its role in personal reproductive health, EC is relevant to a discussion on women's health and is an appropriate choice for a case study that can illuminate principles and operations of society.

While fertility abuse ranks among the most despicable offenses when committed by foreign dictators, it represents an extreme example of personal reproductive choices becoming

political – controlled by government entities and political agents that influence policy and legislative decisions. On a smaller scale, American women routinely endure the politicization of their personal reproductive health decisions as political agents and policymakers, rather than individual women themselves, determine which forms of contraception, if any, will be available to certain women under what circumstances and why. The arguments for and against EC and the maintenance of its current status of limited availability provide an example of the way in which personal female decisions become political. The extent to which this is true for EC is indicative of society as a whole when EC is used as a case study.

American women have continually experienced delayed EC availability if any: EC became available in the US in September of1998 when the FDA approved Preven, a combined hormone pill[3] (Elliott, 1). One year later "the FDA approved Plan B…with even greater efficacy and fewer side effects" (Dickerson, 10). Despite its FDA approval for prescription, Plan B is still not available for OTC use in 44 states; only Alaska, California, New Mexico, Maine, Hawaii, and Washington "allow pharmacists to provide EC without a prescription" (Keller 2004). In consideration of its application for OTC status, "the Nonprescription Drugs Advisory Committee and the Advisory Committee for Reproductive Health Drugs…recommended that Plan B be switched from prescription to [OTC] status; the vote was 23 to 4," (Steinbrook, 2327; Keller, 2004). Despite the nearly unanimous recommendation from its advisory panel and extensive supporting data on the safety and effectiveness of Plan B, the FDA rejected the proposal from Barr Pharmaceuticals, Inc. that its product be available OTC in May 2004 (Steinbrook, 2327). The director of the Center for Drug Evaluation and Research, Steve Galson,

[3] Preven is no longer available in the United States, and was associated with higher rates of nausea and vomiting than is Plan B, the progestin-only form of EC that is available in the United States ("Emergency Contraceptives," 2004).

who "[made the decision himself]…concluded that Barr…had not demonstrated that the use of Plan B was safe in girls younger than 16 years" (2327-8).

Given that 29 women in the formal study on the use of Plan B were between 14 and 16 years old and that " 'the data demonstrate that Plan B is safe for use in the non-prescription setting,'" one might grapple to find a concrete reason as to why Plan B was denied OTC status (2328; 2327). Because the decision was made by a government agency, the immediate political atmosphere may have exerted influence – voters would remember this decision when casting their presidential election ballots. Although the FDA denied that it "[bowed] to political pressure in making this decision," conservative lobbyists and congress members applied political pressure before the decision was made, and post-decision, liberal congress members called for the resignation of Mr. Galson (2328). If there is political pressure from both sides of a controversial decision, then it is undeniable that political agents at the policymaking level make personal reproductive decisions for women who could potentially reproduce.

Equally likely to have influenced the outcome of the FDA decision were religious views of decision-makers, legislators, and prominent political agents involved in public health funding. "The Catholic church…and non-governmental organizations are the primary opponents of women's rights. Their fundamentalist vision …[does not recognize women's right to make reproductive decisions] for themselves," and Catholic hospitals "occupy 15% of the health care market" ("Ensuring," 2003; Skeeles, 1048). The association of EC to abortifacients such as RU-486 has contributed to the stake religious organizations have in the debate for or against EC distribution: "Attempts by Congress and state legislatures to make [EC] more available …have sparked considerable resistance from Catholic hospitals and pro-life activists who believe that the administration of [EC] can cause an abortion…Some Catholic hospitals have threatened to close their doors rather than administer the medication" (Skeeles, 1011-2). The influence of such

opinions is evident in a 2001 study conducted in San Francisco that found 32% of low-income postpartum women to believe that EC induces abortion (Brown, 42). Because of their commitment to strong positions on abortion, EC is easily made into a political issue under the umbrella of the abortion debate, and "Catholic hospitals will argue…that [statues that force hospitals to administer a medication to which they are morally opposed impinge on their religious freedom]" (Skeeles, 1048). While legislature mandating distribution of EC could impinge on the religious freedom of Catholic hospitals, efforts by religious organizations encourage restrictions on EC distribution that affect women who may or may not share their religious beliefs. It is because of the politicization of the debate over EC distribution that religious affiliates are able to project their faith-based doctrines onto an extensive population of women who represent multiple religions. In this instance, a constrained set of acceptable contraceptive methods, as determined by religious political agents, pose as reproductive options.

