

“What does this do?”
The Neoliberal Creep, Sexual Health Work and the
Deregulation of Emergency Contraception

by

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Abstract

Beginning with eight women's experiences in accessing emergency contraception from a pharmacist, this research brings into view the undocumented "sexual health work" of obtaining the drug in northern Ontario. Between 2005 and 2008, emergency contraception was deregulated to behind-the-counter, forcing women to submit to mandatory counselling and screening about sex, menstruation and contraception at the pharmacy. Situating unwanted pregnancy as harmful in this context, an institutional ethnographic analysis explores the activities of health service delivery and identifies the different ideological practices that shaped women's access like the steady creep of neoliberalism, professional specialization and clinical power. Ideological discourses construct an ideal contraceptive user, who is patient, compliant and appears "responsible", contributing to the stigmatization of women. Findings suggest that an inaccurate government definition of emergency contraception contributes to ignorance and misperceptions about function; this, along with an empty federal policy vacuum for women's health contributes to its problematic status in women's contraceptive options.

Keywords

Emergency contraception, women's access, reproductive freedom, deregulation, feminism

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Chapter 1

1 The Problem of Emergency Contraception

1.1 Introduction

Walking into the pharmacy to purchase contraception may appear to be a relatively easy task. Yet women experience different barriers to access to contraception depending on their identity, place of residence, age and also the type of contraception she seeks. In Canada, access to health services happens substantively through provincially-run hospitals and clinics, funded by the provincial and federal governments. While the Canadian health care system is often referred to as “state-funded”, a mixture of industry, government and professional bodies hold different responsibilities with regard to the funding and delivery of sexual and reproductive health services. Women in Canada access health care in different ways, depending on where one lives, who one is, and what services one requires. Many services, such as abortion, maternity care, and children’s health services are not accessible in an equitable way within the Canadian health care system for any woman regardless of where she lives.

Within northern, remote and rural areas in Canada, there is little freedom of choice in accessing health services commonly found in southern Canada; the collective health care system is challenged by a real lack of universality, such as shortages of health professionals and health supplies; the lack of health care in small communities due to the “centralization” of smaller health centres to regional centres and small cities; increased distances to travel for women to seek sexual and reproductive health services (Society of Rural Physicians of Canada, 2001, pp. 1-5), including maternity and abortion services. For instance, in the city of Sudbury only one physician conducts abortions on an irregular basis; for those without Medicare coverage, costs are as high

as \$3,000 for the procedure. These issues are exacerbated by the poorer health status overall for those living in the north including higher rates of chronic health conditions than in southern Canada as well as lower rates of life expectancy (*Ibid*). The capacity to seek private and confidential sexual health advice from health professionals becomes difficult when there may be no facilities or even a health professional regularly working in the community with whom to speak to. Furthermore, issues regarding anonymous screening and testing for sexually transmitted infections or obtaining health education or supplies like contraception may be impossible in a small town since other people could see someone attending a clinic or may know the nurse or pharmacist personally, increasing the potential for stigmatizing practices.

In places where physicians are not available on a daily basis or where there is no pharmacy from which to obtain medications, the lack of choice in health professional or the lack of privacy is intensified given the varied racial, classist and sexual inequalities in Canadian health care. State delivered health services are always tainted with the ideological discourses of the political government at the time. Many examples can be found in Canada of governmental health service delivery being politicized by a long history of oppression on the part of the state or other social forces.

For instance, the Indian residential school system, funded by the government and run by various Christian churches forcibly removed First Nations, Inuit and Métis children from their families while at the same time promoting land seizures by white settlers and criminalizing Indigenous culture, language and ceremonies (Milloy, 1999, p. 77). A part of this history of conquest and resistance included generations of girls and boys being physically, emotionally and sexually abused and experimented upon within the confines of Indian residential schools that led to recent church and governmental settlements and apologies. A current federal law, the *Indian Act*, is the same legislation that forcibly removed generations of Indigenous children from their

families and currently enables health and social services for some First Nations and Inuit people. Other instances of Canadian state oppression with regard to health service delivery included cases like Indigenous and non-Indigenous people being forcibly sterilized because they were regarded as “mental defectives” for reasons like gender, ethnicity, mental illness, ability or class at the hand of the provincial governments in Alberta and British Columbia (BC) up to the 1970s (Boyer, 2006, p. 15) or just this year, rescinding health care services for those individuals who apply for refugee status in Canada. It must be said that Canadian state building imbued the provision of health services with a racist, gendered and class-based character. These moments of oppressive health service delivery should be remembered as occurring in a not so distant past. Canada remains a place of exclusion and inequality for women, especially for those from communities outside of the white, heterosexual, protestant or catholic, Anglophone “settler” narrative that dominates the stories of Canadian history.

Canadian state relations continue to control different aspects of women’s health activities in overt and subtle ways that constrain sexual and reproductive health choices and ignore the social reality of the ability to choose. The social history of abortion and contraception remains problematic to some and is dominated by attempts to regulate or eliminate these services, and by extension, women, by the state, law, family, religious organizations and medical professionals, amongst others. Population policies implemented at the international and federal levels impact women in their daily lives, and even “subtle” shifts in the policies that guides service delivery can have far-reaching consequences, like the case of the deregulation of emergency contraception. Emergency contraception is dose of a hormone that works on a woman’s body so as to prevent pregnancy by preventing fertilization in the period immediately following heterosexual reproductive intercourse where pregnancy may be possible.

In 2005, the federal government shifted the access to conditions from requiring a prescription to non-prescription, that forced women to be counseled by a pharmacist to determine their eligibility for emergency contraception. The only “symptom” for needing emergency contraception is having had unprotected sex, a condition best identified by a woman herself (Grimes et al, 2001, p. 2). Between 2005 and 2008, women in Canada were assessed for unprotected sex and counselled about sexually transmitted infections, sexual practices, timing of menstruation, and other modes of contraception at the pharmacy counter. In some cases, this personal information was recorded and stored in “customer” databases by corporate pharmacy chains. By 2008, Health Canada and the pharmacist regulatory body in charge of determining a drug’s conditions of access at place of sale abandoned its behind-the counter requirement and emergency contraception remains non-prescription in Canada today. But there continues to be major problems in access. I return to this later.

My research question was oriented around why women were forced to submit to mandatory screening and counselling by pharmacists about unprotected heterosexual reproductive sex (hereafter, unprotected sex) menstruation and contraception? This research explores the social relations of access to emergency contraception in northern Ontario. Eight women living in northern Ontario shared their experiences in obtaining emergency contraception between 2005 and 2008. I began my research with women’s experiences, to I ground the actual experiences of women as central to the analysis. I also analyzed government and pharmacist groups’ documentation about deregulation and identified the social forces that contributed to these conditions of inequality. Finally, I end the research with specific recommendations to improve conditions of access for women living in Canada.

1.2 The Context of Unwanted Pregnancy and the Idea of Emergency

Unintended or unwanted pregnancy remains a real problem in Canada, even in this day and age, when there are many ways to reduce the risk of pregnancy using various forms of contraception. The Canadian state, having supported the International Conference on Population and Development in 1994, adopted a broad definition of reproductive and sexual health indicating that, “Reproductive health [...] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so” (International Conference on Population and Development, 1994. “Reproductive health”). This definition has been adopted by many countries around the world and is often cited as the basis by which we can enjoy reproductive rights, and freedom to pursue sex for pleasure and engage in activities to regulate fertility, or have as many children as we wish. Despite having adopted this definition women in Canada do not have equal access to services and this deserves some attention.

Lack of access to services leading to unwanted pregnancy has serious consequences, including death and serious injury - unsafe abortion causes 70,000 deaths globally every year (World Health Organization, 2013). The social and physiological organization of reproduction means that a woman retains the burden of unwanted pregnancy that can affect many spheres of her life, including pursuing education, to work, it can alter her social standing, and change her appearance. As stated by a woman interviewed for this study, “Women assume the risk [of pregnancy] and women feel responsible for being careless. Whatever you are doing, or not doing, falls on you...that’s just the way it works” (Peggy).

The obvious tie between contraception and abortion is that the contraception failed – what we are really discussing is unwanted pregnancy. In Canada, it is estimated that 40 to 50 percent of

pregnancies are unintended and abortion rates appear to be decreasing with 103,768 abortions performed in 2003 and falling to 92,524 in 2011. Currently, the unmet need for contraception and abortion remains unclear since the Canadian statistics do not accurately reflect all abortions due to inconsistencies in service provision, reporting and information gathering.¹ Furthermore, the data does not document the number of women who requested a service like contraception or abortion and were refused (Canadian Institutes for Health Information (a), 2011). The social construction of heterosexuality means that women largely still do the vast majority of child-rearing labour so while the consequences of unwanted pregnancy can be conceptually seen as shared between both men and women in heterosexual couples, the reality means that the consequences of unwanted pregnancy are still largely assigned to women. In dealing with controlling fertility and reproduction, women have more contraception options than men, because this work is socially assigned to them. The most recent data from 2006 for 15 to 24 year olds suggest that women tend to use condoms the most frequently, a method obviously used after being negotiated with their male partner; the next most frequent method was oral contraceptives; and then, withdrawal methods (Black, A., Yang, Q., et al, 2009, p. 627).

Since a woman's body is the site of pregnancy, she must also manage her fertility in the cases when she may become pregnant, either by taking emergency contraception, finding abortion services, deciding to have the baby or seeking adoption services. Due to these issues, I suggest there is a gendered division of labour with regard to fertility, unwanted pregnancy and contraception. By gendered division of labour, I mean that specific activities and responsibilities

¹ The Canadian Institutions of Health Information publishes data about abortions in provinces and territories of Canada in hospital or clinic settings. The data does not include cases where women paid for services in other settings. Furthermore, some provinces do not provide abortion services at all – like Prince Edward Island and women have to leave the province to obtain these services and are thus reported under another provinces' data. For instance, cases where women that reside in say, Quebec, but obtained services in Manitoba, would be reported as having had an abortion in Manitoba. All this to say that the data related to abortions provided in Canada are not reliable.

related to fertility regulation are assumed more frequently by women than men because the direct effects of pregnancy reside with women (Fennell, J, 2011). This is also because of the social construction of gendered work, including reproductive and domestic labour after childbirth. I want to establish at the onset of inquiry that an emergency request for contraception is a serious matter that can result in harm to a woman if a pharmacist refuses to provide her with the drug.

Preventing unwanted pregnancy can be urgent, and the refusal of service can ultimately mean that a pharmacist is forcing a woman to become pregnant. The often-cited remedy to being refused contraception or abortion is that a woman can go to another pharmacist to obtain the drug, that discounts the politically imbued character of health service delivery, as well as inequitable access experienced by different women in Canada. The material and social conditions in Canada, especially in rural and remote areas, are such that pose specific challenges in health service delivery as there may only be one place to obtain contraception, staffed by one person. A denial of service in this context, refusing to provide contraception, may lead to unwanted pregnancy. Furthermore, time is an important consideration when using emergency contraception as its effectiveness reduces as time passes. Thus, all health professionals in Canada should be obliged to provide emergency contraception. As McLeod notes, women and pharmacists occupy different social positions, one as an authority figure screening for unprotected sex, the other as an individual who may experience oppression by the social forces that mediate this interaction as well as issues like gender, ability, race, sexuality or class (McLeod, 2010, p.18). Contraceptive refusals, in this context, reproduce relations of stigmatization that construct emergency contraception as a problem for women to take, rather than, identifying relations of stigmatization that, say, produce sexist notions of women's sexuality and create barriers for future use of emergency contraception. The social relations of stigmatization that I draw from is based on Goffman's (Goffman, 1963) conceptions of stigmatization where those that do not conform to

mainstream conceptions of “the norm” and thus are made to conform in various ways or can be considered “the other”.

As I will explore later in this thesis, other studies reveal that pharmacists and other health professionals reinforce stigmatization about women’s sexuality based on requests for the drug and the women that I spoke with experienced other oppressive views about women’s sexuality like being made to feel neglectful or “careless”. Women of colour, Indigenous women, working class or poor women may experience other forms of oppression through social relations of stigmatization or may have to engage in different activities to obtain the drug. Furthermore, because of “stigmatization” around access to emergency contraception, women in other research report being reluctant to request the drug for fear of being thought of as “that kind of woman” (Shoveller et al, 2007, p. 15).

Stigmatization results in exclusion and refusals to provide emergency contraception due to pharmacists’ moral values, or what I consider sexism and paternalism, ultimately may result in forcing women to become pregnant or to obtain drugs or abortions in unsafe ways. Contraceptive refusals as a form of harm certainly situates pharmacists in a position of having power over a woman’s ability to control her fertility and places the interaction and consultation under a different kind of scrutiny, and is worthy of further research. In addition to assuming this kind of power, pharmacists are health professionals that maintain a certain status in society; they are framed by other authorities (professional associations, governments) as holding a specific form of knowledge about women’s fertilities and emergency contraception so as to be able to provide women with “good information” (Health Canada, 2004). In the period under study, 2005 to 2008, pharmacists also happened to screen and counsel women about their fertility and unprotected sex, menstruation, other “contraceptive responsibilities” and subsequently give the drug to women. Within this transaction, there was a differential relation of power between the pharmacist-expert

and the requesting woman. Thus, a request for emergency contraception should be viewed as an inequitable transaction between a pharmacist and a woman who is experiencing an emergency, and a refusal to dispense the drug must be understood as a harmful practice.

1.3 Methods: “How does this work?” (Peggy)

The quotation used in the title of this thesis and the subtitle above is a quote from a woman who participated in this research; and she asked a simple question: “How does this work?” I am using the expression because I want to reflect a repeated narrative that emerged from participant interviews, that is, a lack of knowledge or confusion about what the drug did. It also serves to organize the outline for this section on “how” the drug works, how the process of deregulation was accomplished and the methods I used in interviewing and analyzing the conversations I had with women.

Different forms of contraception can be used after heterosexual reproductive intercourse, which includes emergency contraception marketed as Plan B™ in Canada and made by Paladin Labs consisting of the hormone levonorgestrel; the Yupze regimen; misoprostol; mifepristone, and the intra-uterine device. In Canada, levonorgestrel is the only type of medical emergency contraception available over-the-counter and entails a two-dose regimen of 0.75 mg levonorgestrel, with the doses taken 12 hours apart (Glasier, A and D. Baird, 1998, p. 1- 4).

Plan B™ is made by Paladin Labs in Montreal; the other medical method of emergency contraception is called, the Yupze regimen, and involves doses of two types of hormones and is cheaper to purchase. A clinical guideline for physicians on emergency contraception recommends that Plan B™ be taken in the first 24 hours after unprotected intercourse to maximize effectiveness but may be used up to five days after to prevent unwanted pregnancy (Dunn and Guilbert, 2003, p. 673-9). Plan B™ is 75% to 89% effective in reducing the risk of pregnancy

when taken within this time frame and effectiveness is reduced as time passes (Dunn and Guilbert, 2003). Much of the published literature on emergency contraception, including the information that is packaged with the medication, recommends the doses be taken within 120 hours of intercourse (World Health Organization, July 2012).

Generally in the literature, emergency contraception refers to contraception used after heterosexual sex and before implantation of a fertilized egg takes place in a woman's uterus. Some of the early studies about the drug were inconclusive on how the drug worked on a woman's body, or in clinical-jargon, "the mechanism of action". For instance, in the early published literature it was thought to "prevent or delay ovulation, prevent the fertilization of an egg by stopping the transport of an egg or sperm, *or* prevent the implantation of a fertilized egg" (Wynn, L and J Trussell, 2006) and does not interrupt an already established pregnancy (International Consortium for Emergency Contraception, 2004). More recent medical evidence, as well as feminist and legal interpretations on the mechanism of action, has roundly criticized this early characterization of the hormone as acting after fertilization or to prevent the implantation of a fertilized egg since there appears to be no evidence to support this claim. A 2013 federal court ruling in the United States is one example of this criticism where the judge summarized the clinical studies used as the basis of the United States National Institute of Health's finding that using levonorgestrel has, "... not shown to cause a postfertilization event – a change in the uterus that could interfere with implantation of a fertilized egg" (Tummino, et al. v. Hamburg, et al. 2013; US Government Accountability Office, GAO-06-109, 2005; Citing H.B. Croxatto et al., 2001; H.B. Croxatto et al., 2004; A.L. Muller et al., 2003; H.B. Croxatto et al., 2003). Medical evidence attests that the drug works before fertilization and works to reduce the amount of sperm in the uterus, stops sperm from moving, and stops the movement of sperm cells into the uterus (*Ibid*). Health Canada, when it developed its 2004 rationale to eliminate the

prescription requirement for levonorgestrel, adopted an incorrect definition of the drug, in that it has a role in “preventing the fertilized egg from attaching to the wall of the uterus” (Health Canada, 2005). This definition of levonorgestrel continues to be included with the medication when it is distributed in Canada, even though it is false (Paladin Labs, 2013).

Levonorgestrel was available as a prescription drug in Canada in 2000. While the federal government sets access to drugs via prescription, provinces determine conditions of sale, the place of sale in the pharmacy and regulate health professionals like pharmacists. Shortly after emergency contraception came on the market in Canada in 2000, three provinces changed their legislation allowing women to obtain the drug directly through pharmacies. Both BC and Saskatchewan made these changes by amending regulations in their legislatures and passed legislation to allow pharmacists to prescribe emergency contraception. In 2001, Quebec went ahead with a similar legislative change, where pharmacists were issued a training certificate from the provincial pharmacy body (Wynn L, Erdman J, et al., 2007, p. 263). This meant that when Health Canada considered the proposal to move the drug to behind-the-counter, there were regional disparities in access to emergency contraception in Canada as women living in the other provinces still had to obtain a prescription through a physician.

Federal and provincial governments have separate roles in health care in Canada relating to drugs, which can be characterized as a federal provincial division of labour in the provision of health services. Health Canada has the federal role to regulate the manufacturing, sale and import of medications and change a drugs’ prescription status by developing a rationale to change prescription status and conduct public consultations before amending the *Food and Drug Act*. The provincial governments have other responsibilities: in drug purchasing for hospitals; regulating provincial physician and pharmacy professions; funding drug coverage for specific groups like senior citizens, those on social assistance and drugs for hospital patients; and

managing a list of drugs these plans will pay for, called the provincial formulary. Once a drug is deregulated from the federal *Food and Drug Act* by Health Canada, the federal agency responsible for this legislation, provincial pharmacy regulatory bodies decide on the conditions for its sale at the pharmacy counter. These bodies determine these conditions on the recommendation of the National Drug Scheduling Advisory Committee (NDSAC) of the National Association of Pharmacy Regulatory Authorities (NAPRA).

In 2001, a year after emergency contraception became available in Canada with a prescription, NDSAC recommended that if Health Canada were to change the drug schedule to non-prescription in the future, that it should be accorded Schedule II status, “after applying factors #1,2,8 and 9” (National Drug Scheduling Advisory Committee Meeting Minutes, November 3-4, 2001). Schedule II status means non-prescription with conditions, and these conditions included that emergency contraception be kept in an area where patients cannot access the drug directly, behind-the-counter, so that the pharmacist can assess and counsel the woman. The 2001 NDSAC meeting minutes did not provide a rationale as to why Schedule II status was recommended, but I looked at the cited factors referred to as 1, 2, 8, and 9 against which the drug was assessed for safety and efficacy, in order to understand the reasons why emergency contraception was kept behind-the-counter and I analyze these factors later in this research. Basically, the Committee assesses a potential non-prescription drug against ten clinical factors to determine if behind-the-counter conditions are required. At that time the Committee decided to retain professional control over access and distribution, research was emerging refuting the need to keep emergency contraception behind-the-counter. Indeed, some studies found that emergency contraception met all the clinical factors required for over-the-counter use, in contrast to the NDSAC decision “low toxicity, no potential for overdose or addictions, no teratogenicity, no need for medical screening, self-identification of the need, uniform dosage and no important drug

interactions” (Grimes D, et al, 2001, p. 153) as well as easy to understand packaging instructions (Health Canada, May 22, 2004). It is difficult to understand why the national pharmacy regulatory body did not consider the literature available in 2001 that attested to the drug’s safety and efficacy record.

In March 2002, an application was submitted by the Society of Obstetricians and Gynaecologists of Canada, the Canadian Pharmacists Association and the manufacturer of Plan B™, Paladin Labs Inc., to change the status of emergency contraception to non-prescription but behind-the-counter. At the time, there was a lack of knowledge about the product, as well as confusion relating to its use and efficacy amongst both women and health professionals (*Ibid.*, and Trussell, J, Ellertson C, et al., 2004, p. 30-38). Some research suggested that the provision of emergency contraception from physicians or other health providers does not meet women’s needs because of time constraints related to taking the drug as well as physician’s working hours typically being during the day, making the drug unavailable from a physician after 5 pm and on weekends (Ellertson, C., Shiochet, T., et al., 2000, p. 145-186). Other research indicated that women understood how to correctly self-administer emergency contraception, and used it more frequently when they had advanced supplies. Most women’s health advocates supported the deregulation of emergency contraception so that women can obtain advanced supplies to keep in their medicine cabinets and use when required. Research suggested that women know how to take emergency contraception, took it properly and when given the chance, used it effectively at home and more frequently when advanced supplies were obtained (Ziebland, S., Wyke, S., et al., 2004, p. 1-4).

