

TWENTY-FIVE YEARS AGO: THEN AND NOW

Of interception, postcoital contraception and the morning after

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Reflecting interest in emergency contraception in the mid-1970s, 'The Morning After' was the title of the daily newspaper of the Sixtieth Annual Conference of the Planned Parenthood Federation of America held in New York.¹ Attending the conference during transatlantic study leave, the Honorary Secretary of the National Association of Family Planning Doctors was impressed during the reception at the 'Windows on the World' restaurant atop the World Trade Center when ministers of religion described their advocacy role in the family planning movement.

Meanwhile, in the UK, official recommendations for improving access to oral contraception² did not specifically mention its postcoital use to reduce recourse to abortion. Noticing numerous requests for abortion after a contraceptive consultation and whilst awaiting menstruation for the insertion of a copper-containing intrauterine device, a medical practitioner suggested that 'if it is inserted within a week after ovulation, a device may prevent conception'.³

Postcoital effects of stilboestrol, a non-steroidal oestrogen, were found soon after its discovery in the 1930s but societal attitudes were not conducive to further developments for another three decades, synthetic sex steroids being available by then. High doses of either stilboestrol or synthetic steroidal oestrogens, such as ethinyloestradiol, were being used for emergency contraception in the early 1970s when the value of d-norgestrel was recognised. Norgestrel, a so-called 'second-generation' progestogen, was already an ingredient in various formulations of combined oral contraceptives that started to be used for emergency contraception, albeit in self-directed haphazard schedules. In 1977, Albert Yuzpe⁴ demonstrated the combined value of ethinyloestradiol and norgestrel in the regimen that became standard. Norgestrel⁵ is a racemate with two equal parts: a biologically inactive enantiomer and an active one, hitherto called d-norgestrel according to its chemical configuration, but known since 1977 as levonorgestrel with the adoption of light rotatory nomenclature.

Several obstacles had to be overcome to improve access. Use of the precise term interception⁶ led to the mode of action of postcoital contraception being misconstrued as being abortifacient whereas confusion regarding its effectiveness, particularly beyond the morning after, caused

'trick or treat' doubts. In the absence of a dedicated product, the numerous pills in a dose caused inconvenience. Moreover, there was little incentive in seeking, from drug regulatory authorities, the approval of another indication regarding a product that was already on the market. Finally, practitioners were reluctant to exercise clinical judgement in prescribing oral contraceptives for an unlicensed indication.

Emergency contraception remained a closely guarded jewel in the black bag of select practitioners for another two decades. Its demystification, through advocacy and service delivery guidelines, was soon followed by the unequivocal demonstration of the comparative advantage of the levonorgestrel-only method. The World Health Organization (WHO) has stated that 'emergency contraceptive pills do not interrupt pregnancy and thus are no form of abortion' besides pointing out their value for adolescents as they tend to be sexually active before seeking contraceptive services.⁷ Access to emergency contraception has improved lately through deregulation with over-the-counter sales, school-based clinics and advice telephone lines with toll-free numbers such as NOT-2-LATE.

References

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- 3 Monks IM. Post-coital contraception by a copper-containing IUD. *J Fam Plann Doctors* 1977; 2: 64.
- 4 Yuzpe AA. Postcoital hormonal contraception: uses, risks, and abuses. *Int J Gynaecol Obstet* 1977; 15: 133–136.
- 5 Jones RC, Singer AC, Edgren RA. The biological activities of norgestrel and its enantiomers. *Int J Fertil* 1979; 24: 39–43.
- 6 Haspels AA. Interception: post-coital estrogens in 3016 women. *Contraception* 1976; 14: 375–381.
- 7 World Health Organization. *Emergency contraception – A guide for service delivery*. WHO/FRH/FPP/98.19. Geneva: World Health Organization, 1998; 8, 9, 20, 38, 39.

Editor's Note. In the UK the pharmacy provision of Levonelle emergency contraception has recently been challenged and taken to judicial review. Anne Weyman, Chief Executive of **fpa** (formerly the Family Planning Association) which is one of the interested parties in the judicial review, attended the judicial review and in this commentary explains the process and the possible consequences should the review find against pharmacy provision of Levonelle. The outcome of the judicial review will be formally reported in the July issue of *The Journal of Family Planning and Reproductive Health Care*.

Commentary: Judicial review of the pharmacy provision of emergency contraception in the UK

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It seems extraordinary that more than 30 years after hormonal emergency contraception started to be used in the UK, the Society for the Protection of Unborn Children (SPUC) has been allowed a judicial review of the pharmacy

provision of Levonelle. In mid-February, the High Court spent 3 days examining the impact of the 1861 Offences Against the Person Act on the provision of Levonelle and contraception more generally.