Furthermore, a popular rhetoric for those opposed to EC is that increasing EC availability will increase promiscuity ("Study," 2004). That is, providing a mechanism by which unwanted pregnancies can be prevented in the event that other forms of contraception were not used or were ineffective increases the chance that younger and more women will increase their sexual activity. This suggests that women who are sexually active – willingly or not – and may therefore have a need for EC do not represent the socially acceptable version of female sexuality. Instead, women, including those who are sexually assaulted, are not supposed to engage in sexual behavior that could lead to a circumstance in which EC use would be relevant.

An argument against EC based on the potential to promote promiscuity ignores the fact that common and available methods of birth control such as condoms are not perfect: a 2004 study found that of all women who requested EC at the study's clinic, the reason for doing so was "condom problems" in 79.5% of the cases ("Epidemiological," 2004). If policymakers are

concerned that women will discontinue their normal contraception use when EC is more available to them, they will be relieved to discover that a 1997 study in Finland corroborates recent data from a 2004 study, both of which show that with increased EC access, "no respondents reported using EC as their only contraceptive method" (Robinson, 2004; Lo, 2404). Increased EC availability and use do not change use patterns of additional contraceptive methods or "increase frequency of unprotected intercourse" ("Study," 2004). The idea that women would rely on EC as a regular birth control technique is unreasonable because EC is more expensive than condoms, birth control pills, and female condoms, EC can cause nausea or vomiting, it has time-limited effectiveness that peaks at 88%, EC does not provide any sort of protection from STIs, and for the majority of women in the United States, acquiring EC requires a prescription from a health care provider (Robinson, 2004; Kane-Low, 2004).

Additionally, promiscuity-based arguments against EC add another dimension to society's doctrine of compulsory heterosexuality. Increased female promiscuity could only result from increased EC use if expressions of sexuality were associated with risk of pregnancy. For lesbian and some bisexual women, however, the risk of pregnancy is not associated with expressions of sexuality. The deeply personal issues of female reproductive health and sexuality do not escape politicization, generating problematic promiscuity-based arguments against EC availability that attempt to define and limit acceptable versions of female sexuality. When promiscuity-based arguments successfully restrain female sexuality, women suffer a loss of reproductive agency in the form of un-prescribed EC: In the 2004 Lothian Emergency Contraception Project, "[health care professionals] were reluctant to offer [EC] to young women because of… a perceived association of EC use with chaotic behavior by women [and] views about the sort of women suitable for advance supplies" ("Women," 2004).

Because the personal is political, the consequences of EC use or non-use on the female body cease to be the center of public health concerns, and reproductive health decisions are made by politicians and religious political agents who project their beliefs and morals on all females. Those decisions and problematic promiscuity-based arguments that attempt to define narrow notions of female sexuality corroborate to maintain the limited availability status of EC.

Ultimately, the politicized FDA decision determines that women cannot have federally approved access to EC without a prescription when personally regulating their fertility. Because the distribution of EC and female reproductive health are politically ingrained, it is unsurprising that access to EC occurs on multiple levels subject to different biases, each with the potential to preclude a female from acquiring the contraception. EC, after all, can only provide a way for women to execute reproductive agency by preventing pregnancy if women have access to the drug within at least 72 and up to 120 hours after unprotected sex.

In order to access EC, a woman must be aware of its existence and function. The information that is available to health care providers and education systems undergoes filtration before distribution to clients and students. Various factors interfere with access to information, as they did at the University of Michigan's University Health Service (UHS) when advance prescriptions of EC were made available in 2003. Staff was not thoroughly informed of the policy change, and as a result, UHS patients with a potential need for EC were often misinformed and denied prescriptions (Henry, 2003). Similarly, when contacted by investigators in New York, one hundred percent of surveyed "city-run health care clinics that provide information about [STIs]…told the inspectors that they did not offer information or access to [EC]" (Cooper, 1). As a result of impediments to EC information distribution, "only 36% [of women at high risk for unintended pregnancy in San Francisco had heard of EC]" (Brown, 42).