In May 2004, then Liberal Minister of Health Pierre Pettigrew announced the government’s intent to re-classify one type of emergency contraception, progestin-based levonorgestrel Plan B™. His remarks follow:

Women facing an emergency need timely access to this type of therapy... Making the drug available in pharmacies without a prescription will help women to prevent unwanted pregnancies....The fact that the drug would be available 'behind-the-counter' means that women would have timely access to the drug and receive professional health advice regarding its use (PR Newswire, May 18, 2004).

The Minister's comments at the time identified one of the key barriers to effective use of the drug as procuring supplies in a "timely" fashion. The Minister touted behind-the-counter access as increasing timely availability at the same time as framing women as needing "professional health advice", despite much evidence that the only requirement is having had unprotected sex or another method of contraception fail during sex. Positioning behind-the-counter conditions as contributing to reductions in unwanted pregnancy, the Minister also widened pharmacists' scope of practice into screening and counselling about women's incidences of sex, menstruation and use of contraception.

Health Canada prepared a Regulatory Impact Analysis Statement (RIAS) that was published in the *Canada Gazette* in 2004 and again in 2005. The statement was a part of the mandatory consultation component to a federal regulatory change, where the government notifies "Canadians" of their intent to change the status of emergency contraception. The RIAS was published and sent to "government stakeholders" to solicit their opinions on the proposed change. After 75 days, the government responded to the "stakeholders'" opinions in a revised RIAS that was published in 2005 when the *Food and Drug Act* was formally amended (Health Canada, 2005, p. 862).

By April 2005, Health Canada had "deregulated" the drug and moved levonorgestrel from Schedule F of the Canadian *Food and Drug Act*, which requires a prescription from a physician, to Schedule II, non-prescription but available *behind* the pharmacy counter, requiring professional intervention when sold. Once emergency contraception was removed from requiring

a prescription, provincial and territorial pharmacy regulatory bodies were left to determine what “professional intervention” or conditions should be attached to the drug when sold. The NDSAC of the National Association of Pharmacy Regulatory Authorities put into effect its 2000 Committee recommendation to classify emergency contraception as a Schedule II drug, requiring pharmacist intervention at point of sale as well as to be stored behind-the-counter, or in an area of the pharmacy where patients cannot access the drug directly. The role of the pharmacist at the counter involved assessing women for eligibility to use emergency contraception and providing counselling and education about emergency contraception, other forms of contraception and prevention and/or referrals to physicians for testing for sexually transmitted infections.

The three-year window of behind-the-counter access from 2005 to 2008 represents a change in levels of “professional intervention” where the place and way that women accessed the medication shifted from the state-supported health system where counselling and education about sex occurred in a private physician’s office to one where these services shifted to the corporate domain, a pharmacy. Screening and counselling became mandatory for women to go through at a publicly visible place and had to be paid for out of pocket. Within the lengthy regulatory process, there appeared to be little thought given to the impacts of visiting a highly visible pharmacy counter to ask for, and be counseled about unprotected sex. Behind-the-counter status for emergency contraception effectively widened the pharmacist’s scope of practice, increased their profits and created new but restricted spaces where women could get the drug (Sicchia S and L Kelly, 2006, p. 84-86).

Research methods

In order to understand why women were forced to submit to mandatory screening and counselling at the pharmacy counter, in 2007, I interviewed eight women about their experiences in seeking emergency contraception from a pharmacist. This moment in time was a period of

transition, where a woman’s relationship with the medical profession as the primary provider of a sexual health “product” and education shifted to access within a for-profit or privately owned, and highly visible place, the pharmacy. The day-to-day activities women engaged in to obtain and use emergency contraception were examined through these interviews with women. Sexual health work is a concept that will be used to describe a number of women’s activities they engaged in to get the drug and which I have critically examined to reveal the regulations that shape access to sexual health services in small cities in northern Ontario. While I will use this concept throughout this thesis, and will build toward identifying a series of activities associated with this work, the concept will be clearly articulated by examining women’s experiences seeking emergency contraception.

By listening to the practical tasks and activities associated with acquiring emergency contraception, I can “bring into view aspects of the social world that remain hidden” (D. Smith, 1987, p. 78). In order to understand the particularities of experiences of women seeking emergency contraception, I am not painting a picture about all women and their experiences, nor am I attempting to formulate a common woman’s standpoint that would generalize the experiences of all women. By learning from these eight women’s experiences, I cannot thus draw conclusions for all women from these narratives; nor am I trying to say that because I am a woman, and those that participated in interviews are also women, and that only women can illuminate the reality about emergency contraception and unwanted pregnancy against all “others” (Frampton et al, 2006, p. 7). Claims based on essentialized gender identities are problematic and I started this research from women’s social experiences, so as to begin my analysis from “outside the frameworks of the ruling discourse” (*Ibid*, p. 7). In seeking to understand their realities from their divergent perspectives, I explored how different institutional relations coordinate a woman’s social world. Institutional relations can be characterized in this

case as pharmacy regulatory bodies, different forms of governments, and texts used by individuals within these pharmacies or government agencies such as pharmacy screening forms or rationales developed to change legislation. These institutional relations are embedded with different ideologies, taken up by those participating individuals to co-ordinate social interaction. Agency is an important consideration here and for this work, agency is social in character, and resides within individuals and groups that participate in or make up the structure-institutions. Agency does not reside within, say, Health Canada, as an entity but rather with the bureaucrats that work there and through the political or policy choices pursued by political representatives of government. Thus, by starting this research with people, I can imagine transforming the social institutions that mediate our activities by mounting criticism, tactics or strategies so as to make the research outcomes work for change.

Institutional ethnography is used to inform my research methods and theorizing that began with treating each woman as an expert of her own life and by documenting her sexual health work. This enables me to piece together the social forces that problematize or stigmatize the use of emergency contraception. I will not generalize from the women I talked to as any sort of “sample”, rather, I find common points of connection, in order to, as put nicely by DeVault and McCoy, “describe social processes that have generalizing effects” (Smith, D, 2006, p. 18) like the people involved in the processes and institutions that deregulated emergency contraception.

Mykhalovskiy and McCoy’s concept health work takes the institutional ethnographic notion of work as being more than paid labour and includes “the work people do to look after their health” (Mykhalovskiy and McCoy, 2002, p. 24) and is expanded upon in my work as sexual health work. Sexual health work involves navigation of a range of activities including goals, purpose, intent, making appointments, seeking other advice, and visiting health

professionals to manage one's health. Health work emerged in Mykhalovskiy and McCoy's research about HIV/AIDS where they examined treatment regimens and the regulation that occurs on decision making, information gathering, knowledge, the idea of "appropriate care", or being a responsible patient that follows medical advice and complies with the norms spread by the biomedical authority extended by people working in health services. The idea of a responsible patient that complies with the regulations of the biomedical authority relates to the neoliberal discourse of a self-educated, knowledgeable health care consumer. I do not believe that the neoliberal and biomedical discourses are mutually exclusive since the Canadian state promoted the idea of individual responsibility for well-being alongside health professionals that require patients to comply with the biomedical authority's advice.

Documenting this sexual health work enabled me to interrogate and analyze the discourses present in interactions between women and pharmacists as well as the screening form used by pharmacists at a major corporate chain, Shopper's Drug Mart, and within government texts like the RIAS developed for the deregulation of emergency contraception, which also help to uncover the social relations of access to emergency contraception. By documenting and examining the types of questions pharmacists asked women, the tactics women took upon themselves to obtain the medication, the sources of stigmatization and conceptions of women's sexualities embedded in these interactions, I unpack the social relations of access to emergency contraception under this period of limited deregulation.

This research is grounded in my own experience in accessing emergency contraception. In 2007, I went to the pharmacy on my lunch break and had an easy time obtaining it from a friendly female pharmacist but I had to ask for it at a public pharmacy counter in front of ten people waiting in line. The pharmacist, asked "what happened?" and I replied, "what do you think?" she was whispering as was I. "When?" she asked, "last night," I replied. She rummaged

through her files and produced a French form for me to sign that she had filled out with my name and address on it, along with a statement about a condom breaking the night before. At the time, I knew enough about emergency contraception to understand how to take it; however, I was uncomfortable being asked questions at the public pharmacy counter about when I had sex or asking about side effects like nausea. After I signed the form, without having the benefit of translating the form into English, she took the copy and placed it in a drawer. I asked what happened to it and she said the pharmacy retains the form for five days and then it is destroyed and said it could assist the pharmacist in understanding when the first course of emergency contraception was taken and that she made her assessment about providing me with the drug after she heard how much time had elapsed since the other contraceptive method failed. From this “line of disjuncture” within my own experience, between my social experiences and the obstacles I encountered, I wanted to speak with other women who also got emergency contraception from a pharmacist, and then focused my investigation on examining how these social forces mediated these women’s experiences.

Since this thesis is grappling with two wide topics - women’s experiences and institutional policies and procedures on drug access, it becomes important here to ground this work in reality, that is, how women secured supplies of emergency contraception. Exploring the compelling and sometimes troubling experiences of women early on in this work, serves to orient the research to the actual experts on unwanted pregnancy and sexual health work, women using contraception.

When I began to analyze the details of women’s activities in accessing emergency contraception under limited deregulation, I became concerned that I was picking apart their experiences. By including only excerpts from interviews in my analysis, I was essentially omitting the totality of women’s experiences and thus may have buried or concealed the impacts

of access, the barriers to health services and the emotions they described in their knowing accounts. To remedy this, and before I began to analyze the details of women's activities, I include here a brief summary of these women's stories. By doing so, I elevate the primacy of insider's knowledge and the sequential process of obtaining emergency contraception. I hope this approach sheds light on the activities and emotions experienced as women sought emergency contraception to reduce their risk of unwanted pregnancy. It will also begin to identify women's sexual health work in accessing contraception. Before I share women's stories of emergency contraception, I outline here how I went about this research.

Interviews and analysis

I began my graduate work with the intent to examine the limited deregulation of emergency contraception and some women approached me at the onset and asked to share their stories. The Research Ethics Board of Laurentian University approved this research topic, but limited my ability to recruit women by using posters or the internet to publicize this study, so I asked those women who initially approached me to refer me to others that would be interested in speaking with me. This was an essential piece of my research and I was eager to hear first-hand what it was like to ask for contraception from pharmacists. What happened during these interactions? Was it easy to access? When did they go to get it? How did they get there? Were they comfortable asking the pharmacist for it? What about telling their friends or partner they had used it? How much did it cost? Had they used it before?

Of course, given my experience in seeking the drug, I tried to ensure I was not asking "leading" questions since I took issue with how I had to get the drug. I thought about my privileged identity, an articulate, white, woman with the money to pay for the drug who was ready to demand access if the conversation became difficult.

The semi-structured interview guide, included in this thesis as Appendix A, was intended to elicit conversation about aspects of access to emergency contraception and was structured around seven main topics to delve into the sequential process of obtaining emergency contraception and related issues about knowledge, privacy and confidentiality. The first idea was women's understandings and knowledge of the drug – how they came to know it was available behind-the-counter and their understanding of how the drug functioned physiologically. The second topic was intended to begin a discussion about the actual access to the drug - the timing of access, when they needed it, how they chose what pharmacy to visit, how they got to the pharmacy. The third topic was about being in the pharmacy – the process of obtaining the drug like approaching the pharmacy counter, asking the pharmacist for emergency contraception, the ensuing conversation between the pharmacist and the woman, if they had to sign a form, and if they got the drug. The fourth topic was about privacy and confidentiality – how the women felt about asking for the drug in front of other people, how their privacy was maintained or not by asking for the drug at the pharmacy counter, if there was information provided about how records were kept about the interaction with the pharmacist. The next subject was to ask women about any feedback they had about access – to identify positive and negative aspects to obtaining emergency contraception behind-the-counter. Lastly, I asked about their sexual partner's role in obtaining emergency contraception and also about their perceptions of it – did they tell their partner, was this something they did on their own, what assistance was provided, was there any joint decision-making about using the drug and unwanted pregnancy. For the most part, I covered all of the questions included in the interview guide and most of the interviews delved into topics the women brought up independently of the questions in the guide.

I met six of the women in their homes to speak about the research and conducted two interviews over the phone. All of the interviews were recorded and transcribed. I asked one of

these women if she would interview me and thus my experience is identified as such in the discussion of women's experiences but is not included as one of the eight women I interviewed. At the end of each interview, I gave each participant a card that described how emergency contraception worked produced by the Canadian Federation for Sexual Health and a small gift. All the women approved the use of their transcript.

Activities and ideas raised during the interviews were grouped together if there were points of intersection or divergent perspectives as I was transcribing and I grouped comments together with every new activity using the participant's direct words. Since I was interested in exploring the ordered process of seeking emergency contraception and uncovering the ideological forces shaping the transaction, I began my analysis by thinking about how the differences and similarities between women's experiences contrasted against one another (Shovellor, et al., 2011). This type of analysis can also be seen as uncovering the different moments in the social relations of access to emergency contraception. For instance, some women asked specific questions about how emergency contraception worked or provided information that may not have been correct about the drug, and this was called, "knowledge." Information about the process of obtaining emergency contraception was called "process", issues related to confidentiality "privacy" and so forth. As the interviews progressed, I began to identify some of the social forces that had an impact on women's sexual health work so some of the narratives were grouped in a more specific manner. For instance, the analysis proceeded by identifying common or different experiences within the transcripts like when women spoke about access to the drug and discussed the emergency nature of the request – "time"; or regarding conflicts with a pharmacist – "stigmatization". After reviewing the experiences related to stigmatization, I delineated some of the discourses present in the conversations as experienced by these eight women.

Neoliberalism was an ideological practice I discovered as increasing pharmacist's scope of practice, transferring sexual health service delivery to privately paid professionals and in the increased cost of the drug for women due to this privatization and expansion of fee for service. Another similarity identified was clinical or biomedical power relations where the pharmacist maintained medical knowledge-authority or power over a woman. Lastly, common topics emerged that related to the social relations of stigmatization included moral regulation or making negative assumptions about a woman's sexuality, contraceptive responsibility, in the act of obtaining emergency contraception. These discourses will be elaborated upon in the discussion on women's experiences of emergency contraception.

In addition to speaking to women, I also had informal discussions with two pharmacists who work in rural areas about their work and the shift in their work and pay structures. This topic will be discussed in further detail in chapter three, as pharmacists have shifted from distributing medications to assuming roles as health educators and counselors. I took notes from the conversations with two key informant pharmacists and they helped to provide an entry point into an aspect of the drug regulatory process and professional scope of practice.

1.4 Women Who Needed Emergency Contraception

The women I spoke with were all different ages, races, classes, wage-earners or students, mothers, sisters, new immigrants, girlfriends. They spoke different languages, had different experiences with their sexualities and in obtaining emergency contraception.

The youngest woman interviewed was 21 and the oldest, 29 with most of the women in their mid-20s. All of the women lived in areas of northern Ontario, three of the eight were white and spoke English; two of the women were African-Canadian, and spoke mostly French; the remaining three women were white, who spoke both English and French and identified as

Franco-Ontarians. Seven of the women were students, six of those women also worked full time waged jobs. The other woman worked full time for wages. All but one of the women sought emergency contraception at a pharmacy in small cities in northern Ontario; the last woman obtained emergency contraception from a pharmacy in a rural area.

Peggy was a 24-year-old university student without drug coverage living in a city. The condom broke and her and her boyfriend checked online about what to do – they had heard about emergency contraception but did not know how to get it. After getting on their bikes and riding for 25 minutes, they arrived at the pharmacy at 4am. Initially, they met with an older, male pharmacist who provided advice about side effects and alleviating them but could not answer specific questions about the timing of taking the medication. This woman insisted upon a second opinion and the pharmacist called for his colleague who was younger and fresh out of school and “was more up on emergency contraception.” After speaking to the second pharmacist about how the drug worked on her, she paid \$40 for the drug and rode her bike home.

Nancy was 28, living in a city, working and going to college. She did not have drug insurance. Nancy spoke about two different occasions when she needed or used emergency contraception. The first time was well before the interview, and she went to a clinic to get emergency contraception. She asked for emergency contraception and “they said to take this now and take this later and gave me a piece of paper saying, like, how it will work.” She was concerned about bleeding and felt certain she was going to experience something similar to a miscarriage. After taking the pills, she went home and stayed in her bedroom all day, all alone, and waited for the pills to work, which she thought meant bleeding. At the time of the interview, Nancy was in a relationship with a man with whom she had a miscarriage and she “didn’t want to go through that

again since I am in school...” She had a difficult time making it to the pharmacy when they were open between school and work so asked her boyfriend to go and get emergency contraception for her. After the three-day window Nancy had to take emergency contraception, her boyfriend told her the pharmacist wouldn’t give it to him, but she suspected he may never have gone as he is very shy and she felt he was too afraid to ask. At the time of the interview, she was still unsure if she was pregnant and was scared to take a test.

Maye was 29, living in a city, working and going to school. She took emergency contraception before this occasion but could not remember if she had received it from a pharmacist or physician. When we spoke, Maye talked about another time more recently when she had gone to get emergency contraception with her boyfriend from the pharmacy. They decided to start trying to have children one night and then realized the next day she wasn’t ready for it. “You wake up the next day and think... holy shit I need emergency contraception now!” So after taking her second emergency contraception pill the next morning, she went to work and was sick and vomited. She worried that the pills had not been in her system long enough to work and did not have the time to wait in a walk in clinic or go to the hospital. After speaking to her boss about her problem – who was supportive and receptive - she called TeleHealth Ontario from her office cubicle to ask for some advice. The nurse on the end of the phone could not help her with her inquiry and asked that someone else return Maye’s call. Maye could not recall if it was a pharmacist or not for sure, but she said that she received good information about whether the pills had enough time to work before she was sick. She said the staff on the phone were able to alleviate her fears that the drug had been in her body long enough to work.

Roberta was 23, living in the city and going to school. She used emergency contraception twice; the first time was a year prior when she had an argument with the pharmacy technician, who is often working the prescription drop off counter where women first approach. Roberta was upset with the technician about the types of questions she was asked before referring her to the pharmacist. She managed to get the drug but not without having to expend a lot of energy to do so in this encounter with the pharmacy technician. Regardless of the problems she experienced previously, the convenience of the location of the pharmacy and her desire to not let someone else deter her from obtaining a drug she thought she had a right to obtain, meant she went back to the same pharmacy the second time. On her lunch hour, she asked the female pharmacist for the drug by its scientific name – levonorgestrel – so that she would appear knowledgeable about emergency contraception. Due to her previous experience, Roberta thought she would have to resort to being sneaky to obtain the drug, which was why she framed herself as a knowledgeable user but had a positive experience in obtaining the drug. She thought that the female pharmacist sympathized with her plight and that the best part was that the pharmacist did not act out of the ordinary at all – not suspicious, angry, judgmental, just neutral, empathetic and professional.

Debbie was 21, grew up in a rural area and goes to school and works in the city. When she was in secondary school, she went to her local hospital's emergency room to get emergency contraception. The nurse that assisted her at the time knew her family and she was nervous that people would find out she used the drug so young. The next time she needed to use it, when she was 21, Debbie heard that she could get emergency contraception from a pharmacy without a prescription. Debbie knew she had to take it within 72 hours of intercourse, but was not sure how it would interact with the birth control pill. She could not recall if she had used or not used a condom during sex; however, she had a real fear of getting pregnant because she took her birth

control pill irregularly and knew there was a chance she could get pregnant. She walked to the pharmacy closest to where she lives in the evening and first spoke with the pharmacy assistant and whispered her request to the woman. The assistant said she had to speak to the pharmacist and asked her to wait over to the side. After waiting 15 minutes to speak to the pharmacist about her request, an older, male pharmacist brought her to a little room and Debbie describes feeling uncomfortable due to the small space that two people were seated in and the intimate questions she was being asked; she also felt the pharmacist was uncomfortable. Debbie asked the pharmacist all her questions about the timing and use of emergency contraception as well as about taking the birth control pill. When Debbie asked him questions about the use of emergency contraception and the pill together, that's when the tone of the conversation began to affect Debbie. She spoke about the tone of the conversation, and how the pharmacist seemed "pissed off" and that it made her want to leave the pharmacy entirely. After realizing Debbie's discomfort – she had tears in her eyes – the pharmacist asked her more questions about the timing and became less abrupt and informed Debbie of the side effects associated with emergency contraception.

