

Editorial

## From American Idol to Plan B: a call for a shift in priorities

This month marks the 1-year anniversary of “behind-the-counter” provision of emergency contraception in the United States. For years, the hope that emergency contraception would make a significant dent in unintended pregnancy rates fueled women’s health advocates, policymakers and donors to create programs and products to promote this “second chance” contraceptive option in the United States and abroad [1]. The level of progress leading up to the current behind-the-counter status granted by the U.S. Food and Drug Administration (FDA) in August 2006 has been tremendous. The United States now has a highly effective, dedicated emergency contraceptive product — Plan B® — marketed by a U.S. pharmaceutical company. Previously, women had to punch the correct dosage out of regular pill packs or take a large number of minipills, all without official product labeling or instruction. In addition, American women are more aware of this option than ever before. Some 64% of reproductive-age women surveyed in 2004 said that there was something women could do to prevent pregnancy following sex, and 75% of those women mentioned emergency contraception [2]. Even before the FDA decision, women were able to obtain emergency contraception directly from pharmacists in 10 states [3,4]. Recently released sales data indicate that women are purchasing more Plan B than ever before: sales are expected to total about \$80 million in 2007, almost double the sales in 2006 and eight times the total in 2004 [5].

Even with this progress, advocates are well aware that we have not yet arrived at a place where the full impact of emergency contraception on reducing unintended pregnancy can be realized in the United States. This was made clear by an analysis of studies conducted prior to the advent of behind-the-counter access. Although increased access to the pills enhances use, it has not been shown to reduce unintended pregnancy rates at the population level [6]. Yet, since clinical trials have demonstrated that using emergency contraceptive pills can reduce pregnancy risk following a single act of unprotected intercourse, we are left trying to understand the disconnect between their known efficacy at an individual level and a lack of effect at a population level [7]. One reason may be that women underestimate their risk of pregnancy and consequently fail to use emergency contraception when it is most needed. The review authors

noted that qualitative studies have identified a number of reasons why women do not use emergency contraception, including that women do not recognize their risk of pregnancy, neglect that risk, associate stigma with using emergency contraception or misunderstand the method [8–10]. While this offers some explanation for the lack of an observed effect to date, the finding may be a symptom of two much deeper problems.

First, in contrast to many developed countries, Americans continue to view sexuality through a puritanical lens. While other societies work to foster healthy sexual behavior, Americans routinely erect roadblocks — such as abstinence-only education requirements — to prevent access to contraceptive and sexual health information and services. Failure in this arena is evident when we compare pregnancy statistics in the United States with those in similar societies in the developed world that have taken a less moralistic view of sexuality and health, such as the countries of Western Europe. Americans have the same pills, shots, patches and IUDs, and yet, we have much higher rates of teen pregnancy and abortion. For instance, the U.S. teen pregnancy rate is more than nine times higher than that in the Netherlands and nearly four times higher than the rate in France [11]. In the United States, the percentage of people aged 15–49 who are infected with HIV/AIDS is three times the percentage in Western European countries [12].

It is not difficult to find examples of American society’s moral queasiness around sexual health. The FDA’s decision-making process about over-the-counter access for emergency contraception was rife with comments that the product would be used by “playboys” and “sexual predators.” The final decision, with access restricted by age (18 years and above) and location (behind the pharmacy counter), suggests that the decision was based more on morality than science [13]. In our popular culture, the same sources that bring us sexually suggestive television programming and Viagra® advertisements also exert moral control over sexual health messages. For example, earlier this year, a creative advertisement for Trojan condoms that featured cell phone-toting pigs and promoted responsible sex was rejected by both Fox and CBS. Fox rejected the ad because “Contraceptive advertising must stress health-related uses rather

than the prevention of pregnancy” [14]. Finally, for years, the U.S. government poured funding into abstinence-only-until-marriage programs — US\$176 million in Fiscal Year 2007 — despite the lack of research proving that they are effective, thereby perpetuating the “morally correct” image of humans as asexual beings [15]. It was only earlier this year that congressional leaders allowed the funding mandate for abstinence-only education to lapse.

A second area in which we have failed is in understanding that we cannot just provide a contraceptive method and expect that it will be used effectively. If we look historically at efforts to introduce family planning methods, emergency contraception is not the only example of a product introduction that has failed to achieve the desired result. Thirty years ago, our approach to uncontrolled population growth in developing countries was to flood them with contraceptives. After millions of dollars without making an appreciable dent, we have come to understand that improving contraceptive practice is more dependent on women’s literacy and education than in the actual access to contraceptives. Similarly, on an individual level, we cannot just provide a method and expect that it will be used correctly and consistently. Truly empowering a woman or a man to prevent pregnancy or disease does not begin by giving him or her things that he or she does not know how to use. We do not empower teenagers to drive by handing them keys to the car. Rather, we provide them with driver’s education to make them less likely to have a problem. Sex, sexuality and contraception are no different. Unfortunately, even health care providers lack sufficient “driver’s education” in this arena.