If personal beliefs and cultural values of a woman do not preclude EC usage, and if she is mentally and emotionally willing to pursue EC, then she must have the financial resources to do so. The government and its recent FDA decision interface with an economic level of access defined by the need for financial resources to have health care and a provider, to afford transportation and the clinic visit, to take time off from work to keep her appointment, and to pay for the EC if prescribed: “If Plan B were made available without a prescription, women who are uninsured or without a medical home would have a better chance of obtaining it” (Elliot, 1).

On the professional level, a woman faces barriers that could arise with physician and pharmacist refusals to prescribe EC. Some refusals occur in the interest of the holistic health of the woman. For example, EC use could present health risks for patients who suffer acute migraines or who have diseases associated to blood clotting (Kane-Low, 2004). However, prescription refusals can also be based in personal beliefs in the same way that some physicians and hospitals refuse to perform abortive procedures because of personal convictions (“Emergency Contraception,” 2004). “In some states – Mississippi, Arkansas, Illinois, and South Dakota … medical providers may refuse even to fill EC prescriptions if doing so conflicts with their religious beliefs” (Keller, 2004). Michigan joined those states last April by passing The Conscientious Objector Policy Act, which states “a health care provider may object as a matter of conscience to providing or participating in a health care service on ethical, moral, or religious grounds” (“HB-5006,” 2004). Corporations, too, have the prerogative to establish policies against EC prescription. In 1999, for example, Wal-Mart, a corporation that targets low-income shoppers “instructed its pharmacists to fill [EC] prescriptions with birth control pills or to refer customers to other pharmacies” (Skeeles, 1021). Low-income women who rely on Wal-Mart as the sole supplier of prescription medications would be unable to obtain EC.

The opportunity for health care professionals to deny prescriptions allows cultural biases and societal depictions of racialized sexuality to influence decisions about the medications a client may receive. For instance, it has been found that health care providers that serve minority women and women of low socioeconomic status have a tendency to provide less information about EC and exhibit lower EC distribution rates (Brown, 43). In fact, "Hispanic women who spoke only Spanish, Asian and Pacific Islander women…all had reduced odds of being familiar with [EC]," according to a 2001 study (42). This trend may "place a disproportionately heavy burden on those with few options, such as a poor teenager living in a rural area that has a lone pharmacy… a refusal to fill a prescription for a less advantaged patient may completely bar her access to medication" (Cantor, 2010). A Hispanic woman who was perceived by her physician to fit an accepted racialized hypersexual stereotype is subject to different treatment than a white patient who has a lesser chance of being pre-diagnosed as sexually deviant. The Hispanic woman, for example, would be unlikely to receive oral EC if her physician held the moral belief that hypersexual women should be fitted with permanent forms of contraception that also function to prevent pregnancy, such as a copper-T IUD. Given the history of eugenics and contraception and sterility abuse in the US that operated along racial and classist lines, it is conceivable that disproportionately low EC distribution rates result from institutionalized racism and classism to which physicians are not immune (Kane-Low, 2004).

Exaggerated by the fact that "only a small proportion of females are aware that [EC] is available…[and] very few, especially those who have low incomes…have access to prescribing physicians," reproductive health care patterns that are biased according to class, race, and ethnicity will ultimately lead to differential allocation of resources, availability of health care services and medications, and subjective distribution of education on certain medications to targeted health care users (Dickerson, 10). Projecting the differential access to EC that occurs

along lines of religion, race, and class onto the health care system and the society it services exposes the way in which systems of oppression like classism and racism exert influence whenever subjectivity is permitted in professional decision-making. It is thus apparent that the health care system that appears to objectively, professionally, and altruistically provide medications is subject to biases that result in disproportionate constraints on women that prevent choice and agency in their own reproductive health care. Financially disadvantaged women including "women and girls who are refugees or displaced or those who live in areas of conflict" are most vulnerable to sexual assault and therefore have a proportionally increased use for EC, but ironically have disproportionately less access to EC ("Ensuring," 2003).