Diana was 22 when she first used emergency contraception and took a taxi to a pharmacy where she knew they offered services in her first language, French. She was a student at the time without drug coverage and knew she could get emergency contraception directly from a pharmacy. After the taxi ride, before which her boyfriend told her she didn't need emergency contraception as she was "paranoid", she waited in the very busy pharmacy for her turn and whispered to the assistant about needing the drug who asked her to wait to be seen by a pharmacist. After waiting 15 minutes, the male pharmacist came to speak to her and brought her to a little room. He asked her the same questions over and over, "quizzing" her about how the

drug worked, why she needed emergency contraception and what else she used for contraception. These questions left her feeling frustrated since she had to repeat the same information to the pharmacist as she did his assistant. Since Diana had never used the drug before, she asked him to explain the process. Diana felt like the pharmacist was being judgmental – and this hampered the conversation because key information was not relayed to her - since he did not inform Diana that the sooner you take emergency contraception, the more effective it is, nor did she understand the side effects. She was asked to sign something that was not explained to her. It included her name, address, and “details about her sex life”.

The second time she needed the drug, Diana was 24 and was living very close to the pharmacy. She relates that she rushed down there right after she had sex. She was surprised that the pharmacy had maintained records about the time she used emergency contraception beforehand. The second time she requested emergency contraception was much smoother for Diana since the pharmacist recognized her and they went to the tiny room to speak about the drug. The pharmacist quizzed her about how the drug works and how to use it, smiling the whole time. After determining that Diana should use emergency contraception, the pharmacist realized that they had run out of the drug. So he called another pharmacy, ensured that services were available in French, and sent her there. Thinking she just had to pick up her prescription, much to Diana’s dismay, after getting a friend to drive her to the second pharmacy, Diana waited for over an hour, even after the pharmacy assistant identified on her arrival that she had been referred there to get emergency contraception. Diana then realized she had to be screened and counseled all over again, and dealt with sexist questions from the pharmacist, that were paternalistic. So after waiting an hour that reduced the effectiveness of the drug, Diana left the second pharmacy with emergency contraception.

Francis was a working mother in her early 20s living in the city without drug insurance. She had a long-standing relationship with a female pharmacist of the same age that worked at a couple of pharmacies in the city. When she needed emergency contraception, she walked to her local pharmacy to get the drug. Since Francis had a friendly rapport with this pharmacist, she walked into the pharmacy in the local supermarket to get emergency contraception hoping she was working. “...Even now, if I have some sort of personal concern, I would probably travel to the other end [of the city] and go and seek her out.” While the pharmacist was busy serving another client, as soon as she realized what Francis was looking for, she ensured that the counter was clear of other customers, used a low voice while speaking to Francis about side effects and the timing around which to take the drug, and wrapped it up quickly and “...sent me on my way.”

By documenting women’s experiences in seeking emergency contraception between 2005 and 2008, I pieced together the story about deregulation of emergency contraception in Canada. Using the concept sexual health work, I examined women’s activities as they sought emergency contraception. From these experiences, I have identified some of the activities that comprise sexual health work that will, in turn, expose the ruling discourses and practices within the drug regulatory process. By speaking to these eight women, my goal was to provide a good understanding of the social relations of access to emergency contraception in Canada. By using the method and theoretical approach of institutional ethnography, and starting my inquiry with women’s experiences, I then analyzed government and pharmacist groups’ documentation about deregulation in order to identify the social forces and discourses that foster these conditions of inequality. In the next chapter, I define some key concepts as well as unpack some of my understandings of how I used institutional ethnography to speak to women about emergency contraception.

Chapter 2

2 Understanding the Standpoints of Different Women

When thinking about women seeking emergency contraception from a pharmacist, it becomes important to document the different social forces and accompanying ideological and work practices that shape this transaction. In Canada, women are legally entitled to get the drug by different means like the *Charter of Rights and Freedoms*, and under the United Nations *Convention for the Elimination of All Forms of Discrimination Against Women*. However, in actual practice these rights do not mean the conditions exist for all women, living in any place, to get emergency contraception and this is especially true given the specific challenges women face in accessing health services in rural and remote areas in the north. Differences between ideology and practice mean that, “reproductive experience exists outside of or apart from law” (Bridgewater, P., 2009, p. 404). These ideas will be explored in this chapter on theory where I develop some of the epistemological and ontological criteria to think about ideological discourses like neoliberalism and its impacts on health service delivery as well as individual legal rights to control one’s body. I will also delve into the theoretical perspective used for this work, institutional ethnography, which includes the concepts of embodied knowledge and experience, sexual health work, and transforming these legal means under the concept of reproductive freedom. Expanding the ideological conception of rights to include reproductive freedom, I will develop the idea that women and men have individual agency *over* their social bodies as well as a *social need* to control their reproduction which, given the current gender division of labour and social construction of heterosexuality, has differential impacts on different “women” and on “men.”

2.1 Impacts of Neoliberalism on Health Service Delivery

The current form of neoliberalism can be considered in operation since the early 1980s and continually requires new places to generate revenue and expanding market oriented policies and activities to make more money. The re-orienting of social services and entrenching of the neoliberal discourse within public policy effectively widens the capitalist market into traditionally state-led sectors. In Canada, there has been a slow process of privatization of aspects of health service delivery that in this work I coined neoliberal creep, reflecting the gradual way aspects of health services are being transferred to private, capitalist interests. The common features of this form of neoliberalism that has crept into the Medicare system includes the de-listing of specific services and/or forms of care for specific people, enabling new private forms of health care alongside wait-listed state systems, or the centralization of care from community clinics to regional centres and small cities. The distinguishing characteristic of modern-day neoliberalism is a transfer of power and accountability from government to “private, unaccountable market actors” (Whiteside, 2011, p. 259).

This neoliberal creep increased throughout the 1990s as federal cash transfers to provinces diminished for health spending and provinces created different arrangements to come up with funding as they faced increased costs for delivery (Browne, P.L, 2000, p. 21-22). At the same time, as Whiteside notes, federal commission reports like those of Romanow (2002) and Kirby (2002) were calling for “innovation and transformation” of service delivery to deal with the funding shortfall in transfers to provinces. Representing a shift in language and policy, the transformation in health service delivery meant “accumulation by dispossession” where certain services have been sub-contracted, others privatized, others “de-listed” from provincial formularies (Whiteside, 2011, p. 260-261). The expansion of neoliberal capitalism requires new

places to generate revenue, including widening the reach of capital accumulation into sectors previously assumed by the state or “held in the name of citizenry as state property” (Whiteside, 2011, p. 259).

By the late 1990s, Ontario’s state-funded social services, including health services, were being eroded by the expansion of market interests into health care alongside cuts in government funding to health programs and services. This situation was further problematized since the slow erosion of state health care delivery was accompanied by policy discourses being promoted by the state that included an increased personal responsibility for well-being (Mykhalovskiy and McCoy, 2002, p. 21). By 1997, Health Canada and the Canadian Nurses Association had finalized a three-year research project studying the expansion of the rhetoric of “self-care” within Medicare, defined in the study as “decisions and taking actions regarding their health... it is generally considered to refer to the efforts of health care professionals to assist consumers in making decisions and taking actions regarding their health” (Canadian Nurses Association, 2002). This notion was being used by Health Canada to promote the idea that individuals ought to be informed health care *consumers* so that people are “knowledgeable, make informed choices, and improve or maintain their health” (Mykhalovskiy and McCoy, 2002, p. 21). Self-care in this context differs from feminist notions of “health literacy” or taking up an understanding of one’s body and how to take care of it, largely due to the insertion of consumerism within the health and well-being lexicon.

By promoting a decreased reliance on state-paid visits to doctors for sexual health education and counselling and devolving these services to privately-paid professionals, in this case, pharmacists, the government could see savings within the larger health-care system. Under the ideology of neoliberalism, the idea of self-care was being promoted alongside the devolution of state-funded health services and new roles for privately paid health professionals.

Neoliberalism helps us to understand that the deregulation of emergency contraception was tied to the expansion of capitalist markets and had an influence on women accessing emergency contraception. The expansion of pharmacist's scope of practice into areas like paying out of pocket for mandatory sexual health education embeds the transaction with the idea of a health care consumer where pharmacists provide health advice on a range of topics. Emphasizing self-care within this system of health delivery embeds consumerism and individualist conceptions within the collective health care system.

A shift from publicly-paid to privately-paid health education has an effect on this discussion about women's sexual health work in accessing emergency contraception. The concept of health work is borrowed from Mykhalovskiy and McCoy, who describe this work as "the wide range of practices that people engage in around their health, without defining in advance what that work might or should involve" (Mykhalovskiy and McCoy, 2002). This conception of work as being a broader concept than those tasks individuals are paid to do by their employers is critical to document. Work here is based on understandings derived from institutional ethnography that draws from feminist approaches to sociology that expose and document the hidden or invisible work women do around domestic labour (D. Smith, 1987). To D. Smith work is "what people do that requires some effort, that they mean to do and that involves some acquired competence" (Smith, D., 1987, p. 165). Work, by her definition could include a range of activities; and in taking up this definition and attempting to expose what can remain hidden, we may be able to understand the different ideological practices that shape women's experiences.

Analyzing the work women engaged in to access emergency contraception from the perspective of a pharmacist involved looking at the language and narratives. These included other activities assumed by women that may be hidden and include having unprotected sex, intimacy, decision-making, partners, cost, transport, moral regulation, communication, knowledge, and

stigmatization. Echoing Mykhalovskiy and McCoy's argument, women's narratives revealed how their sexual health work was also shaped by the ruling neoliberal and biomedical, or clinical discourses, as I use these words interchangeably. Thus women's sexual health work in obtaining emergency contraception and the social forces that shape these experiences are brought together, and linked within the analysis.

Accompanying the shift from public to private sexual health education and contraceptive delivery is a context in Ontario where more health information is being delivered by an array of organizations, including health professional organizations, to encourage a "health consumer" armed with good information, to make active decisions about their wellness and treatment so as to comply with being "responsible" actors in the health system. This also means devolving responsibilities from state to other actors that transmit knowledge and education about different aspects of health and well-being. This also means devolving responsibilities from state to other actors that transmit knowledge and education about different aspects of health and well-being. Mykhalovskiy and McCoy identified a transformation in the 1990s within the state-led health information discourse to a focus on a health care consumer within state-led health education framework. The objective of this shift in discourse was to create an informed, self-educated consumer who has an individual responsibility to manage their health. Furthermore, the pluralization of health information meant the federal and provincial governments were alleviating themselves of the collective responsibility for the material and social conditions of health service delivery like knowledge production. The practice of encouraging individual responsibility for health within the publicly paid system deserves examination in light of neoliberal creep in all aspects of state-delivered health care. As Campbell emphasized in her work about capitalist-management systems transforming practices of nursing care to patients, identifying the ways

neoliberalism has “subtly incorporate[d] a market orientation” in delivery of health services may assist in finding solutions to this “public policy shift” (Campbell, M.L., 2006, p. 105).

Institutional ethnography is informed by Marxism and is thus interested in power and practices or activities that “...coordinate us with the interests of capital...” (Campbell, M.L., 2006, p. 39). Class relations in addition to “capitalist or neoliberal practices like governance, management and regulatory processes” (Campbell, M.L. 2006, p. 39) widen the reach of capitalism. The expansion of current forms of neoliberalism as an ideological practice includes activities that were not fully developed during Marx’s era. For instance, certain social forces were not organized by the research paradigm, like “management practices” or “automated decision processes” (Campbell, M.L., 2006, p. 39). Neoliberal management practices in the deregulation of emergency contraception include the emphasis on individual responsibility for health, delisting services from public formularies, the increased profit from activities previously assumed by the state, like health education, or the proliferation of organizations that mediate drug access making it difficult to trace the roots of decision-making and lay blame on oppressive/sexist practices.

At this point it is important to return to my concept of sexual health work in order to introduce the theoretical perspective I adopt for this work, institutional ethnography. Institutional ethnography begins with feminism. My view on feminism means that all women are different from one another and I recognize that global and national population policies and practices have had differential effects on different women. I see that there are individual and social needs for contraception within a woman’s socially organized ability to reproduce as pregnancy and childbirth reflects these individual and social needs (Petchesky, p. 9). These needs occur in tandem where, a woman’s unwanted pregnancy for instance is also affected by the social and material conditions that shape her experience within a socially-shared state health system.

Having both individual and social needs are not opposing but simultaneously occurring phenomena, in that a woman has an individual need to regulate her body and fertility, and yet her pregnancies occur within shared social space, influenced by her identity, status within Medicare having coverage or not, her relationships, language and so forth. A shared social space contributes to having unprotected sex and needing emergency contraception and obtaining supplies from a pharmacist, and ending an unwanted pregnancy. Thus pregnancy, and unwanted pregnancy, is both individual and social at once. Thus the concept sexual health work, explores the ‘doing’ of health and maintenance of well-being, the small details of life that people administer for themselves within the social; the institutions that mediate women’s experiences of access to emergency contraception.

The place where women obtained emergency contraception in 2005, and sexual health education on emergency contraception, sexually transmitted infections and other contraceptives shifted to a forced education session, paid for by each woman. By engaging in research using the approach of institutional ethnography, I deepen my inquiry into women’s knowing accounts and I contrast this approach with the discourse, ideologies and social institutions that influence and restrict access to emergency contraception.

2.2 Institutional Ethnography

Institutional ethnography intends, as its main mode of inquiry, to describe social activities that departs from traditional ethnography as it turns the insights of ethnographic investigation against the ruling relations in society. Institutional ethnography as a theory and method has three key components that relate directly to my research. These are: a critical analysis of institutional ideologies; a broader notion of work than paid labour; and linking these two components with a broader investigation of social relations. First, I critically analyzed people’s accounts to

understand the ideologies that may intrude into the talk of people I interviewed. In order to do this, I started by speaking to women about how they obtained emergency contraception. I moved to textual analysis of documents and analyzed texts produced by institutions that have a stake in decision making around deregulation of drugs in Canada, and, rather than focus on these organizations and the texts produced by people working within them, I analyze the ideological practices present in the interaction (Kinsman and Gentile, 2010, p. 40).

The second feature of institutional ethnography is its understanding of “work” which goes beyond the activities to earn a wage. When we examine institutional ideologies from the standpoint of those outside of the institutional relations, we begin to see that certain work activities and processes become concealed for a variety of reasons. Work exists materially within a specific context oriented by history, time, and effort. Exposing invisible work requires “taking the totality of work processes” (Smith, D., 1987, p. 166), to include those activities that require some effort. The interview guide for this research focused on uncovering the activities of sexual health work required in getting emergency contraception like, learning about emergency contraception, where to get it, traveling to the pharmacy, navigating or negotiating access from the pharmacy, outlining the timing of sex and the nature of her contraceptive practices to pharmacists to gain access to the drugs.

The third feature of institutional ethnography starts with the activities of people and their “work” to illustrate the larger social forces at play that affect their day-to-day lives. In D. E. Smith’s book, *The Everyday World as Problematic*, she argues that knowledge is embodied and institutional ethnography privileges the experiential as a way of accessing the social. In addition to listening to the local, specific experiences of people to understand the social relation, or ideology within it, much can be learned from critically examining documents produced by social actors – government, industry, professionals that can reveal text-mediated social organization

(Smith, G. W., 2006, p. 45). Words, concepts and terminology are the ideological part of how this coordination gets done and these texts can be used to reproduce the larger social order. By starting my inquiry with women using emergency contraception and analyzing two texts produced by pharmacists and governments, I try to understand what social relations shaped the authority held by pharmacists as they enforced the regulatory practice of screening and counselling women about their sexual health activities.

A good example of looking for invisible activities through a broader notion of work is in the work of George Smith, a student of D. Smith's, who took up institutional ethnography's research practices. G. Smith's research from the late 1980s and early 1990s, documented how the lack of access to treatment regimens for those living with HIV/AIDS were influenced by HIV/AIDS being defined in "official" texts as fatal. These inaccurate definitions of HIV/AIDS in official texts directly impacted treatments as those living with the virus were only extended palliative care "...rather than accelerated care" (*Ibid*, p. 49) which included expanded treatment access. After this discovery, activists targeted mobilizing activities on changing the definitions of the disease, so as to widen treatment options and access.

G. Smith's investigation not only identified false scientific information in the government definition of HIV/AIDS but also proposed solutions; thus, institutional ethnography as a theory and method, works toward transformative health research. Through G. Smith's example, ideology is situated within the documents and is activated by people reading and using documents, not simply as a "mental phenomenon" (*Ibid*, p. 50), but as expressed by, or activated by (Campbell, M. and Gregor, F., 2002, p. 33), people. Official texts mediate a particular understanding of their representative organization as they conceptually coordinate social action. Analysis of text mediated social organization enables the exploration of how people work together to reproduce ideological practices that enables the "investigation about aspects of power

operating in social life that otherwise lie hidden and mysterious” (Ibid, 2002, p. 32). Using institutional ethnography identifies social relations that coordinate people’s activities that are “concerted by *something* [emphasis added] beyond their own motivations and intentions” (Campbell, M.L. and Gregor F, 2002, p. 31). Reflexivity refers to knowledge produced through mutual determination.

Institutional ethnography rejects “rationality” as a mode of analysis as we are all situated or socially located, and that the understanding of social forces is shared through institutions, each other, and the documents we produce. Women’s knowledge can be considered reflexive and hence the importance of speaking to them about seeking emergency contraception. The interaction between a woman and a pharmacist is regulated by rational texts that “govern” (Smith, G. p. 50) activities in multiple locations and this text mediated social organization enables ideology to be present in a number of locations or communities – or trans-locally – therefore impacting people in different places at different times. Delving into the work of obtaining emergency contraception from the onset of inquiry situates finding women’s reflexive knowledge as the first step in research. Texts, for this work mean the regulatory impact analysis statement that embedded mandatory screening and counselling, pharmacist’s regulatory bodies assessment of emergency contraception for risk as well as the screening form used by pharmacists. An “epistemological problematic” (Ibid) occurs when the reflexive knowledge of women intersects with the ruling ideological practices within the objective/rational text. My epistemology is reflexive, understanding that knowledge is embodied and derived from women in their activities as they go about their lives. The next section will explore the idea of ideological practices that govern our experiences through the activities of different social actors.

2.3 Ruling Relations: Texts and Experiences

Feminist standpoint theory epistemologically privileges women in a way that institutional ethnography does not. For instance, like Roxana Ng (Ng, R, 2006, p. 179) I can take up the position of the women who participated in this research so as to develop a standpoint from their perspectives. Standpoint is used to indicate experience as a site of understanding where the “political vantage point” is entrenched within people outlining their experiences, or embodied knowledge directly from women that leads to knowledge that is “interested and invested...rather than disinterested, [or] neutral...” (Ng, R, 2006, p. 179). Taking up women’s standpoints allows me to identify some of the differing ideological practices these ruling institutions or “regimes” that affect these eight women’s experiences.

With emergency contraception, women negotiated access to birth control that often subverted the ordered process intended to keep women “safe and in compliance” with pharmacist recommendations, the clinical authority. Each woman I interviewed provides a partial view of the ruling relations and activities that are coordinated around them. Accounts of their health work illustrates similarities and differences in “expressing the relation of local courses of action to the institutional function” (*Ibid*) and explores the idea of ruling relations. To D. Smith, the traditional domain of sociology was *transliterating* in that it reproduced the institutional order from which there is a construction of an absence of position. With regards to contraceptive access, the government and professional regulation and related discourses are ways that the transliteration of women’s experiences occurs, meaning women were largely ignored in these official texts. By expanding this investigation to texts activated by people, I can begin to relate experiences to the overarching ruling relations and develop a map of sexual health work activities, social actors and their ideologies and practices.

People produce the social world through our embodied actions and certain social processes can have generalizing effects – transliterating experiences – like the texts that ignored women and the socially shared and material conditions of access to emergency contraception. What practices coordinate our activities and health outcomes? The regulation of women's fertility and sexuality through her interaction with a pharmacist can be thought of as mediated by “ruling relations” (Smith, 2005). How do the social processes we encounter day-to-day – or ruling relations – produce common experiences and activities? Do these ruling relations perpetuate systemic or other forms of inequalities and do they enforce ideas of compliance-responsibility or consumerism?

Ruling relations are intricate relationships that work like a web and occur locally and trans-locally in that these relations organize and define people and are abstracted away or have generalizing effects from daily social interactions, in that they are experienced as external to any person or place. These relations are still produced by people. Earlier in this work, I argued that health service provision funded by the federal government and administered by provinces and territories is imbued with the political, historical and material ideologies of the state in various forms. Keeping in mind the historical and material context of health service delivery, I examined the interactions of women as they sought to control their fertilities.