Thus, when we see research analyses that suggest that emergency contraception is not having a measurable effect, we must recognize that it is not the method that is not working, it is us.

To improve the effective use of emergency contraception, Americans need to go beyond the obvious answers of increasing the availability of products and information. Certainly there is still important work to be done to remove concrete barriers such as the age and identification restrictions, behind-the-counter limitation, high cost of the product and lack of insurance/Medicaid coverage. Also important are efforts to improve the preservice and in-service training of health care professionals so that they gain both the technical knowledge necessary to provide a range of sexual health services, including emergency contraception, and the interpersonal communication skills to openly discuss this intimate topic. However, the full potential of emergency contraception is not likely to be realized until we see a significant change at the societal level in how we view sex, sexuality and sexual health, as well as the responsibilities that go along with each of these. If we, Americans, as a society, can reach a point where we value our sexual health as much as we value American Idol, which has an audience share of nearly 50% of female viewers aged 18–49, then we will have made progress [16].

Elisa S. Wells  
*Association of Reproductive Health Professionals*  
 Washington, DC 20037, USA  
 E-mail address: ewells@arhp.org

Mitchell D. Creinin  
*Department of Obstetrics*  
*Gynecology and Reproductive Sciences*  
 University of Pittsburgh, PA 15213, USA

Pablo Rodríguez  
*The Warren Alpert Medical School*  
 Brown University, Providence, RI 02912, USA

## References

- [1] Trussell J, Stewart F, Guest F, Hatcher RA. Emergency contraceptive pills: a simple proposal to reduce unintended pregnancies. *Fam Plann Perspect* 1992;24:269–73.
- [2] Kaiser Family Foundation. Emergency Contraception. Women’s Health Policy Facts; November 2005. <http://www.kkf.org/women-health/upload/3344-03.pdf> [Accessed June 17, 2007].
- [3] Guttmacher Institute. Access to emergency contraception, state policies in brief, as of August 2006. [http://www.agi-usa.org/pubs/spib\\_EC.pdf](http://www.agi-usa.org/pubs/spib_EC.pdf) [Accessed June 10, 2007].
- [4] Wynn L. EC pharmacy access in Montana. Personal communication. February 6, 2006.
- [5] Crary D. Sales soar for morning-after pill. *Washington Post*; 2007. <http://www.washingtonpost.com/wp-dyn/content/article/2007/08/22/AR2007082201593.html> [Accessed September 17, 2007].
- [6] Raymond E, Trussell J, Polis C. Population effect of increased access to emergency contraceptive pills: a systematic review. *Obstet Gynecol* 2006;109:181–8.
- [7] Croxatto HB, Devoto L, Durand M, et al. Mechanism of action of hormonal preparations used for emergency contraception: a review of the literature. *Contraception* 2001;63:111–21.
- [8] Moreau C, Bouyer J, Goulard H, Bajos N. The remaining barriers to the use of emergency contraception: perception of pregnancy risk by women undergoing induced abortions. *Contraception* 2005;71:202–7.
- [9] Goulard H, Moreau C, Gilbert F, Job-Spira N, Bajos N, Cocon Group. Contraceptive failures and determinants of emergency contraception use. *Contraception* 2006;74:208–13.
- [10] Sorensen MB, Pedersen BL, Nymberg LE. Differences between users and non-users of emergency contraception after a recognized unprotected intercourse. *Contraception* 2000;62:1–3.
- [11] Advocates for Youth. Adolescent sexual health in Europe and the U.S. — why the difference? Second edition, October 2001. <http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsst.pdf> [Accessed June 10, 2007].
- [12] Population Reference Bureau. World population data sheet. <http://www.prb.org/pdf06/06WorldDataSheet.pdf> 2006 [Accessed June 10, 2007].
- [13] Wynn LL, Trussell J. Images of American sexuality in debates over nonprescription access to emergency contraceptive pills. *Obstet Gynecol* 2006;108:1272–6.
- [14] Newman AA. Pigs with cellphones, but no condoms. *New York Times*; 2007.
- [15] SIECUS. A brief history of federal abstinence-only until marriage funding. <http://www.siecus.org/policy/states/2006/explanation.html> [Accessed June 10, 2007].
- [16] Carter B. Why hold the superlatives? ‘American idol’ is ascendant. *New York Times*; 2006 <http://www.nytimes.com/2006/01/30/business/media/30idol.html?ex=1296277200&en=807d2a99a6cf8581&ei=5090&partner=rssuserland&emc=rss> [Accessed June 10, 2007].