Much of the impetus for health care providers to stock and distribute EC is to meet the specific health care needs of survivors of sexual assault after mental and physical violations strip them of agency. EC prevents unintended pregnancies, a fraction of which are identified to result from sexual assault: "The Planned Parenthood Federation of America estimates that 300,000 U.S. women are sexually assaulted each year, with about 25, 000 becoming pregnant as a result. More than 80% of these pregnancies could be prevented with use of [EC,] Planned Parenthood contends" ("Drive," 2003).

Specific EC distribution to victims of sexual assault acknowledges that sexual assault happens while at the same time providing a way for victims with sufficient access to manage one physical consequence of the assault. In 2002, New York adopted a series of policies and bills that "would require hospitals that receive funding or maintain contracts with the city to make [EC] information and products available to rape victims [and require all] hospitals to inform rape victims about [EC] and to make the pills available, if requested" (Cooper, 1). On the other side of the country, however, "South Dakota lawmakers rejected a bill…that would have required hospitals to provide [EC to] women who have been raped and don't want to risk becoming

pregnant" ("Emergency Contraception," 2004). Opponents that defeated the bill argue that it "forces [Catholic hospitals] to compromise beliefs and values that they hold very dear" despite the idea that "women who have been raped should at least be informed about the availability of [EC]" ("Emergency Contraception," 2004). Regardless of the impact of state legislature on the relative availability of EC in hospital environments, the legislature relevant to EC availability demonstrates that lawmakers accept sexual assault as occurring frequently enough and being a destructive enough crime to invite legislative proposals. Political action aims to alleviate consequences of the crime. While legislature prohibiting sexual assault exists, if sexual assaults are still occurring and leaving "one in seven females in South Dakota…the victim of rape or attempted rape," there must be room for political action that would enable existing legislature to effectively reduce the occurrence of sexual assault rather than simply offer bandages for the crimes that occurred ("Emergency Contraception," 2004).

While it is important to recognize that all cases of EC use do not result from sexual assault, there is still a certain percent of women who consider EC only after such an event. As such, a portion of arguments advocating advance prescriptions of EC concern health care needs of victims of sexual assault. Arguments for attainable advance prescriptions on the basis that any woman could be the victim of sexual assault intrinsically accept that our society is one in which sexual assault is a reality that women must face. Because EC usage is not restricted to victims of sexual assault, its availability should increase in the interest of promoting female reproductive agency, but in the meantime, efforts should focus on encouraging society to question its acceptance of sexual assault as normative. EC can be used to diagnose the direction of political efforts and resources towards rape crimes and their consequences for victims, revealing the societal tendency to focus on healing the consequences of un-prevented and acknowledged

crimes rather than forcefully identifying and targeting systematic societal factors that allow those crimes.

Adoption of EC as a case study and examination of forces behind arguments that support or oppose EC, the access different women have to EC and determinants of access, and the way in which legislators approach EC for victims of sexual assault reveal insights into societal structures and characteristics. Arguments for and against EC demonstrate that one aspect of larger society is the routine politicization of the personal at the expense of female agency, and with resulting limited notions of female sexuality. The access women have to EC is disproportionate because of characteristics of a health care system and the society it services: decisions within the health care system and society are subjective and vulnerable to institutionalized racism and classism, in addition to sexism and other biases. Finally, the way in which the legislation dealing with EC for sexual assault survivors targets consequences of sexual assault that is admittedly allowed to happen demonstrates the societal tendency to bandage injuries that are not prevented rather than focus on systematic causes of those injuries.

The insights gleaned from a case study analysis of EC can be used to model characteristics and operations of society as a whole: this model is characterized by politicization of personal issues that work in conjunction with institutionalized oppressions on the basis of race, ethnicity, class, sexuality, and gender to systematically disadvantage particular people – women, with some women suffering disadvantage of multiple oppressions. Because legislative efforts tend to bandage injuries suffered by individuals rather than break down systematic causes of those injuries, disadvantaged people continue to be disadvantaged just as there continue to be victims of sexual assault regardless of the anesthesia that is subsequently applied. Constructing a model of society based on insights from case study analysis of EC provides the opportunity to effect change in societal operations that contribute to decreased and disproportionate female

agency. In the same way that providing EC education to female patients tends to improve their acceptance and access to a drug that can augment their reproductive agency, education has the potential to deconstruct myths and societal structures that support modern society in which the personal is political, people are disproportionately advantaged, and sexual assault occurs.

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