Previously, I identified a few ruling discourses that frame access through the gendered division of labour, race, class, sexuality, neoliberalism and biomedical/clinical authority. By making visible activities that often remain hidden, the findings of this research transform the idea that the interaction between the woman and the pharmacist is the only contributing factor to access. Institutional ethnography’s focus of inquiry enabled the identification of the social relations of neoliberalism and the market oriented approach to health service delivery, clinical power in rendering individuals compliant to professional authority and the otherizing of certain

women through the social relations of stigmatization. By using Goffman's conception of stigmatization as a series of ideological practices, I acknowledge the social relations of sexism that contribute to negative assumptions about women and the use of emergency contraception. Institutional ethnography makes it possible to focus research activities on systemic changes in order to transform the social relations of access.

To produce "order" within a drug regulatory system that has fragmented responsibilities, where none of these responsibilities include putting a women's individual and social needs first, the people in the bureaucracy developed textual practices that included the RIAS. This "rationale" that effectively expanded pharmacist's professional role within the health system presented clinical evidence to manufacture a rationale for deregulation. The second "order" was the use of a screening form produced by Shopper's Drug Mart, re-producing knowledge in this fashion, women's experiences were marginalized from the bureaucratic text and within managerial practices.

Institutional ethnography develops a distinction between forms of discourses like bureaucratic, official accounts and experiential accounts based on first-hand knowledge. Factual, "objective" accounts like the regulatory statement do not provide any particular context to the action, and give a detached account of the events that is not constrained by what any individual saw, allowing for institutional factors to dominate the discourse and have generalizing effects. These accounts are contrasted against the knowledge embedded within women's knowing accounts. Objectified discourses or forms of consciousness become standardized within texts that can be removed from the situation where the particular, grounded actions happened, so as to become "standardized across multiple conversations in different local settings..." (Smith, D. 1999, p. 218).

Text mediated social organization becomes a specific way to coordinate people's trans-local social lives; and by critically reading these texts as social forces used to co-ordinate social practices, I identify different ideologies or authorities that operate within the text to see how "people are related to one another in predetermined ways, even though they do not know each other and never even meet" (Campbell, M and Gregor, F, 2002, 32 and Smith, D. 1999, 148-151). Texts, like the forms used at corporate pharmacies to screen women become "activated" through the pharmacists filling the form with "facts" to "screen" women to see if they are eligible to use emergency contraception and in pharmacists' choices on how to conduct these activities. This text perpetuates ruling forms of consciousness trans-locally, between say, Ottawa and Thunder Bay. The sequential analysis of texts provide information about how texts or documents mediate people's response to bureaucratic forms of accounts (Eastwood, L, in Smith, 2006, p. 195) shaped by the ruling ideology and are often authorless and take up a particular form of writing that excludes embodied knowledge and elevates clinical or biomedical "facts" as the authoritative "truth" (Smith, D., 1987, p. 161).

D. Smith sees discourse and discursive practices as social which differs fundamentally from Foucauldian discourses of knowledge being produced simply through power relations. D. Smith sees there is a participatory – and thus social – element to discursive practices as people produce the social and therefore discourse, knowledge and power are resisted as people go about their lives and are produced, ultimately, by people. I like to think about discursive practices as lenses that I look through to see the presence of stigmatization, neoliberalism or clinical discourses (Campbell, M.L. and Gregor, F., citing Devault and McCoy, 2002).

2.4 Feminism and Reproductive Health

Returning to feminism in this section, I explore women's socially organized ability to reproduce and continue in the next section by exploring the state-sanctioned means by which we access sexual and reproductive health services. The feminist theoretical approach adopted for this thesis, does not make universal claims for all women, as there is no common standpoint of women (Lorde, A, 1980, p. 2). But the stigmatization that some women in this study ran up against as they sought to regulate their fertilities suggests that there are some institutional and ideological assumptions about women's sexuality held by some pharmacists, government or other social forces. The idea of sexism as a discourse I find is present in the "ideal contraception user" promoted by pharmacists. Sexism, is defined by A. Lorde as "the inherent superiority of one sex over another and thereby the right to dominance..." (Lorde, A., 1980, p. 2). Given the current gendered division of labour related to fertility and reproduction, the neoliberal creep occurs in all aspects of our sexual health work and is also the site of construction of sexism.

Knowledge is situational and social in character and differs based on every person's own history, race, gender, class, age, ability and/or sexuality. There is a need to see the mediated character of these social relations; they shape our oppression and are both autonomous and specific but are also always coordinated "in and through" each other (Frampton et al, 2006 and Bannerji, 1995). This is not to say that all women are different and I hesitate towards a reductionist view as a focus only on differences can tend to dissolve social relations. However, there are real social differences between women and, "refusing to recognize differences makes it impossible to see the different problems and pitfalls facing us as women" (Lorde, A, 1980, p. 1-2). Differential experiences of contraception, fertility and reproduction among women are

historically and materially grounded and those differences continue to influence fertility and reproductive decisions and they shape the availability of contraceptive options to the current day.

Since you and I produce discourse and are active agents in producing the social, I have also located myself in the investigation. This line of rupture or fault is a central research practice of institutional ethnography that starts with the problem in order to expose the social relations mediating these experiences and is reflected by my experience seeking emergency contraception from a pharmacist. Moving towards investigating the social relations of emergency contraception from this line of fault means I am tied to this research, making my reflexive knowledge a central organizing feature of this work.

Reproduction is socially organized and women's connection to reproductive activities is historical and physiological at the same time. "Women's reproductive situation is never the result of biology alone, but of biology mediated by social and cultural organization" (Petchesky, 2008, p. 107). The social relations of physiological reproduction are grounded in historical and material realities and these social relations shift with us as we change social relations. In this way, women can be seen as "conscious agents of reproductive processes" (Petchesky, 1987, ix).

Women's experiences of obtaining emergency contraception reveal a particular construction of the "ideal contraception user", a view promoted by the pharmacists. When the women visit the pharmacies they are influenced by the different ruling relations – the state, pharmacy bodies, pharmaceutical industry, professional organizations – to appear as patient, compliant, and "responsible". This idea of a normative construction of an ideal user against which all behavior is measured is troubling; leading to provider's perceptions of women seeking emergency contraception idealizing certain behaviours and activities over others. Different women I spoke to articulated how these discourses influenced their activities as they confronted the social power relation. As such, emergency contraception was not seen as real contraception

by pharmacists and women had to rationalize their choice to seek the drug. The ideal user meant women had to report a responsible understanding of sexuality and sexual health practices to pharmacists forcing women to articulate notions of being careful and planning for contraception in advance of sex; and ranking abortion as worse than emergency contraception, with the pill and condoms being better than emergency contraception. These discourses influenced women's encounters with pharmacists and are a form of moral regulation which is a part of a larger process of stigmatization.

These ideological discourses like neoliberalism or compliance with biomedical authority are rooted not simply in our minds as a reality, but in institutional practices related to women and sex. For instance, when women go to the pharmacy to get emergency contraception, they are already seeking to reduce the risk of unwanted pregnancy so why the questions about sex and other forms of contraception? How does the construction of the ideal contraception user intersect with sexist ideas about women's behavior? It seems as though this process was set up as state-sanctioned regulation or surveillance by pharmacists and industry thus establishing the seeking of birth control as a punitive practice.

A neoliberal creep is occurring within health service delivery in Canada. The partial de-listing of sexual health counselling and education that occurred under deregulation subtly degrades women and Medicare overtly by downloading provision of health information to private industry and then, forcing women to pay for it.

How are false, and often paternalistic, generalizations about women being perpetuated by the social order, or, ruling regimes? A woman being able to access to emergency contraception reflects her agency and “power to” regulate and control her body in the face of the “power over” or surveillance about sex, menstruation and other contraception by pharmacists (Holloway, J., May 2002 and Holloway, J., 2002). In the “doing” of sexual health work, women can submit to

the clinical gaze, consciously or unconsciously, be partially transformed into moral gatekeepers, arbiters of “responsibility”. An example of this is in ranking certain health behaviours as better than others such as contraception being “better” than abortion.

To summarize, women are different from one another due to differential social experiences of colonialism, violence, poverty experienced by different women. The social is shared, so while gender, sexuality, ability, race and class create different experiences, we all occupy a common social world where privileged and oppressed reside and where social relations come together with differentiating impacts. As Holloway argues, people maintain agency or “power to” do and we all share the world, we can imagine that transformation is possible. What is common between women is that reproduction is individual and social at once and women seek services regardless of legal status or rights, and women maintain individual and social needs to regulate their fertilities.

2.5 Rights, Needs and Freedom

In the introduction to this chapter I outlined that access to contraception exists for women in Canada via state-sanctioned legal means, but as Bridgewater argues, in reality, reproduction exists outside of this legal abstraction (Bridgewater, 2009, p. 404). A reliance on rights may provide for the legal means to access sexual and reproductive health services, but as I will argue in this section, in reality rights do not grant actual services. When thinking about how access to sexual and reproductive health services happens for women, these legal forces do not automatically translate into actual access. A right to the liberty to choose or the right to control one’s body are ideas rooted in the *Charter of Rights and Freedoms* to enable fairness in state policy and practice in health service delivery so as to not deprive individuals of “the right services, the right provider, the right time and the right place” (Kouri, R.P., citing Gosselin v.

Quebec 2002, McLachlin C.J. at 491, in Flood, C.M., Ed., 2006, pp. 147 and 186). The *Charter* outlines the freedoms that individuals living in Canada should expect, and section 7 of the *Charter* reads that, “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice” (Justice Canada, 1982).

Important to this discussion, the *R v Morgentaler* Supreme Court ruling sheds some light on how section 7 rights operate in Canada. As Erdman and Cook identified in their work on the impacts of deregulation of emergency contraception, the ruling speaks to the discrimination of women under the *process-related* aspects of deregulation under the umbrella of an oppressive state. The *Morgentaler* ruling struck down Section 251 of the *Criminal Code of Canada* that entrenched a process developed by health professionals and imposed on women seeking abortions that was similar to the process imposed during the deregulation of emergency contraception. For instance, between 1969 and 1988, when women requested abortion services they were forced to be screened by a committee of health professionals in the hospital against certain eligibility “criteria” (National Abortion Federation, 2010). After answering questions about sex, stage of pregnancy and other invasive and sexist questions, Committee’s of health professionals “approved” of women’s abortions under certain circumstances. These Committees made different decisions for each woman, rendering abortion services inequitably available across Canada. At the same time as these hospital-level committees were restricting access for women, Dr. Morgentaler and his supporters began to open free-standing abortion clinics to subvert these hospital-level institutional restrictions. Abortion clinics opened in different provinces like Quebec, Ontario, Manitoba, Newfoundland and Nova Scotia and women sought services at these clinics rather than hospitals which subverted the hospital screening committees (National Abortion Federation, 2010). As identified by Erdman and Cook, the *Mongentaler*

ruling found that, “procedural access of the provision were held to violate section 7 of the *Charter*. . . ‘state interference with bodily integrity and serious state-imposed psychological stress... constitute a breach of security of the person’ ” (Erdman and Cook in Flood, C.M. 2006 citing [1988] 1 S.C.R. 30 [Morgentaler], p. 176).

Justice Wilson’s concurring opinion in the *Morgentaler* decision provides an expanded interpretation of the ideas of legal rights to liberty in Canada; she sees the rights of individuals as paramount to those of the state and refers to section 2 (a) of the *Charter* to make visible that “this freedom [of individual conscience] belongs to ‘everyone’ ” ([1988] 1 S.C.R. 30 [Morgentaler], p. 176). Individuals should thus enjoy substantive freedom before the state. Justice Wilson cites “the notion of the centrality of individual conscience and the inappropriateness of governmental intervention to compel or to constrain its manifestation” (*Ibid*). Justice Wilson derived her understanding of the individual as not being “totally disconnected...from the society in which they live.” She recognized the socially connected individual in this quote and concluded that the *Charter* guarantees freedom to autonomy over private and intimate decision-making (*Ibid*, p. 171). I use this idea from Justice Wilson’s concurring opinion in the *Morgentaler* ruling to develop the concept of reproductive freedom in the next section.

Reproductive freedom

Feminist theorists like Correa and Petchesky provide a good definition of self-determination, the body is viewed as an essential part of being a person and good health and wellness are needed in order to participate fully in social life (Correa and Petchesky, 1994) and in order to maintain that health, there is a need for substantive equality and freedom. Ideology differs from reality and in reality, formal rights and the framework that is supposed to permit access to health services is often abstracted from the context-dependent and mutually determined character of the social world. For instance, individual rights often leave tangible access to

services open to political coercion and contestation (Petchesky, p. 117). Rights are all encompassing in the *Charter* and other legal means, and operate by presuming that anyone who falls into a particular category, like women, can access the right and have the ability to seek recourse if the right is withheld. Yet political coercion of rights occurs in many ways, and the reality of living in the north may mean that tangible access to emergency contraception could be withheld by a pharmacist, leaving the woman open to unwanted pregnancy. Rights in this situation, with the added complexity of the five-day timeframe for emergency contraception to work, leaves women with little recourse. Another example of political coercion via legal means are exposed by past practices of international population agencies who engaged in forced coercive population “control” activities like forced contraception or sterilization and abortion that targeted certain women on the basis of class, race, sexuality and identity. The same agencies would later contribute to the development of concepts like sexual and reproductive rights. The International Planned Parenthood Federation and other agencies have more recently tied basic human needs as a manifestation of sexual and reproductive rights. What I am really seeking here is to expand the material and social possibilities of choice, that links individual needs with the social, historical and material conditions that have an impact on who chooses and the ability to choose.

The *Charter* is supported by international policy frameworks adopted by Canada like the *International Conference for Population and Development* a consensus statement that adopted sexual and reproductive rights and supported a wide definition of sexual and reproductive health. Petchesky reminds us that “rights are merely the codification of needs”, speaking to the need for substantive equality and freedom required for good sexual and reproductive health (Petchesky, 2000, p. 21). How do we ensure that our social institutions meet these needs? Formal rights are problematized since they do not enable social institutions to meet the material and social

conditions of contraceptive or abortion access. Should we move toward acknowledging that individuals require reproductive freedom, a concept that integrates the right to liberty that remains socially-based?

Rights are based on individualist notions tied to liberal democratic political systems and can be used to extend oppression as they can be taken away or altered. A reliance on human rights does not take into account any obligations beyond the individual, and it is troubling to deny other social forces any responsibility to ensure that the material conditions for freedom in sex and reproduction exist. Furthermore, in practice, there is little recourse if a right to access health services is withheld, particularly for those individuals that are vulnerable. Rights can be obscured or altered by political forces, divergent ideologies, or the ruling relations may not allow all women to access birth control. Finally, a focus on the formal and abstracted character of individual rights render women's ethical decision making, and the social factors that constrain her choices, as moot. Petchesky reminds us that the debate around these issues therefore begins to exclude actual women and their health needs (Petchesky, 1987, p. 7).

A. Smith argues that women obtain choices around reproduction if they can "afford them" and if women are deemed "legitimate choice-makers" (Smith, A., 2005, p. 98-99). Choice operates in the same way as stigmatization and rights can be abstracted from our daily sexual and reproductive lives. Unwanted pregnancy remains an experience shared by women around the world regardless of class, ethnicity, religion, age or legal status and many women share the social *need* to regulate their individual reproductive and sexual lives. While abortion may maintain a different legal status depending on where one lives around the world, women still continue to seek these services, sometimes at great risk. Reproductive freedom moves the definition of rights away from state-sanctioned means to expose sexual and reproductive health as a basic human need, and elevates the primacy of sexual and reproductive health within our daily lives while

acknowledging the social, material and historical conditions within which we exercise these rights.

What about many other ways of understanding the social character of day-to-day life like non-western constructions of connectedness between genders, ages and identities or holism, and obligations outside of the individual (Bulbeck, 1999)? There are social forces beyond an autonomous individual where an individual maintains the basic human need that requires the freedom to control one's fertility and reproduction. Another problem with rights is that they cannot be extended to mount a challenge to the social constructions and limitations of the gendered division of labour with pregnancy and childbirth remaining the primary domain of women. Rights do not allow for the social activism that can change the conditions and subsequent responsibilities of pregnancy and childbirth. The abstracted character of sexual and reproductive rights remains so in Canada, where, for instance, abortion and contraceptive accessibility differs by region, and place of residence in spite of the right to liberty that exists to procure emergency contraception. For emergency contraception, the right to access the drug existed nationally, and in reality access was unequal for women as different provinces had shifted rights to obtain the drug to pharmacists before others.

The clinical and government activities make women's experiences in reproduction a women's-only domain, because of history and social forces and not simply biology. Women do not all maintain the inherent ability to reproduce and society has changed from the past and contraception, child birth and raising children are no longer the exclusive domains of women but often still are given the gendered division of labour. Reproduction is socially based and determined by changing material conditions that include ruling relations, and the discourses that shape the right to access emergency contraception. Thus, the ethics around choice, who chooses, access, barriers and systems that should function to enable access, reveal that a woman maintains

the individual need to maintain power over her body while at the same time relying on socially shared material conditions – pharmacists, doctors, governments, pharmacist organizations - by which to exercise that power. Do we not live in a place that has some sort of duty to ensure women can exercise this self-determination? In other words, broadening access to sexual and reproductive health services from a rights-based discourse to one that recognizes that women make decisions around their individual unwanted pregnancy in a socially-shared world, individual and social obligations for reproductive freedom may allow for more access and furthermore, may permit people to identify the social forces that shape access.

Summary

Rights are a formal means by which people enjoy the liberty to control their bodies; and yet rights are abstracted from our daily lives and do not grant access to actual health services. Rights enable some form of recourse to be pursued by individuals in courtrooms; but in the case of emergency contraception, if access is denied, the drug has less of a chance of reducing the risk of unwanted pregnancy. Institutional ethnography provides the means by which to uncover the ruling relations that shape women's sexual health work and is a solid organizing theoretical perspective for this work. Change can occur from the ground up since agency is within each of us and we all have “power-to”, (Holloway, J) even though we do not have equal agency, since it is mediated by race, class, gender, sexuality, age, ability and history. Agency can also be social and collective since people are active agents in producing the social. Expanding an understanding of work to include those broader activities related to maintaining one's health enables me to identify activities that may be influenced by ruling ideological discourses that may remain invisible by using conventional definitions of “paid” work. Sexuality, gender and reproduction are socially constructed and the body is individual and social at once. Since the body is needed to fully

participate in social life, it is social, which contradicts the notion of bodily autonomy, as it is present in current discourses around human rights. A rights discourse will not provide a solution that will transform the social relations of reproduction since they are derived from a specific time and place, and political systems as well as being embedded with notions of individuality. Women and men should have a right to power over their social bodies. They also have a social need to control their reproduction.

A reliance on rights may provide for the legal means to access sexual and reproductive health services, but as I have argued, in reality, rights remain open to political coercion and contestation. In *R. v. Morgentaler*, Justice Wilson's concurring opinion proposed that freedom resides in individuals to be able to make personal decisions outside of state oppression. Thus, women should be able to exercise freedom in reproduction rooted in their basic human needs to live, outside of state-sanctioned legal abstractions, like rights. I argued that this freedom exists within all of us, like agency, because a common feature of being a woman is the shared need to control one's body. Neoliberalism is a powerful discourse visible in different facets of health service delivery in Canada, and within the process of deregulation, in many forms. Neoliberalism's creep to privatize services previously provided by the state has meant the Medicare system is being taken apart, piece-by-piece. The de-listing of sexual health counselling for emergency contraception from physician's duties is but one aspect of neoliberalism's creep into state-provided health care.

Chapter 3

3 Inequality and the Problem of Women's Sexuality

This chapter explores literature related to women and sex and the introduction of emergency contraception in Canada. Building on the work in the previous chapter, where I identified some of the ruling relations related to contraceptive access, in this chapter I develop the idea that emergency contraception has a “problematic” status which is reinforced by anti-choice discourses, health professionals’ perception of the drug and the corresponding stigmatization of women who use it.

In the late 1990s and early 2000s, research was emerging that attested to the ease and effectiveness of women self-administering emergency contraception (Grimes et al., 2001; Ellertson, C, Shochet, T et al. 2000; Fairhurst, K, Ziebland, S 2004; Glasier, A, Baird, D 1998; Trussell J, et al, 2001). The terrain within which the deregulation of emergency contraception occurred is influenced by the embittered and taboo history of female sexuality and contraception. This history is informed by a familial ideology where reproduction and childrearing, while socially constructed, remains the domain of women in the gendered division of labour. In light of this history, what led government and pharmacist organizations to limit non-prescription access to emergency contraception to behind-the-counter? Moving forward, I review some of the literature related to: the historical and material discourses that coordinate contraceptive access; the role of the pharmacist in the health division of labour; pharmacists’ knowledge and perceptions of emergency contraception; and the social relations of stigmatization related to women’s sexuality and emergency contraception use. Lastly, I look at the results of

projects in British Columbia and Ontario that tested the pharmacist provision of emergency contraception using different models to understand the specific activities that informed the deregulation of emergency contraception.

3.1 Historical and Material Conditions of Contraception

Who controls access to emergency contraception remains a major issue of power and surveillance for women in Canada. Regarding the deregulation of emergency contraception, it has been suggested that this history be regarded as one of conflict between women and health professionals (Barrett and Harper, 2000 and Hawkes, 1995), where the medical establishment, even once the restrictions have been lifted on the medication, still seeks some sort of control over its distribution (Ziebland, S, 1999, 1410). The deregulation experience in Canada certainly reflects this reality.

It is essential to discuss the historical and social character of contraception since this clarifies the historically-based moral regulation and surveillance of women's encounters with the clinical gaze and stigmatization of women who use emergency contraception. Around the time that the birth control pill came into use in the mid 20th century, there were many fears that contraception would lead to “unregulated” sexual activity in women since women did not have to plan to use contraception in advance and could engage in spontaneous heterosexual sex for pleasure (Marks, 2001, pp. 3-4 and 41-42).

The early proponents of birth control in the 1900s were white, middle class “reformers” whose perspectives were imbued with racism and classism. Arguments around population control were mounted for “certain kinds” of people, mostly those who were poor and outside of the white middle-class; this idea of population control for specific groups were influenced by Malthusians, social Darwinists and later, eugenicists (Ziebland, 1999, p. 1410 and Marks, L, 2001, p. 26-27).

After World War II, the United Nations Population Fund, International Planned Parenthood Federation and the Population Council, all part of the ideologically rooted population discourse, conducted activities to decrease the population of the “Third World” which contributed to shoring up a system of neocolonialism for people living in poverty and people of colour within Canada and the US and between European and North American countries and the rest of the world. During the Cold War, these newly formed population organizations developed the idea that the overpopulation of the “third world” was the reason for its economic decline, tying population control discourses to national security (Goldberg, 2009, p. 5). Indeed, if the Cold War period was intended to control liberation movements in the “Third World” (Kinsman, G, et al., p. 2010, p. 23) by different means, then population control within North America and beyond can be viewed as one tactic by which to control the “exploding” population of people living in poverty.

Following this, contraception can be seen as being used as a threat or tool against different groups of people as part of state formation. This occurred by distributing or “testing” different forms of birth control that were sometimes expired and/or dangerous, or still being developed so women were experimented upon with new contraceptive methods, sterilization and some cases of coerced abortion (Smith, A, 2005, p. 100-103 and Marks, L, 2001, p. 23-28) at the hands of the state and/or these new forms of social organization. Given these historical roots of family planning in attempting to “control” what was seen as a burgeoning “lower class” in the West and an exploding population in the “Third World”, it seems obvious, but worth stating, that there is a gendered, racist and class-based character to the family planning movement over the 20th century. Currently, different perspectives on contraception are largely due to this differential, historical impact of population policies on different women.

The development of oral contraception in North America was controversial from the beginning with outright reluctance from the pharmaceutical industry associated with sex and reproduction. For instance in the early 1950s, scientists approached the company Searle to assist with funds to develop the oral pill. Searle refused to participate in the contraceptive project in order to safeguard the company's reputation. At the same time, Goodyear Rubber, while making \$150 million off of the production of condoms would not associate the company brand with contraception either (Marks, L., 2001, p. 35). Both companies were fearful of the economic, social and economic reprisal from the Catholic Church and other religious forces. This fear of early anti-choice opposition hindered the development of the pill as other drug companies like Parke-Davis and Pfizer also refused to assist in procuring synthetic hormones or in manufacturing the drug due to outright opposition from male, Catholic executives working in those companies (Marks, L., 2001, p. 35).

The reluctance of the pharmaceutical industry in the 1950s and 1960s to be associated with the development of oral contraceptives for fear of religious or anti-choice reprisal was repeated again in the 1990s with the development of emergency contraception. Over the preceding three decades, some doctors knew they could create emergency contraception by combining multiple doses of oral contraceptives to be taken at once (Page, C., 2006, p. 49). Before 1994, many countries were producing and marketing forms of emergency contraception but the drug was not available to women in North America. In 1994, the Centre for Reproductive Law and Policy had to "file a Citizen's Petition requesting the FDA [Food and Drug Administration] declare emergency contraception safe and effective" (*Ibid*, p. 100). By 1997, with no companies manufacturing emergency contraception, the Food and Drug Administration in the US, took unprecedented action by publishing a notice about the relative safety of concentrated doses of oral contraceptives. Still, by 1998, no company had come forward to

manufacture and market emergency contraception, despite dozens being approached (Sessions, 2004), including some of the same companies that produced the birth control pill. So, a number of pro-choice organizations banded together to establish Women's Capital Corporation to market emergency contraception in Canada and the US (Page, C, 2006, p. 103). By 2003, Women's Capital Corporation had filed requests to move emergency contraception to women over-the-counter at the American Food and Drug Administration (*Ibid*) and to the National Association of Pharmacy Regulatory Authority in Canada (NAPRA, NDSAC Meeting Minutes, November 2001). Later in 2003, Barr Pharmaceuticals purchased Women's Capital Corporation.

Anti-choice forces developed from this early opposition to contraception. Not only are these discourses anti-abortion, they widened the ideological discourse to be against forms of contraception and emergency contraception provided a new area to make this argument by equating emergency contraception with abortion.

3.2 Biomedical Power and Moral Regulation: Pharmacists' Knowledge of Emergency Contraception

Clinical gaze

Purchasing medicine at a pharmacy is a mundane, everyday occurrence and it represents an important relationship within the health care system. The authority wielded by health professionals depends upon the expertise of a specialist body of knowledge that serves to legitimate their social position (Edmunds & Calnan, 2001, p. 943). This commercial transaction to treat ailments enables people to engage in self-care with the advice of medical professionals and represents consumerism within the health system in Canada.

Over the second part of the twentieth century, the pharmacist's role working at a community pharmacy, and in Canada, there may only be one in rural communities, or none, has

shifted somewhat. This is due to the pharmaceutical industry's development of original pack dispensing, which has reduced the need to mix medications behind-the-counter. This left pharmacists with a lesser role as a legitimate health profession within the health division of labour (*Ibid*, p. 945-7 and Hibbert, Bissell & Ward, 2002). Thus, the deregulation of medicine provided some space for pharmacists to re-assert their legitimacy within the health field by assuming new roles or areas of work.

Around the world and in Canada, national pharmacy bodies have taken up the professionalizing rhetoric and have sought to enhance the pharmacists' role as gatekeepers that consumers must interact with in order to access medicines. In Canada, the structured, textually mediated interaction between pharmacist and woman that the deregulation of emergency contraception established sets up pharmacists as the expert educator and counsellor. This reinforces the notion that pharmacists are carving out a role for themselves in women's health service delivery and establishing legitimacy as assessors of unprotected sex and educators on contraception and sexually transmitted infections and creating a functional role of referring women to a physician.

Some literature from the UK and the US explored the different normative perspectives and resulting moral regulation by doctors and pharmacists that are similar to the experiences of the women I spoke with. Research suggested that pharmacists and physicians in Europe and the US knew about emergency contraception, but had different reservations in providing it to women (Kaiser Family Foundation, 1997; Deblanco et al, 1997; Blanchard, 1998). In the years preceding the period of deregulation in Canada, emergency contraception was being underused in different countries due to a lack of information and misinformation about the drug on the part of health providers (Kettyle and Klima, 2002, p. 68). Many providers were confused about the way emergency contraception worked on a woman's body, perhaps contributing to the stigmatization

of the women who use the drug. One study in Michigan found that 62 percent of health professionals agreed that emergency contraception is a form of contraception, while 20 percent thought that emergency contraception is an “abortion-inducing agent” (Brown and Boulton, 1999). Several of the respondents suggested that emergency contraception was often confused with abortion and its provision was constrained and informed by the debate around abortion. One health professional stated that the reason why her clinic did not provide emergency contraception was because of “Politics. People may see this as an abortion issue” (Brown and Boulton, 1999).

A. Glasier’s widely cited 1997 study unequivocally rejects the view that that emergency contraception works after the egg has been fertilized and stated that the drug works by “interfering with ovulation, [and thus]… cannot be regarded as an abortifacient” (A. Glasier et al, 1997, p. 1063).

Ziebland suggested some providers were uncomfortable discussing sexuality as it relates to contraception and this awkwardness about women’s sexuality guides clinical interactions (Ziebland, S., 1999, p. 1416). Zielband challenged this notion and indicated that health professionals “resort to medical rather than moral discourse” (*Ibid*) to frame emergency contraception as a harmful, long-term contraceptive. Another study found physicians felt it was inappropriate to offer emergency contraception during a visit about other health matters (Fairhurst et al., 2004). These studies suggest some deeply rooted problems the medical establishment has with emergency contraception and women’s sexuality.

Studies produced in the period before deregulation of emergency contraception in Canada suggest that health professionals in Europe and the US had high levels of knowledge about emergency contraception, but had different reservations in providing it to women. A 1997 Kaiser Family Foundation survey indicates that almost all (98 – 100 percent) of providers thought that emergency contraception was safe and effective; yet only 10 percent said that they communicate

information about this method with clients (Delbanco et al, 1997). Much of the research was dominated by views that argue that if women and providers knew more about emergency contraception, it would lead to increased use. Ziebland argued that providers are simply uncomfortable discussing sexuality and contraceptives in their clinical practices and in the next section, I examine the social relations of stigmatization of women who use emergency contraception by health professionals.

Moral regulation

Emergency contraception has a contentious status based on social and historical struggles over women's need to control their bodies that informs the anti-choice discourse and has contributed to the drug's association with abortion and confusion about its use. The "problem" of irresponsible use of emergency contraception, is extended to those who use emergency contraception repeatedly or request it when they are young. This type of paternalistic ignorance can shape the interaction between a woman and the pharmacist and may affect if, how and why a woman got the drug, or if she gets pregnant. I identify this sort of social relation as moral regulation that is mediated by pharmacists' "power over" women and their status as the clinical authority. Moral regulation is a term that references the social relations "that involve a continuous, coercive suppression of some identities and forms of life and the encouragement and enhancement of preferred forms" (Hunt, 1999, p. 15-16 and Brock, D., 2003, 57-59).

As mentioned, health professionals may rely on their biomedical power by using a medical discourse to build legitimacy to identifying the underlying moral "problems" with women requesting emergency contraception. Research indicated that pharmacists did not provide emergency contraception when it was requested and age was a factor that providers took into account when responding to requests for emergency contraception. A pharmacist in a 2003 study reported that she would not supply emergency contraception to a girl who said she was 10 years

old as she, “found it quite shocking” (Bissell and Anderson, 2003, p. 2373) and referred the girl to a sexual health clinic nearby. Age was a point for debate more recently in 2006 in the US when emergency contraception was deregulated for those aged 18 and over. The politically appointed Food and Drug Administration (FDA) Chair over ruled the clinical advice of the FDA and attempted to limit access to those 16 years of age and younger. Another study revealed that providers saw offering advanced supplies of emergency contraception as akin to condoning “promiscuity” and being young and wanting it was especially problematic:

It’s a very middle class practice and women here are very well aware what they should do and shouldn’t do. Which is not to say they don’t have accidents like everybody else and they would come along. But they’re not your 15/16 year olds with the high pregnancy rate (Fairhurst, et al., 2004).

Another study found that when physicians and pharmacists were asked about offering emergency contraception over-the-counter, they had negative attitudes toward deregulation. This stance was not reflected by the policy statements of the responsible professional bodies and instead was rooted in sexist ideas about women. Specifically, according to these health professionals, women “are sexually irresponsible, chaotic and devious” (Barrett & Harper, 2000, p. 202-204). The same research suggested that the deregulation of emergency contraception would lead to “sexual excess”. Another study found that pharmacists suggested that if pharmacies supplied emergency contraception, it may lead to an increased frequency of unprotected sexual intercourse (Bissell and Anderson, 2003). These pharmacists were also concerned that the increased availability of emergency contraception may lead to an increase in sexually transmitted infections since women would not use barrier methods of contraception (*Ibid*). These notions represent a gendered, sexist double-standard and frame women as uninformed and promiscuous. The assumption that women will do anything to obtain emergency contraception, including engaging in devious behaviour, conveys rhetoric about an insatiable woman.

In a study from 2003, health professionals used the words “responsible” and “irresponsible” to frame emergency contraception requests and some of the women in this thesis experienced similar forms of regulation. “Irresponsible” requests were seen as those who used emergency contraception repeatedly, with little regard for having had unprotected sex and not planning in advance (Bissell & Anderson, 2003). Deregulation and increased access to emergency contraception, was characterized as increasing the likelihood of irresponsible behavior - revealing a responsibility/irresponsibility binary - and the drug should not be used as a reliable form of contraception.

Other research has shown that emergency contraception use does not correspond with increased risk of infection or pregnancy (Sander, P., Raymond et al, 2009, p. 149) nor does it lead to a decreased likelihood of engaging in preventative contraceptive behaviours (Brown and Boulton, 1999). In the late 1990s and early 2000s, there was confusion about the mechanism of action of the drug on the part of both women and providers suggests that the stigmatization is rooted in ignorance and underlying sexist assumptions about women and sex, linking emergency contraception with abortion, because both happen after sex.

Regarding constructing emergency contraception as “risky”, some health professionals in the US began to criticize that the side effects and contraindications included on the early American and Canadian approved rug labels were misleading as the governments conflated the side effects for emergency contraception with those listed for oral contraception (Grimes et al., 2001). Grimes suggested that these drugs have different amounts of hormones and patterns of use. By adopting the same contraindications as oral contraceptives, emergency contraception was being constructed as dangerous requiring professional oversight for accountability. By framing pharmacists as the clinical authority that makes the case to tie access to mandatory screening and counselling. Since taking emergency contraception does not interfere with an already established

pregnancy, rather operating so as to prevent fertilization, the same study rejected the idea that women require a health professional's advice to determine if she was currently pregnant or had unprotected intercourse (Grimes et al, 2001, p. 152).

A broader theme that emerged is how pharmacists felt they had the right to ask a woman about her sex life. Health professionals embedded any request for emergency contraception as warranting a discussion about sexuality and sexual health. This simple request coordinates subtle and not-so-subtle forms of stigmatization. Broader messages relating to the social ordering of female sexuality is implicit in this construction of a woman who uses emergency contraception repeatedly as irresponsible, devious and excessive who has “risky”, spontaneous sex. An ideal contraception user is a woman who is responsible and complies with the norm of using regular contraception. Thus, one of the key contributions of neoliberalism to access to emergency contraception is the formulation of gender identity in opposition to the biomedical authority. By this I mean, gender and the social and material features and conditions that frame women and men, are not considered relevant to the expansion of capitalism; thus, gender challenges the homogeneous goals of neoliberalism. Neoliberalism asks for conformity and uniformity and gender becomes problematic in this regard. By reviewing the pilot studies conducted in Canada in the next section, some facets of the social relations of access to emergency contraception behind-the-counter are made visible.

3.3 Inequality of Access to Emergency Contraception in Canada

Emergency contraception was available unequally to different women in different parts of Canada between 2001 and 2005 since Saskatchewan, BC and Quebec had all changed conditions of access to be under the supervision of a pharmacist. When Health Canada began to develop the rationale to change the status of emergency contraception to behind-the-counter, it identified this

inequality of access as one of the main justifications. It is reasonable to expect access to emergency contraception regardless of being a citizen or non-citizen since the freedom resides within socially grounded individuals as I established in the previous chapter. Universal access remains one of Medicare's five governing principles (Whiteside, 2011, p. 258) and impeding access in small towns or remote areas of Canada makes refusals to dispense unethical due to the harm caused to women. Women should be freely informed with accurate health information about emergency contraception by the state that would require fairness in health delivery and placing greater importance on women's good health. Some studies were published examining these early oversight arrangements in BC and Ontario between pharmacists and doctors that enabled behind-the-counter access to emergency contraception before the federal shift in legislation. While BC had already approved prescriptive authority for pharmacists at the provincial level, Ontario's project was conducted in a legislative vacuum of theoretical rights versus practical access, with neither federal nor provincial authority to provide the drug through pharmacists. Many of the features of these early arrangements reveal restrictive practices experienced under deregulation like surveillance, lack of privacy or confidentiality and increased costs for women and these will be discussed in the following section.

J. Soon et al. (2002) reviewed how BC deregulated access to emergency contraception through different oversight arrangements with the pharmacy or physician regulatory body (Soon, J. et al., 2002, p. 605). In 2000, certified pharmacists were allowed to prescribe emergency contraception to any woman regardless of age, to be used at that time or in the future. "Informed consent" was obtained during the "intake screening session" and the pharmacist was encouraged to refer the woman to a physician for other forms of birth control and/or sexually transmitted infection screening, or to other community services.

The research on the BC pilot project outlined the kinds of activities pharmacists engaged in to screen women “who met criteria for emergency contraception” (Soon, J et al, 2005, p. 879). Women in BC underwent a 15 minute standardized interview with the pharmacist and consented to information collection on a treatment form (Soon, J et al, 2005, p. 879). The types of information collected by pharmacists about women included: whether the drug was to be used right away or in the future, the timing of her last menstrual cycle, time of unprotected sex and her age. Pharmacists were coached to note the date and time of the request, the pharmacy where the drug was provided, the identity of the pharmacist, the type of emergency contraception that was provided and whether anti-nausea medication was offered. When referrals to physicians or other community services were made, pharmacists noted this as well (*Ibid*, p. 879-880).

In Ontario, another study discussed the early models for obtaining emergency contraception in 2003 with arrangements negotiated between pharmacists and doctors (Dunn, S, Brown, T et al, 2003, p. 879). An “eligibility intake questionnaire” used by pharmacists to determine a woman’s indications and collected information on side effects commonly associated with the long-term use of oral contraceptives, like blood clots, strokes, heart attacks or angina, that have not been associated with emergency contraception. These side effects are not linked to emergency contraception due to different patterns of use (Grimes et al, 2001). The questionnaire screened women about “preexisting pregnancy” by asking questions about the date of the women’s menstrual cycle, if she had had a normal period or if her period was overdue. The next category included “determining at-risk activity” like having had sex in the previous three days, despite the fact that emergency contraception is effective for use up to 5 days after sex, and there is no reason to ask a woman to give a reason for needing the drug. The suggested “correct” answer included on the form being “an appropriate reason.” The form attempted to see if women

wanted a referral to a physician to speak about birth control or sexually transmitted infections (Dunn, S, Brown, T, 2002, p. 926-928). The vast majority, 77.6 per cent of women, were provided with Plan B™. In the client satisfaction survey that was completed by 20 per cent of the women, the majority found the process easy and another 42.7 per cent found emergency contraception expensive (Ibid, 928).

A second study in BC examined the same arrangements of pharmacist's providing emergency contraception after pharmacist deregulation and measured the change in use of as compared with physician prescription. By 2002, the number of doses of emergency contraception increased by 102 per cent relative to the average doses provided in the five-year period before deregulation (Soon, J et al., 2005, p. 878). Overall the Ontario project provided more prescriptions for emergency contraception than the BC project over the same period and Dunn found two reasons for this. First, Ontario had a marketing campaign on direct pharmacy access and second, the medication was less expensive in Ontario. The project kept the costs of each medication the same as through physician prescription at \$30 for Plan B™, and \$15 for the Yupze method without insurance (Dunn, S and Brown, T, et al., citing Task Force on Postovulatory Methods of Fertility Regulation, 1998). In BC women paid for the pharmacist's professional fee for assessment and counselling that cost \$25 as well as the actual cost to purchase the medication. In Ontario, costs ranged from \$2 with insurance coverage to \$30 for the more expensive levonorgestrel method without insurance. Women did not pay extra for counselling (Ibid, p. 928). Women in BC who obtained emergency contraception paid the cost of the medication, the pharmacist dispensing fee of \$5 and a "pharmacist counselling fee" of \$16 (Soon, J et al., 2002, p. 605). In Ontario, the Yupze method was chosen more frequently (40 per cent) that had a reduced cost of \$15 than the levonorgestrel method at a price of \$30.

In BC, the project identified women with low incomes, through their eligibility for provincial drug benefits coverage through social services or the provincial drug plan and analyzed their choices in requesting emergency contraception. More women with the greatest financial need obtained their prescription from a physician over a pharmacist (33.6 per cent over 21.5 per cent) and the BC Medical Services Plan paid for appointments with the doctor for the drug making the drug cheaper.

What emerges from these pilot projects during these early phases of deregulation is the development of the initial eligibility standards that women had to meet in order to get emergency contraception. This included pushing forward the idea that emergency contraception had significant side effects that required professional oversight from which pharmacists would derive increased clinical authority. Within both intake questionnaires, repeat users and young women were problematized, and treated as “difficult cases” requiring referrals to a physician. Emergency contraception was viewed by health professionals in BC and Ontario examples as a last resort even though little evidence has shown that women can take it regularly. The construction of the ideal, responsible contraception user who complies with medical advice began to emerge out of these early pilot projects and were extended under deregulation arrangements in 2005 to 2008.

Privacy and confidentiality were identified as concerns by women in a 2005 *Canadian Medical Association Journal* editorial that discussed access to levonorgestrel under the context of deregulation. A separate evaluation of pharmacist provision of levonorgestrel revealed that women are primarily concerned with these issues (*Canadian Medical Association Journal Editorial*, 2005, p.845-847 and Cohen, M, Dunn, S et al, 2004, p. 28). Indeed, women’s access under deregulation occurred in a more publicly visible terrain, and within a for-profit health service delivery model. Further, upon receiving a wider scope of practice within women’s health

delivery, pharmacy professional associations created forms and other tools for screening and information gathering by pharmacists that were in use for about a year before being phased out. One of these forms is included in this research and analyzed in Chapter Four.

As demonstrated in the research outlined earlier, cost was a barrier to emergency contraception access, particularly since emergency contraception access shifted to be available through a for-profit institution. There is a charge for levonorgestrel in every province and territory, with the exception of Quebec, which offers it to some women free of charge, including those on social assistance, students under 25 years of age and women under the age of 18 and the costs vary anywhere from \$30 to \$50 (Canadian Federation for Sexual Health. No Date).

Summary

This chapter has explored some of the literature related to the historical, material and social conditions related to emergency contraception. From this discussion, I identified that women experienced different modes of access to emergency contraception in Canada prior to deregulation and early research indicated that cost and issues related to privacy and confidentiality formed barriers to access. From this, I explored some of the early research on pilot projects in Ontario and BC that occurred before the deregulation of emergency contraception. Social relations identified in these projects included the portrayal of pharmacists as the new clinical authority on women's health, being able to assess serious (albeit unrelated) side effects for oral contraceptives, to determine if women had unprotected heterosexual intercourse or if they were pregnant by analyzing their menstrual cycles. These early conceptions of "eligibility requirements" develop pharmacists as the clinical authority to provide women with emergency contraception and likely informed the tools used later by corporate pharmacies during deregulation, including the screening form I analyze later in this work. External research shows

that health providers engage in the social relation of stigmatization of users of emergency contraception for various reasons. In all, they have contributed to a conception of an idealized contraceptive user, who engages in responsible behaviour and complies with health advice. “Irresponsible” users were those that used emergency contraception more than once or more than as a last resort, did not use other forms of contraception, were young, or lacked the ability to position herself with the social standing so as to be able to perform herself as “responsible”.

Chapter 4

4 Social Relations of Women and Emergency Contraception

This section of the thesis describes women's experiences in seeking emergency contraception during the three-year period of deregulation when the drug went behind-the-counter. As I mentioned, sexual health work is used as a term to describe the range of activities women engaged in, and I will continue to develop the concept as my analysis of the social relations of access progresses over this chapter (Mykhalovskkiy, E and L. McCoy, 2002, p. 24). I captured women's experiences to further develop the idea that women continue to be marginalized, in subtle and not-so-subtle ways, by the steady creep of neoliberalism in health service provision. I also explore the social relations and ideological practices present in the interaction between a woman and the pharmacist. This brings into view forms of sexual health work that align with, or rupture with, the compliance and related clinical-authority discourses, or "following" medical instructions from a professional expert. In a preceding section, I identified some of the ideological discourses that inform the historical, material and social contexts that mediate women's access to emergency contraception under deregulation.

While none of the women that I spoke to were aware of the minute details regarding the pharmacists' role in compulsory education and screening, all their social experiences were shaped by the larger institutional order that contributed to the conditions at point of sale for emergency contraception. After transcribing each interview, I identified ways that women's stories had common activities within them or had other points of connection or intersection as well as points of disjunction or difference. I also examined the ways through which women spoke about looking

after their health, and how these activities were tied to the ruling discourses in a sequential fashion about health and women's sexuality. In this chapter, I discuss the practical means of access – time, costs of the drug, women's reasons for taking emergency contraception, wait times, "eligibility" or screening for unprotected sex and side effects and sources of the social relations of stigmatization. Finally, I analyze the bureaucratic texts like screening forms, informed consent and privacy.

4.1 Substantive Means of Access

Reasons women needed emergency contraception

All of the women I spoke to were straight-forward in their reasons as to why they sought emergency contraception. Six of the eight women were using other forms of contraception and when asked why they needed emergency contraception, the reasons were all different. The same women used emergency contraception more than once and these women spoke about the recent instances when they needed emergency contraception. Six women indicated they needed the drug due to other contraceptive failure and did not rely on emergency contraception as a regular form of birth control. In terms of the type of birth control that failed, four of the women had a condom break during sex and another was on the pill, "I wasn't taking my pill correctly and there was a chance I might be pregnant" (Debbie). Another woman was on the contraceptive patch and found it strong so she stopped using it and needed emergency contraception for back up protection against unwanted pregnancy. The last two women did not use other forms of contraception: one decided to try to get pregnant and had second thoughts the next day; the last woman wanted to have sex and did not have contraception at the time so used emergency contraception the following day: "Pretty much one of those heat of the moment [situations where], no protection used..." (Francis). Regarding changing her mind about wanting children, Maye explained, "It is a

little bit embarrassing, it is because me and my boyfriend got drunk and we decided for one evening we wanted to have kids and then I changed my mind” (Maye). Another woman who had the condom break said, “I am constantly worried about being knocked up, even though I’m using birth control, it is just a paranoia...so it was a paranoia fueled visit” (Roberta).

With regards to the women interviewed for this study, most were seeking emergency contraception because the condom broke and they needed the drug as a preventative measure to reduce the risk of unwanted pregnancy. With one exception, every woman knew how to use emergency contraception and that they needed to use it quickly. In the research produced in the period leading up to deregulation that I outlined in Chapter Three, it was suggested that some health professionals make assumptions about client’s sexual behaviour when they are requesting emergency contraception. Responding to some of the generalizations about women from the literature in the previous chapter, the increased availability of the drug did not factor into any of these women’s decisions to have sex, use other forms of contraception or that emergency contraception was a form of birth control to rely upon regularly, even though it could be. Condoms were used most frequently and the majority of women used these means to prevent unintended pregnancy and the prevention of sexually transmitted infections. For these eight women, none of the generalizations about the increased availability of emergency contraception in some of the literature I reviewed were true. Where do these beliefs come from?

Making the decision to use of emergency contraception tended to be predicated on a need, at the time, for the woman. Decisions women made were impulsive determining a risk of pregnancy immediately, driven by anxiety, stress or fear. One woman reflected that she could go ahead and enjoy sex because the drug was there to use afterwards. Stigmatization or the potential for different forms of surveillance were mediated by women through their choices about what pharmacy to go to, what pharmacist was working, language of service or being open 24 hours a

day. One woman decided not to claim the cost of the drug through insurance, preferring to pay rather than having her boss find out she was using emergency contraception. When asked why, Maye said she was embarrassed and uncomfortable discussing her decision-making around having children and being viewed as “immature” by her employer.

Deciding to take emergency contraception and getting to the pharmacy

Regarding where women went to get emergency contraception, all went to Shopper’s Drug Marts in Ontario, except one woman who went to the pharmacy counter in a chain grocery store, Loblaw’s. The timing of their visits was different in each case; and, most cited the pharmacy’s long operating hours as being helpful in obtaining emergency contraception. All of the women knew about emergency contraception being available at the pharmacy and seven of the eight women interviewed had used the drug before, with a few more than twice.

Choosing which pharmacy to go to was the third step in the sexual health work of emergency contraception and there were different reasons why women chose a specific pharmacy: proximity, type of transportation available, language of service, comfort with the practicing pharmacist and hours of service. Convenience of the location, language of service and the pharmacy operating hours or an easy relationship with a pharmacist factored into women’s decisions. Two women chose pharmacies where they could access services in French.

Getting to and from the pharmacy was an issue for all of the women and the issue of being pressed for time was a common one. Given the 72-hour window to use the drug, and the resulting urgent situations women experienced after determining they had unprotected sex and were at risk for unwanted pregnancy, the issue of time was a central coordinating relation against which all activities were organized. Any barriers women faced in obtaining the drug contributed to the drug’s diminished effectiveness and any long wait time for women was a harmful practice.

While no one had access to their own car, all the women got to the pharmacy in different ways, taking into account time, proximity and comfort with the services. For instance, one woman began to strategize about getting to a pharmacy right after sex, “it wasn’t even unprotected sex, the condom ripped, so right there from the point that it happened, I gotta go, I know what I gotta do, I’ll see you when I get back. I knew how to get it, the time, and how it worked” (Diana). She chose the pharmacy because she could receive service in French. Another took a cab to a pharmacy to a different neighborhood as she knew they were bilingual. Another woman walked to a pharmacy specifically to visit a pharmacist she knew well, “Even now, if I have some sort of personal concern, I would probably travel to the other end [of the city] and go seek her out.”

(Francis)

One woman had to take two buses since it was during the weekend and nothing was open nearby. Two women rode their bikes, one with her boyfriend for a half an hour to a 24-hour pharmacy in another part of the city at 4 a.m. Another woman needed her boyfriend to go to the pharmacy for her as she did not have time to before she had to go to work. “So yea he was supposed to get it and he went and they wouldn’t give it to him; we never really talked much about it because I was so pissed off about the whole thing, I mean you only have certain hours to take these things.” Lastly, a woman relied on a friend for a ride which caused her to feel guilty while her friend waited as the woman had significant wait times. She strategized about what to tell her friend as she initially concealed her reason for a pharmacy visit. I think this illustrates some of the dilemmas women face when seeking emergency contraception – even if privacy about using the drug was desired, it may not be possible as the ride to the pharmacy required asking for some assistance or concealing her activities from her friend.

Three women sought out pharmacists that they had a friendly relationship with or chose a location for services in their first language, where they could articulate their request clearly. A

lack of transportation for all of the women did not inhibit access; it simply made women think about how to get to the pharmacy as an activity of their sexual health work. Time was an organizing feature of decision making in multiple ways because of diminished effectiveness of the drug like strategizing immediately after sex about how to get to the pharmacy quickly, asking a friend for a ride, or using a bike. Lastly, a couple of women returned to the same pharmacy where they had a difficult time procuring supplies before, implying defiance with regards to the surveillance or stigmatization they experienced. These experiences will be discussed later in this chapter.

Knowledge about behind-the-counter access

Women conveyed two different types of knowledge about emergency contraception; on the one hand, they discussed their understanding of how it worked on their body and, the other about how they knew they could obtain it through a pharmacist. Four of the women listed specific ways they came to know about emergency contraception and where they could acquire it: from advertising on TV or the internet, at the pharmacy, a family member, or a public health nurse working in the education system. One woman noted she heard about it from TV advertisements and relayed clinical knowledge about when and how to take emergency contraception,

...from what I've heard it pretty much has the effect of taking a bunch of birth control pills at the same time. It can cause nausea and ... is most effective in the first 72 hours.
(Francis)

The same woman spoke about how she trusted its effectiveness and that the directions provided by the manufacturer were clear and easy to understand:

Yes. You take one right away and then you take one 24 hours later; they are pretty specific in their directions. I mean there are only 2 pills, right, so I think most people can understand that. (Francis)

Another woman first learned about emergency contraception in another country, where she attended secondary school. She contrasted the information relayed in France against her experience of contraceptive education in Canada:

[In France, they] really educate you... they don't make it look like a shame that they make you feel like you just did the right thing. If you might be pregnant they say, do you want to be pregnant or do you not want to be...and if you don't want to be then don't take the chance, take the pill. And protect yourself still ... (Diana)

All of the women that were interviewed thought that the directions included with emergency contraception about when and how to take the drug were clear except three individuals. The first woman was scared because she did not understand how emergency contraception functioned on her body, another woman had a vague understanding about the drug and sought out more information and the last experienced vomiting which left her unsure if she may become pregnant. These experiences contrasted against one another revealing how important it is to understand how to take the medication and how it functions on her body. For instance, the fear one woman felt about her misconception about emergency contraception works led her to miss work since she expected to experience side effects similar to a miscarriage:

I didn't know about it...you see when you don't know about something you get nervous so I was more thinking it is ... something that it is a pill that you take that makes you miscarriage [sic] so I was as scared as hell. ...you call someone and they tell you can take the morning after pill and that's all you know...(Debbie)

Debbie went onto explain that she did not ask for more information directly from the pharmacist because she was embarrassed. Her lack of information and reluctance to request more information due to the social relations of stigmatization directly affected her.

The two other women who did not have enough information about emergency contraception found different ways to obtain it. Maye relayed a web of people and knowledge she had to pursue in order to get information when side effects were experienced,

... I threw up that day, the day that I took it I remember I was at work and I told my boss and it was this big deal and I was all scared that I threw up too quickly and may have to take it again...I called Telehealth Ontario and they got me in touch with someone from ...a pharmacist because we talked but I don't remember too well but I think it was from the association but am not sure...I might not be aware because...it was not a doctor it was someone associated with pharmacy because that is what Telehealth saying well it's a drug thing so you have to talk to someone who is an expert in that...They told me I should be ok. (Maye)

The second woman read about the drug and how to get it on the internet and went to the pharmacy to get more information. She wound up speaking to two pharmacists at 4 a.m. about the efficacy of taking both emergency contraception pills at the same time. Peggy suggested she had to be dogged in her pursuit of good, clear information about how the drug worked on her body as the first pharmacist she spoke to could not relay how the pill worked on a woman's body:

They suggested I take gravol half hour before I take the pills and that with both pills that I can take them both at once or with a 12-hour gap in between. Two pharmacists talked to us; the first one said that if I took the first pill and then waited 12 hours and took the second one, that I would be less likely to feel nauseous. And the second pharmacist said, no that probably doesn't make a difference, you can take them both at once.

Q: So you ended up speaking to two pharmacists. Was that because the first pharmacist couldn't answer your questions?

Yes...The first pharmacist was older and the second pharmacist was fresh out of school and he was more up on emergency contraception. They were both male...[and the first pharmacist] He didn't seem uncomfortable, but I wasn't comfortable with his lack of knowledge. Like I was asking questions where I felt like I knew more about the answer than he did. [Laughter] like it was almost like where he was starting to make stuff up and then he was like wait, I'm going to get this other pharmacist for you to talk to. (Peggy)

The women I spoke with sought information about contraception from a variety of clinical and non-clinical sources and accessed information where and when they needed it; asking for a second opinion from a pharmacist, doing research on the internet, conferring with colleagues or calling health information lines. However, poor knowledge had some serious consequences – like one woman believing she would experience a miscarriage, getting sick at work, and having to speak to one's boss about not wanting children.

4.2 Waiting, Approaching the Pharmacist and Cost

None of the women I spoke with had reservations about approaching the pharmacy counter and asking for emergency contraception from a pharmacist. However, two women concealed their activities from their friend or boyfriend or the stigmatization from people whose opinions mattered to them as opposed to “not caring” about what the clinical authority thought of their requests. These two women explained their defiance/resistance within a “compliance-responsible” discourse, in that they were responsible in spite of their need for emergency contraception, like Diana emphasizing, “it wasn’t *even* unprotected sex, the condom ripped...[emphasis added]” (Diana) as if unprotected sex would not be the correct reason to take emergency contraception.

Two of the women had to speak to assistants before speaking to a pharmacist and these were two women who sought out specific pharmacists, one who had a prior relationship and the second to the same pharmacy, where she could speak to the pharmacist in French. Pharmacists’ conduct is governed by respective provincial colleges of pharmacists which hold them to professional standards of behaviour and yet their assistants likely have no professional conduct “regulated” by a governing body that can impose sanctions. People regularly interact with technicians or assistants prior to speaking to the pharmacist and in these examples, women reported that everyone involved in the transaction lowered their voices for privacy, you still have to talk to the assistant and she goes and whispers in the man’s ear and the assistant isn’t a pharmacist so why do I have to talk to you? Unless you are picking up a prescription, I don’t think you should talk to people that just work there. (Diana)

Waiting

As stated in the earlier part of this chapter, women had to wait to get the drug in some cases or were delayed, and always referenced the time sensitivity of taking the drug and the

ensuing stress of waiting. The different views of women related to wait times was interesting as it exposed some of the ruling relations governing their activities. The urgent need to take the medication quickly is juxtaposed against the time spent waiting. Some were as simple as, “As soon as you take it [emergency contraception] it works” (Roberta). Another woman related that, “...even waiting like 15 minutes seems so long. When it is an issue as sensitive as that, you want to get in and get out of there really quickly” (Francis). These women tried to minimize wait times at the pharmacy – more time means more possible time to be seen getting the drug as well as diminishing the drug’s effectiveness. Five women spent time waiting in line which may be why they spoke about feeling increasingly stressed or self-conscious as the time passed.

Another woman spoke about waiting and how you need to take the drug as soon as possible and seemed exasperated about how she had to wait, “Exactly so you want to nail it right then and I had to wait 10 or 15 minutes and then he came to talk to me” (Diana). One woman asked for the drug and then waited close to an hour for the drug. She describes,

I had to wait for 30 to 45 minutes and some people were before me waiting for their prescription; and... he put me in a stupid booth, while he talked to all the other customers... (Diana)

Overall, time was a factor for women and they demonstrated their different needs to access emergency contraception in a timely manner which was a central issue to access. The amount of time contributed to feelings of stress or anxiety over waiting. Two competing discourses emerged from the discussion with women. First, these women expressed little anxiety over refusal of service or having to request the drug from the pharmacist as a common comment was not caring about judgment or stigmatization from the pharmacist as they were comfortable asking pharmacists for emergency contraception and framed themselves as “responsible” health care clients – having related information about using other contraceptives or asking for the drug

in the right way by using clinical language, saying “levonorgestrel” rather than emergency contraception. Their anxieties came waiting, the time that passed and a lack of privacy, the “other people” in line hearing, having to communicate quietly and trying to conceal her activities. They feel like they are put under forms of moral regulatory surveillance.

The social relations of stigmatization related to the use of emergency contraception meant some were stressed after sex, worried about others finding out about using the drug, yet acting in defiance to the idea that a pharmacist may withhold the drug. Second, there is evidence of the compliance-responsible discourse in a few of these transactions – even with the ideal portrait of proper contraception use beginning to be constructed: soft spoken, quiet, patiently waiting in line as they are being watched and listening to pharmacist’s questions. For the most part women were defiant about being assessed with regard to the problems they identified; one felt they deserved the drug; and alongside ideas of responsibility, a resistant discourse emerged that challenged this idea. This resistance is really important, as there was a consciousness that was in opposition to the biomedical authority and yet in practice or reality was compliant. Women seemed to be compliant with the biomedical authority but that does not necessarily mean they agree with how they had to present themselves – they are actively navigating this set of relationships.

Privacy will be discussed later in this chapter but these experiences of waiting in line, speaking to pharmacy technicians and waiting in a private, yet visible glass box while the clock ticks away on emergency contraception’s effectiveness is a harmful practice. Women wanted privacy as a common feature of service and it was largely impossible because of the nature of the transaction at the public pharmacy counter. However, when two women were in a private space, they expressed discomfort in speaking with a male pharmacist about sex in close quarters or knowing that other people will know this privacy is about sex just by being escorted to a private room and made to wait.

Costs

All of the women I spoke with were in their 20s and seven of the eight women were students, with the last woman working full time for wages. The last woman had private health insurance coverage through work, which she did not file as she did not want her employer to know she took emergency contraception. Five of the eight women I spoke to about emergency contraception found the cost of the medication expensive, paying between \$40 and \$60 for the medication out of pocket. “Yeah, it was kinda [sic] a lot of money,” (Peggy) and another woman reflected, “I was a student without drug coverage and it cost about \$40 dollars and I found it expensive to purchase at the time” (Diana). These costs were higher than those cited in the pilot studies that occurred between 2001 and 2003 in BC and Ontario, which appears to mean that the pharmacist dispensing fee was added to the price of the medication, as were costs for determining a women’s eligibility for the drug by screening for unprotected sex and side effects as well as the related costs to provide education on other forms of contraception, sexually transmitted infections and/or referrals to other service providers like physicians.

4.3 Manufacturing Ignorance and Compliance

How the drug works

All the women except one felt the instructions for use given out with the medication was easy to understand and the side effects were plainly understood. Only one woman did not understand the way emergency contraception should be taken and thought the symptoms were similar to a miscarriage or heavy bleeding and she needed more information and was too embarrassed to ask. The other woman was discussed in the preceding section and did not have enough knowledge and asked for more information from a more knowledgeable, and younger, pharmacist. She was comfortable asking for more information from the second pharmacist about

the merits of taking both doses of levonorgestrel at once. However, Peggy also wanted to know more about how the drug functioned on her body, “Like, what does this do? How does it work on my body?” (Peggy). Yet, the information on the instructions for use, prepared by the manufacturer and reviewed by Health Canada and the pharmacy regulatory body, included incorrect information about emergency contraception working after fertilization. The implications for women will be discussed in greater detail in chapter five.

While most of the women knew how to obtain emergency contraception and how to use it, only a few women knew that the drug functions so as to prevent fertilization. Two women indicated they thought it worked like an abortion, having effects after an egg is fertilized by sperm, causing symptoms similar to a miscarriage. These women did not reflect on the ideas about when ‘life’ supposedly begins at implantation or at fertilization, a tactic anti-choice groups use to confound using contraception with abortion. Further, people do not have to know or reflect upon issues such as when ‘life’ begins. While women should certainly understand how the drug works and have ready access to accurate information about the drug to make informed decisions. This does not mean forcing women to think about issues or information that they may not consider relevant or important. In two cases, women contrasted using emergency contraception against having an abortion, with contraception being seen as morally better than abortion. Contrasting the means by which women control their bodies and regulate their fertility and ranking sexual health work activities results in some women gatekeeping and stigmatizing others. For instance, “I mean I’m here, I’m doing the right thing instead of going and getting an abortion stupidly because I don’t want to be pregnant. So how dare you make me feel like this” (Diana). I argued in the second chapter how anti-choice ideological discourses have been opposed to all forms of birth control and abortion and to sex for pleasure. I am suggesting that this misconception, that emergency contraception functioned like abortion, is the result of inaccurate

portrayals of the drug in “official texts” and that this contributes to the stigmatization experienced by women.

The manufacturing of ignorance related to emergency contraception is also important to consider as anti-choice factions organize around educating women about the supposed abortion-inducing properties of the drug so that they are “informed” about the way emergency contraception works. As I discuss further in Chapter Five, and introduced in the first two chapters of this research, the idea of making an informed choice comes out of the medical field where results of emerging research undergo peer review and decisions for treatment are based on the best evidence available at that time (Page, 2006, p. 8). The idea of informing women about abortion or contraception differs significantly from research or medical ethics practices like informed consent or feminist notions of body literacy. Rather, anti-choice groups blatantly use false information about abortion or contraception to falsely associate these activities with one another so as to dissuade women. The extension of the work of anti-choice forces into other domains of women’s health is but one tactic to extend influence over “contentious” aspects of sexual health service provision like birth control. Thus the clinical authority is supposed to make treatment decisions based on the best evidence, so that women can make informed choices around their well-being. Yet anti-choice ideological groups take up the positions of the clinical authority and use false information to further the idea that emergency contraception is akin to abortion since they falsely claim it functions after fertilization on a woman’s body. As I discuss in Chapter Five, poor evidence was used to extend the social relations of moral regulation. Furthermore, as will be discussed later, Health Canada also included post-fertilization effects within the rationale to deregulate and ties the Canadian state to problematizing emergency contraception.

Some women revealed that they did have poor knowledge about the drug working on the body; when reviewing the official texts from the time of deregulation, there is a real absence of informative and accurate health information about emergency contraception. Government deregulation did not include significant funds to increase awareness of the new mode of access for emergency contraception specifically. Women revealed that they seek health information from a range of sources and some of the women had a lack of knowledge about emergency contraception. By including a flawed definition of the drug in “official” texts, the ruling relations contribute to the confusion around emergency contraception, and in doing so, promotes the idea that it works as an “abortion-agent”. The confusion about emergency contraception by women I interviewed was set up by the misinformation about how it works by Health Canada, and the pharmacist regulatory body, all of which had authority over the information included on the drug label and over where it is sold in the pharmacy.

4.4 Ruling via Stigmatization: Eligibility, Negotiation, Counselling and Privacy

Eligibility

As I am arguing, the women who participated in this research experienced the social relation of stigmatization from pharmacists in different ways. Screening and counselling factored into the majority of women’s negative experiences of seeking emergency contraception due to surveillance and moral regulation. I move forward with a few assumptions: first, that the criteria to determine “eligibility” from the Ontario pilot project informed the creation of the screening form that myself and another woman had to sign due to the similarities in information and format. Five of the six women who took issue with some aspect of their exchange with the pharmacist needed emergency contraception due to previous contraceptive failure and all six

women took issue with being screened by pharmacists for unprotected sex due to different reasons.

The screening that took place regarding around unprotected sex and menstrual cycles was more contentious for two women than the counselling they received related to contraception use. The conversations they endured involved questions about other drug use, the last time they had sex, time of last intercourse, and if their periods were regular and when it began and ended. This was highly sensitive and personal information to be required to recount and is problematizing women's sexuality and their knowledge about their own bodies.

Negotiation

As stated, six women took issue during their negotiations with the pharmacist, feeling awkward, annoyed, angry or stressed. Two women spoke about "getting lectured" (Roberta) or "being quizzed" which occurred when pharmacists were counselling women about how emergency contraception works to determine if these two women actually needed the drug. One woman described the experience as uncomfortable and was on the pill but had missed some in the days preceding unprotected sex. The first time she went to get emergency contraception, the male pharmacist had a problem with her taking emergency contraception in addition to being on the pill. Roberta describes feeling like she was obliged to explain or justify her behaviour:

it wasn't a pleasant exchange, he was abrupt or seemed pissed off or passing judgment on me...he said something like, if you are on birth control, why do you need this? Making me explain why I need to take the pill...I felt I had to say, I was just being safe and he made me feel like I had to explain myself. I hadn't obtained emergency contraception and it didn't seem like the product would be withheld but he was making it seem like I shouldn't be getting it....(Roberta)

Another woman reported feeling like she was being quizzed when being screened for emergency contraception.

...he [pharmacist] was asking me the question again, like, I already told the girl, [pharmacy assistant] that's why I talked to you are here talking to me so why are you asking

me that stupid question again? So that's how I felt first of all. And then he was like, do you know it works? Did you ever took [sic] it before? He kept asking me if I knew how it works. And I was like, no I never took it before, I heard about it but I never took it so I don't know how it works. ... I'm a people person and it is very hard to throw me off [it] doesn't matter the situation, but he kind of threw me off. (Diana)

All six women who felt getting emergency contraception was challenging endured questioning to determine if they had unprotected sex or used other forms of contraception. Women had a problem with the types of questions being asked and the tone of the conversation. Roberta and Diana reported the subtle forms of moral regulation and surveillance. Diana experienced other problems, after being “lectured” by a pharmacist she was referred to another pharmacy as the first was out of supplies. Arriving at the second pharmacy, she had to speak to a pharmacist assistant for a second time and,

do the whole thing all over again and then he tried to lecture me and I was like, I just left from somewhere where they told me how it works, and [they] already consulted me and I stopped the pharmacist right there because he was feeling like he...was my dad or something...and I had to put him back in his spot. ... I just felt he was cocky, you know? (Diana)

Most of the women who had negative encounters, felt the pharmacist assumed they had not used other forms of contraception, making them feel “irresponsible,” “careless” or “immature” in their sexual health choices. These assumptions by pharmacists form two overlapping categories: “chaotic” or “risky” sexual behaviour as well as what some pharmacists considered were irresponsible requests for the use of emergency contraception. External research published around the time of deregulation in Canada showed that some pharmacists felt that loosening access conditions would lead to “sexual excess”, and increased risks of infection and/or pregnancy as women would begin to rely upon emergency contraception instead of other forms of contraception. These kinds of assumptions informed the sexist and gendered stigmatizing practices some of the women experienced, that they were “chaotic”, engaging in unprotected sex

without any thought as to the consequences of infection or that they were pregnant, are untrue; all but one woman were using other forms of contraception and all understood they were at risk of pregnancy. Furthermore, these assumptions reveal the sexist nature of the compliance-responsible discourse beginning with the notion that first, women do not know their menstrual cycles or bodies and second, women do not understand the consequences of not using contraception.

Counselling

Three women had positive experiences when they spoke to female pharmacists these women felt that there was appropriate conversation taking place with one woman emphasizing conversation, “she was respectful and not intrusive into my personal life” (Roberta) with all three finding an appropriate demeanor and a positive tone to the encounter. The other point of connection between these women is that they received the drug with no questions asked. Roberta explains the second time she sought emergency contraception from a pharmacist, “it was a woman and she was very positive and just went and got it.”

Regarding the counselling part of the visit, two of the six women who characterized their experiences negatively felt they were being lectured. Both said they were treated “stupidly” (Roberta), or “like a child” (Diana) because the pharmacist assumed she did not know how to take the pill or emergency contraception properly. One woman was quizzed about how emergency contraception worked before finding out the pharmacy was out of stock; she received emergency contraception counselling twice, which led to her feelings of exasperation around access to emergency contraception:

Almost like he was being judgmental and I wasn’t being paranoid because really I don’t care about what people think. But that is the impression that I had ... maybe I was wrong; but that is what I thought. (Diana)

Maye navigated the social relations of surveillance by going about her sexual health work activities to get the drug and not caring about the scrutiny she experienced, in that, “I was

comfortable because I don't care, I was doing it for my health" (Maye). Diana revealed "the process was easy if you don't care what other people think... you have to put your problems public. ...do you sneak up to the counter and they sneak it to you? You feel weird" (Diana). Maye, Roberta and Diana outlined what they used in anticipation of this surveillance, including resistance: one felt she had to be sneaky or subversive; another identified "other people" as being involved in the process, meaning there was stigmatization related to use and she factored in "other people" in the pharmacy finding out; and two of these women described ease of access as long as one "doesn't care...". Peggy discussed how the pharmacist felt he *had* to provide information about other forms of birth control as part of his role as an educator,

I think he ... said a line that he has to say about using condoms. Like he quickly inserted that at the end, sounding a bit awkward about doing it... (Peggy)

Privacy from the social relations of stigmatization

Maintaining one's privacy from "other people" while waiting in line to be served in the pharmacy or for their medication order to be filled was an important feature of mitigating the effects of moral regulation and stigmatization. A couple of women reflected upon the ways that they spoke about the drug to others due to stigmatization about using the drug or what taking it implied – being "disorganized", "irresponsible" or "immature". Both women were defiant and unapologetic about requesting and using emergency contraception, undaunted about the social process of stigmatization and dealt with the judgment by concealing their activities from others, like a friend or boyfriend.

The social relations of stigmatization also occurred while waiting in line at the pharmacy to be served or to have their prescription filled and these wait times presented barriers to the use of the drug. Maye waited around until there was no line up before asking for the drug; she was indifferent about asking the pharmacist but did not want other customers to hear her request, "I

am always attentive about who was around me due to the nature of my order...I would ... approach when there were less people around" (Maye). Five of the women related that they knew they were in a visible, public space and noticed who was around them while they waited in line and three of those felt ashamed or self-conscious about making the request in front of other people. These women whispered when speaking with the pharmacist, who responded with hushed tones. One woman, who had a confrontational exchange with a pharmacist the first time she asked for emergency contraception adopted clinical language the second time around, "...I think I actually used the scientific name..." (Roberta). She referred to using the clinical name, levonorgestrel, for two reasons, the first, to disguise her request from others in the pharmacy. Second, in using the drug's clinical name, she felt she was being "sneaky" and hoped to appear knowledgeable about emergency contraception so as to avoid having a long, and perhaps difficult, conversation with the pharmacist. Roberta returned to the same pharmacy that she went to the first time, explaining defiantly, "...what am I supposed to be inconvenienced by some pharmacist that is an asshole?"

The responses to these ideological practices contrast against one another and reveal how women experienced the social relations of stigmatization differently. Some women framed themselves as being "responsible" to the pharmacist, and others were defiant during their interviews about their rights to access the drug. Conveying these experiences pivots their sexual health activities - the performance - against their beliefs. For instance, women conformed to the clinical gaze by appearing responsible, concealed their activities from a friend or boyfriend, or being cognizant of other people waiting in line; which contrasts against their internalized defiance voiced by saying they are unconcerned about a pharmacist's judgment or maintaining an absolute "right" to the drug. I conclude that women recognized pharmacist's operate with "power over" some aspects of their agency in access to emergency contraception and women responded

by performing and conforming different aspects of their sexual health work activities to denote responsibility, maturity and good knowledge. While the women recognized the “power over” relations, this does not mean that any of these women believed in it.

While privacy was important to women, some of the means by which pharmacies are oriented to offer a private consultation were problematic since small booths are private once inside but are not confidential in that others in the pharmacy can see:

right where I was and I was in the little booth, you know what I mean? Let's separate her, it kind of shows...that you are a woman, you know, and what else? (Diana)

Another woman was taken to a private area after she made her request. This occurred with mixed feelings,

He took me into a private area...it kind of makes you feel like, if the pharmacist takes you to a private area to talk to someone...everybody knows there must be something embarrassing or something really wrong. I was like, oh well, I don't know if that was supposed to be private but everyone spotted me going in there so I don't know how confidential that is...(Maye)

These two experiences reflect some of the resources that pharmacies created to respond to requests for confidentiality and privacy; however, in these two cases, both women experienced the confidential space as a public space where they experienced shame in waiting. To these two women, this public space highlighted the sensitivity of the women's request, and women were left to feel ashamed because the social relations of stigmatization are built on a sexist double standard. The public space opens up women to assumptions by the pharmacist as well as others in the pharmacy since a young woman was put to the side to wait while the pharmacist continued to serve other customers. Furthermore, it appears that even though the national pharmacy association prepared training for pharmacists on sexual health assessment and counselling (Government of Canada, 2005), it appears pharmacies undertook no new practices for ensuring privacy with the partial deregulation of emergency contraception but simply fit these new

activities into their already existing prescriptive practices. While these may work for people who need some discussions about how to use a particular drug, it did not work in this situation. The irony here is that this private space was still publicly visible, and contributed to two levels of stigmatization, the first, from other people seeing the woman entering the booth and then being made to wait there. The second aspect of stigmatization entailed having to speak about personal matters with a pharmacist in a confined space that initiated stigmatizing practices. Experiencing wait times to access the drug and having to wait while other customers are being served was a harmful social relation as it has the potential to increase women's chances of becoming pregnant, and women here reported experiencing stress as well.

Another woman reflected on the stigmatization associated with emergency contraception and the reasons why privacy is important. Francis had a good experience with the pharmacist but had still been "afraid that her staff might hear." She also reflected about how every time she obtained emergency contraception, they assumed that she did not use a condom, reinforcing the sexist notion that women do not understand the "real" consequences of unwanted pregnancy and that emergency contraception is not a normal form of birth control. Francis identified many barriers around access to contraception, including the idea of "carelessness" as it relates to unplanned sex or contraception, and lists many reasons why access through a pharmacist benefits women,

There are many reasons why women may not be able to get the pill [oral contraceptives] – the doctor may not have the time to see you in time, and you couldn't get a refill or I couldn't get to the clinic. There is a stigma attached to it [emergency contraception] that women are just careless. And yes I was this time, but that's not the point... (Francis)

Consent about the collection of personal health information is governed by the respective provincial governments' privacy legislation. This practice was in line with the guidelines established by the NAPRA and this example troubles the practice. Given emergency

contraception's problematic status, it is conceivable that women could experience stigmatization or surveillance about her repeat use of the drug over time. Informed consent has been a longstanding area of concern for women in health research and the NAPRA produced guidelines in 2001 to ensure privacy of personal health information.

Ultimately, individuals have to consent to the collection of personal health information. However, guidelines for pharmacists developed by the NAPRA reveal some troubling practices related to data collection and use. First, the individual health information remains the “property” of the patient and the pharmacist must obtain consent to disclose health information as well as notify the person about any disclosure. The guidelines outline that consent can be overt or “inferred if the pharmacist has fulfilled the duty to inform and has sufficient reason to believe that the patient would consent under the circumstances (NAPRA, 2001). While the health information belongs to the individual, electronic and hard copies of these records that “carry” (NAPRA, 2001) this information remains the pharmacy’s property. Individual personal health information can be collected and used for the purpose of providing pharmacy service; aggregated prescription information from a number of individuals and locations can be shared with third parties that includes information like the medication, pharmacy, prescribing physician and pharmacist. Such aggregated data would not include the identity of the individual (NAPRA, 2001). Finally, personal health information and prescriptive information can also be disclosed to a guardian.

An example of these data collection policies in practice reveal another woman was surprised to see when she returned to the pharmacy to obtain emergency contraception for a second time, that the pharmacy had her information on file “I was shocked. I was like oh you know about that, don’t you?” (Diana) Thus, this practice conforms to the guidelines produced by the NAPRA and which troubles the retention and use of this information. Given emergency

contraception's problematic status, it is conceivable that women could experience stigmatization or surveillance about her repeat use of emergency contraception over time. Diana's experience made me consider the sensitive information women were being asked to share with a pharmacist, that is collected by a corporation and stored in a database. Who could access the prescription information and for what purpose? When are records destroyed?

Diana remembered, "I had to sign a paper the first time, not the second time. I can't tell you what was on the paper but I remember I had to sign something..." (Diana) which is clearly not a case of informed consent. Diana and I both went to Shopper's Drug Mart to obtain emergency contraception. In my case, I signed a form that I discuss in section 4.5 of this chapter. The screening form included personal information about unprotected sex, side effects, the date of my last period and was retained by the pharmacist with a promise that it would be destroyed later. We were not provided with information on consent to collect information about sex and menstruation, nor records management policies. Rather, the form was signed in order to consent to being referred to a physician for more information on contraceptives and/or sexually transmitted infections; neither of which we had requested or agreed to.

Providing education on other forms of contraception is not an easy task as identified by most of the women. When women took issue with the conversation, it seemed to be when the pharmacist assumed women were "ignorant" about their health and/or their bodies, or did not understand the "grave" consequences of unprotected sex. Two women justified their behaviour to the pharmacist and articulated this sexist element of a "compliance-responsible" discourse creating a moral distinction between types of sexual health work between bad (abortion) and good (contraception), adding more complexity to the construction of the ideal contraception user. This ideal user is someone who plans to use contraception in advance of sex, does not use

emergency contraception repeatedly, does not seek abortions, and who bases her decisions on rational information sought out from people in the health profession and governments.

Through these examples, I revealed how the stigmatization of women who use emergency contraception “operates”: by being made to wait; vis-à-vis other people in the pharmacy; by quizzing her; making her feel like she has to explain because she is ignorant; forcing her to appear responsible and compliant. The harm of unintended pregnancy loomed large for all of these women and represented an emergency. The “clinical-compliance” discourse was being wielded in a visible public space so as to screen out women that were ineligible and to “educate” those that are ignorant. The expansion of neoliberalism into the health education sector meant the drug was falsely associated with post fertilization effects in official texts, confusing people about its function. Neoliberalism in health education meant more social forces intruding into the personal lives of women, making it more difficult to discern who is responsible for evidence-based drug definitions in official texts. The pluralization of health education and of organizations involved in drug deregulation further obscures identifying the social forces responsible for ideological practices, making this research important.

4.5 Keeping Track: Form Filling and Recordkeeping

I had to sign a form in order to access emergency contraception and I have included a copy in the following pages. While the form had space for my signature, I signed it in French and upon translating the form later; I realized that the signature was to request a referral to a physician. This means that I did not consent to my personal information being collected and was not informed if my personal health information was stored and used by Shopper’s Drug Mart. This section of my thesis will analyze a textual practice that organized social relations of

emergency contraception trans-locally, affecting many women in different spaces throughout Canada.

The screening form is structured as an interview guide on one side to collect personal health information about women and information about the use of and function of emergency contraception on the other. Specific questions and eligibility standards that women had to meet were developed and the text formalized and entrenched the pharmacist's role in assessing women for emergency contraception. Furthermore, the form can be considered an active text as it served to shape and organize pharmacist's activities around so-called "eligibility" screening for unprotected sex and counselling and education regarding other forms of contraception (Smith, D, 2005) in multiple Shopper's Drug Mart pharmacies. Women had to comply with the clinical authority, performing as responsible as an ideological practice and which becomes evident by exploring the social relations of form filling and record keeping. The clinical gaze is part of how neoliberalism operates in this context as both discourses serve as a means by which to regulate women morally and sexually as this work was transferred from the state agencies to state mandated and sanctioned medical professionals in the pharmaceutical industry and related professional organizations.

Additionally, by blurring lines of responsibility about clinical definitions, side effects and informed consent for the collection and use of personal information, corporate pharmacy chains may derive profits from "good" record keeping; in that the data, even once aggregated, could be used to market the drug more effectively to "better serve" its clients. Furthermore, "good" record keeping on the part of corporate pharmacies may also serve to limit risk as this information could serve to protect the corporation from liabilities in cases where a particular drug may be found to have harmful properties in the future. Data collection and disclosure of said data for marketing or profit places the sorts of questions on the screening form under a different kind of scrutiny due to

privacy and confidentiality. Women could be penalized for obtaining the drug more than once, or even, having their personal health records about emergency contraception use released to their guardian if under the age of consent.

As an Anglophone that speaks French, I was able to understand the form that I signed. While the pharmacist did not review the educational material with me that was included on one side of the form, she did record my answers to the questions related to eligibility for emergency contraception that I discuss further below. I signed the form and dated it and the pharmacist said it would be destroyed in five days; my form was placed in a drawer beneath the cash register in the pharmacy.

The first page of the form guides pharmacists through criteria “assessment” so as to evaluate a woman’s candidacy to use emergency contraception and collects demographic information like a woman’s name, address, phone number and date of birth. The second section, titled “questionnaire” asks a series of questions related to a woman’s menstrual cycle, including asking for the date of the first day of her last period, if her menstrual cycle is “regular”, meaning one period per month, and then if her last period was “normal.”

It is important to recall that the only “symptom” for using emergency contraception is having had unprotected sex; questions about a woman’s menstrual cycle are unwarranted and invasive. Given one woman’s experience of seeking information from Telehealth Ontario, it is conceivable a woman could call the prescribing pharmacist at a later time with questions. In this scenario, it would be helpful for a pharmacist to review the time and timing of when the woman took the drug to give advice or refer to a physician for other services. However, the questions were asked in a visible public space, with little to no privacy, and the questions should be considered as guidelines without compulsory answers since some women may find them without merit and potentially humiliating.

ÉVALUATION DU PATIENT POUR PLAN B

Nom du patient : _____

Adresse : _____

Téléphone : _____

Date de naissance : _____

QUESTIONNAIRE

Date de la première journée des dernières menstruations (aa/mm/jj) : _____

Votre cycle est-il régulier (une période de menstruations par mois)? Oui Non

Vos dernières menstruations étaient-elles normales? Oui Non

Raison du recours à la contraception d'urgence :

Relations sexuelles non protégées récentes ou échec de la méthode contraceptive : _____

Besoin projeté : _____

Avez-vous eu des relations sexuelles non protégées au cours des cinq derniers jours? Oui Non

Dans l'affirmative, indiquez la date (aa/mm/jj) : _____ Heure : _____

Enumérez les médicaments auxquels vous êtes allergique, selon le cas : _____

RÉSERVÉ AU PHARMACIEN

Délivrance de plan B Date : _____ Date du suivi : _____

Renvoi au médecin Date : _____ Raison : _____

Médecin : _____

Suivi requis pour assurer l'emploi continu d'une méthode de contraception.

Remarques :

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LISTE DE VÉRIFICATION DU PHARMACIEN : CONTRACEPTION D'URGENCE

Nom du patient : _____

- Mode d'action de plan B.**
 - Dans les 72 heures qui suivent l'administration.
 - Prendre une dose toutes les douze heures jusqu'à concurrence de deux doses.
- Efficacité de plan B.**
 - Prévient 89 % des grossesses lorsqu'il est pris dans les 72 heures qui suivent.
- Contraception d'urgence et grossesse.**
 - N'interrompt pas une grossesse déjà entamée.
- Effets indésirables potentiels de plan B.**
 - Nausées, vomissements, fatigue, étourdissements, seins sensibles, crampes, maux de tête, pertes vaginales, menstruations précoces ou tardives.
- Que faire si vous vomissez après avoir pris plan B.**
 - Si les vomissements surviennent dans l'heure qui suit l'administration, prenez immédiatement la deuxième dose et procurez-vous un autre emballage de plan B.
 - Prenez un antinauséeux une demi-heure avant l'administration.
- Consultez un médecin, une infirmière ou une clinique de planification familiale si vous n'avez pas encore eu de menstruations trois semaines après le recours à la contraception d'urgence.**
- Comment recommencer la prise de contraceptifs après le recours à plan B.**
 - Si vous prenez un contraceptif oral, commencez un nouveau paquet le jour après avoir utilisé la contraception d'urgence et employez une méthode anticonceptionnelle obstructive, comme un condom, pendant sept jours.
- La contraception d'urgence ne doit pas être utilisée à long terme comme méthode contraceptive.**
- La contraception d'urgence ne vous protège pas du sida ni des autres ITS, ni ne traite ces maladies.**
 - Consultez un médecin ou une infirmière.
 - Si vous le désirez, je peux communiquer avec votre médecin. Veuillez apposer votre signature ci-dessous pour autoriser la divulgation de vos renseignements.

Nom du médecin : _____

Signature du patient : _____ Date : _____

Signature du pharmacien : _____ Date : _____

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The conversation between a pharmacist and a woman is an opportunity to share good, accurate information and should likely begin with the pharmacist trying to discover if she has any questions related to using the drug, how it works on her body and referring her to a physician if needed or requested. Thus the questions should be structured in such a way for the pharmacist to understand if the woman should go to a physician for more information or a pregnancy test. Pharmacists do not operate as a profession with the ability to diagnose nor can they create a binding referral to another health professional; by asking a woman to consent to a referral, they are giving the illusion that they have the authority to diagnose a condition. So if a pharmacist is simply going to refer any problems or detailed questions to a physician, these questions are moot and sexist and contribute to problematizing women's bodies and sexualities in different places, i.e. with this questionnaire which is now owned, stored and possibly shared electronically in many different sites. These practices of documenting and storing women's sexual health information say a few things about what health professionals and the industries built around them believe about women: first, that she may need assistance understanding her menstrual cycle or her body or documenting it in relation to her request for emergency contraception. Much of this information was collected without informed consent and without merit, as I will reveal in the next chapter, none of these questions relate to women's eligibility to take emergency contraception and this is invasive surveillance based on sexist assumptions. The conversation between a pharmacist and a woman should begin with the pharmacist trying to discover if she had any questions related to emergency contraception and if the questions cannot be answered by the pharmacist, sending her to her physician for more information.

Emergency Contraception

The next few questions establish why a woman needs emergency contraception, the first question was having had unprotected sex, the second was the failure of another method of contraception and the last option on the form was “anticipated need”, or providing advanced supplies. The pharmacist was then prompted to ask the woman if she has had sex in the last five days and if yes, to indicate the date and hour.

Here it appears the pharmacist is evaluating the woman’s candidacy for the drug in terms of her intent, which should be of no concern to pharmacists, her use of other contraceptive methods and her social need for the drug. Both questions are without merit – one’s intention to use emergency contraception now or in the future was irrelevant but perhaps it made sense in relation to oppressive moral and sexual regulation? As three of the women that participated in this work attested to, the tone of the encounter and style with which emergency contraception was provided were both cited as positive aspects of obtaining emergency contraception from a pharmacist. Basically, quickly obtaining the medication, in addition to having a positive and empathetic exchange between a pharmacist and requesting woman were beneficial aspects of behind-the-counter access. Pharmacists operate with discretion to interpret the questions on the form as they wish and when a woman visits a pharmacy to get emergency contraception, it should be seen as an opportunity to make sure women have supplies of the drug to reduce the risk of unwanted pregnancy.

The last question on the form related to any allergies to medications women may have in order for pharmacists to assess if taking emergency contraception may cause a dangerous drug interaction or allergic reaction; in spite of much evidence that reveals no serious side effects with the use of emergency contraception. In many ways, the questions on the form served to reinforce a few discourses that were also present within some of the women’s experiences. Being

compliant to the clinical authority and ideas about responsible contraceptive usage discourses were present and yet sexism operates through both of these discourses that assumed women's incompetence in taking regular forms of birth control as well as ignorance about her body. Sexism enforces certain clinical standards that had to be met in order to be deemed responsible to use emergency contraception. In the context of a neoliberal health care creep and transforming pharmacist practice, the questions included on the form appear to be a blatant attempt to "make work" for pharmacists and construct a woman as needing pharmacist's advice as she was ignorant, asking for details on her menstruation, its regularity and normality. Furthermore, the questions and information collected depict pharmacists as the clinical experts and provided a basis for two new pharmacy services constructed by power/knowledge relations. The first manufactures a "referral" role for pharmacists to refer a woman to a physician; the second attempts to establish pharmacists as being able to "diagnose" unprotected sex, any problems in menstruation and so-called dangerous drug interactions. Of course, all of these questions are irrelevant; the only question a pharmacist could ask, with a clinical basis, is if the woman had unprotected sex within five days of the request.

The second side of the form included health information about emergency contraception, which I have outlined in the introductory chapter of this thesis. The health information appears accurate and may be helpful for women to have. For instance, the timeframe within which emergency contraception works was included; that each pill should be taken 12 hours apart; that the drug is 89 % effective in preventing pregnancy if it is taken in the appropriate timeframe; and that the medication will not interrupt an already established pregnancy. Since one of the common side effects for emergency contraception was vomiting and nausea, information on what to do if a woman becomes sick after taking the medication is included and a woman is instructed to see a nurse or doctor if she did not get her period within three weeks of taking the drug. Finally, the

information outlined when to start taking oral contraceptives again after taking a dose of emergency contraception. All told, the information included on the form actually addresses some of the challenges that the women who participated in my research had regarding some of the sexual health work they did to prevent unintended pregnancy.

Finally, the form concludes with some warnings that set up emergency contraception as dangerous or problematic, including that it should not be used as a long-term method of contraception, that it does not prevent or treat sexually transmitted infections. The form ends with a signature portion, which both myself and the other woman signed and dated; as stated previously, this was not for informed consent on data collection and storage, but was actually for a pharmacist to refer the woman to a physician for further information.

Lessons learned from the analysis of women's experiences as well as the screening form used by Shopper's Drug Mart pharmacists, expose some sexist and stigmatizing practices that can be easily remedied. Concrete records management policies and procedures about sensitive health information should be provided to patients as well as collecting informed consent as a standard pharmacy-visit activity. Corporate pharmacy chains and the pharmaceutical industry could conceivably use this information to better understand, market and sell their products to women since they would know the demographics, timing, class, age and other factors related to emergency contraception users. This becomes particularly problematic in the context of the privatization of counselling and education and the subsequent collection of women's personal information about sex and emergency contraception.

By asking these types of questions, in a public place, and the assumption of women's ignorance about their bodies on the part of the pharmaceutical industry, ruling relations contribute to establishing their "power-over" women, shoring up the compliance to a clinical gaze and neoliberal discourses already pervasive in these social relations. The pharmacy

screening form should be seen as a site of moral and sexual regulation, that attempted to restrict access to emergency contraception; or further problematized the interaction so as to set up taking emergency contraception as a punitive practice that coordinated and mobilized this conception.

Summary

The shifting relationship with health professionals, and the devolution of sexual health service provision to a private, for-profit institution like a corporate pharmacy, requires further investigation. How does the creep of neoliberalism transform access? Deregulation of emergency contraception provided some space for pharmacists to re-assert their legitimacy within health care delivery systems and to increase their profits since pharmacists were successful in obtaining fees for assessment and counselling women about emergency contraception.

In the context of this research, women had different problems in obtaining emergency contraception and experienced different forms of stigmatization individually; within her community, like between friends, boyfriends or one's boss; systemic stigmatization from the pharmacist at the counter, in a private booth, and, through the collection and retention of her personal health information that included, sexual history and use of emergency contraception. Women should not be judged or refused access based on someone else's moral standards; and the example of deregulation of emergency contraception reveals extensive moral and state regulation of delivery of services and access to care, with little thought to the repercussions on women's lives.

Women were active agents in seeking emergency contraception and experienced some barriers due to cost, transportation, language of service, in being screened for unprotected sex and the appropriate use of the drug as well as the gender of service provider. Time and quick access were considered in all of the instances where women sought the drug. Women knew it

worked better when taken sooner and the need to access the drug quickly informed their selection of what pharmacy to go to, the mode of transport and the time during the day when they accessed the drug. Women experienced subtle and overt forms of social relations of stigmatization from many people when accessing the drug, their friends, strangers listening in when making the request at the pharmacy, and from the pharmacist due to sexist and paternalistic notions about women who use emergency contraception. Other research shows that inadequate knowledge about how the drug works on the part of the pharmacist may pose more barriers to access. Misinformation in official texts about emergency contraception contributes to this stigmatization as a few women indicated they thought the drug worked after fertilization and associated using emergency contraception with abortion and miscarriage which is also how anti-choice discourses work to confound people about abortion and contraception.

Since official “texts” produced by those people in institutions also shore up this conception, I argue that this type of false information left women open to further stigmatization which was a powerful force in deciding how and when to access the drug. The ruling regime contributed to making some women more vulnerable to unwanted pregnancy through this stigmatizing practice. Women identified they had a fundamental basic human need to use emergency contraception as well as maintaining the right to get it and used different means at their disposal like complying with the clinical gaze, by appearing responsible and planning to use regular contraception, using the clinical name of the drug to show they knew a lot about it, or confronting a pharmacist on their need to access the drug. Institutional policies like the collection and storage of personal information, surveillance of women’s repeat use of the drug, or asking that they complete and sign a form were problematic. Women required privacy and discretion at the pharmacy counter, including around policies like the collection of personal sexual information. Lastly, screening and counselling by a pharmacist on sexual health did not go

smoothly; the women largely were able to identify their vulnerability to unintended pregnancy on their own, and knew how to follow the simple instructions on using the drug. There is no need for pharmacist involvement unless requested.

Chapter 5

5 Deregulating Drugs in Canada

Throughout the course of this research, I argued that emergency contraception has a problematic status. The lack of accurate information produced in official texts like the government rationale to deregulate, the manufacturer's drug labels and in assessment documentation produced by the pharmacist regulatory body, the NAPRA, around the period of deregulation contributed to the stigmatization of the drug and women who use it. The social relations of stigmatization occurred in two ways. First, by women themselves who created a moral distinction between good (contraception) and "stupid" (abortion) behaviour and who had some confusion about the mechanism of action of the drug on a woman's body. Second, pharmacists extended the social relations of stigmatization, did not recognize unwanted pregnancy as a real harm, and used their new role in screening and counselling women to extend rhetoric about an ideal contraception user. Stigmatization was shaped by two wider discourses, neoliberalism and compliance-responsibility, these discourses influenced many of the decisions made by the different ruling relations that have a stake in drug availability in Canada, and ultimately affected women's access.

This chapter explores Health Canada and the NAPRA's textual practices that facilitated women's oppression. Recall that Health Canada and the National Drug Scheduling Advisory Committee (NDSAC) of the federal pharmacist regulatory body (NAPRA) act in concert with one another regarding drug status. Health Canada publishes a review of clinical evidence, consults the organizations and individuals regarding deregulation, and develops the rationale for a drug's schedule change in order to modify access conditions in the *Food and Drug Act*. The

NAPRA provides a recommendation to Health Canada and respective provincial organizations on a drug's schedule based on a review of clinical evidence. In this chapter, I analyze the NAPRA's recommendation that preceded the federal change in law as well as the document produced by Health Canada called the Regulatory Impact Analysis Statement (RIAS, or the rationale). The purpose of this chapter is to analyze these text-mediated institutional relations in order to account for some of the social experiences of the research participants.

To accomplish this, in this chapter I outline the places where the official texts adopted incorrect information; the federal and provincial health division of labour in drug approval and availability; the clinical reasons used by governments and pharmacist bodies to assess risks the drug poses to individuals; and expose ideological practices within the government rationale to keep emergency contraception behind-the-counter. In doing so, I expose the fallacy of these clinical reviews that excluded women from the analysis and that resulted in the stigmatization of the use of emergency contraception as well as its function on a woman's body. The two clinical reviews, one conducted by pharmacists, the other by government further problematizes relying exclusively on a clinical discourse with little mention of the individuals that use the drug and the liberty they enjoy to access it, which resulted in the government continuing to evade responsibility for ensuring social and material access to emergency contraception.

5.1 Risk Management and the Federal and Provincial Division of Labour

The NDSAC makes a recommendation on the place of sale and conditions at point of sale to the provinces and territories. In 2001, the NDSAC reviewed the drug against clinical factors and recommended that if Health Canada were to deregulate emergency contraception in the future, it should be kept behind the pharmacy counter subject to pharmacist's intervention at place of sale. By 2003, the Canadian Pharmacists Association, the Society of Obstetricians and

Gynaecologists of Canada and Palladin Labs applied to Health Canada to change the status of emergency contraception. Subsequently, in 2004, Health Canada began to develop the rationale to ease access conditions for emergency contraception. This activated text is called the RIAS and like the screening form I analyzed in the preceding chapter, coordinated ideological practices trans-locally, enabling pharmacist screening and counselling. By critically analyzing these texts, different discourses come into view like neoliberalism, biomedical-compliance discourse and systemic sexism. What I get at in this chapter is why women were screened and counselled by pharmacists under a system that was supposed to enable access to emergency contraception between 2005 and 2008. How did pharmacists obtain this authority to ask women intrusive questions and to collect data about their requests?

Access to emergency contraception occurs via women's sexual health work and relies upon two ideologically rooted processes of ruling. The first includes the processes that alter a drug's status in federal legislation. The second is grounded in state policy-making processes that serve to identify priority areas for the government to engage in to improve health. Due to the high number of organizations with different responsibilities with regards to policy making and drug deregulation, these activities are fragmented and activities like the identification of policy priorities on women's health, risk assessment, consultation, changing the *Food and Drug Act* are organized by different organizations and thus shape different facets of sexual health work.

In terms of a federal policy with a focus on women's sexual and reproductive health, Health Canada's definition was last updated over in 1999 and aims to "... fosters good health by promoting health and protecting Canadians from harmful products, practices and disease. Sexual and reproductive health is as important to quality of life as other key aspects of health" (Health Canada, 2005). Protecting women in Canada from "harmful products, practices and disease" is language rooted in risk management and compliance discourses, one that frames sex as a risky

practice and the use of emergency contraception is seen as diminishing one's so-called "risky" activities like unprotected sex and unwanted pregnancy.

Risk management

Managing risk, or limiting state or private companies' liabilities against individual citizens, based on principles of insurance, can be seen as a social relation that seeks to externalize harm or risk from the social world onto individuals. Women's distinct health needs are often not considered a part of the risk management process. Risk management can be seen as being tied to self care, biomedical power and the responsible health care consumer discourses that includes informing people of the risks "inherent" in certain activities and framing certain activities as dangerous or risky so as to reduce systemic or health professional's accountabilities/liabilities to "consumer-citizens". Managing risk, or setting up emergency contraception as a "risky" practice from which women need to be "protected" (Government of Canada, 1999) served to establish pharmacist "power-over" women, to ensure compliance to the clinical authority. This practice can also be seen as a neoliberal accountability exercise that framed the social and material conditions of sexual and reproductive health as an individual responsibility thus creating the space to reduce the state's responsibility for overall health and well-being. The neoliberal creep in health care delivery was evident in the very format of the state-rationale to increase the availability of emergency contraception. Embedding risk management practices within the bureaucratic textual regulations meant that women's reproductive needs or her freedom to address her health are not at the centre of the social relation of access.

Risk management contrasts against my definition of reproductive freedom, that I define as women having the freedom to engage in sex for pleasure and be free from state practices and oppression, including accessing unbiased, informative and accurate health services and information. Health Canada's rational to deregulate, the RIAs, contained many references on

reducing harm or risk by easing access conditions to emergency contraception, which I explore in the following sections.

Federal – provincial division of labour

At the time the decision was made to pursue deregulation of emergency contraception, research about over-the-counter provision and the safe and effective self-administration of emergency contraception was emerging. By 2005, when Health Canada amended the *Food and Drug Act*, its decisions should have been informed by this growing body of literature that attested to women being able to self diagnose having had unprotected sex as well as their abilities to take the medication without supervision from a health professional. Indeed, health advocates were promoting the idea that women should be able to freely obtain emergency contraception to keep at home and use when required (Erdmann and Cook, 2005, p. 144).

A key difference in the responsibilities of the federal and provincial governments is that the federal government sets drug policy and the provinces pay for the costs of the drugs. Pharmacist regulatory organizations operate federally and provincially; the federal NAPRA makes recommendations about a drug's status to Health Canada as well as to the provincial regulatory organizations around conditions to be met at the place of sale, at the counter. In 2001, the NAPRA assessed emergency contraception against a set of ten criteria and found the drug sufficiently risky so as to require supervision by a pharmacist at the counter, upon request. The results of this review were revisited by the organization again in 2004 and its recommendation was sent to Health Canada prior to the development of its rationale to amend the *Food and Drug Act*. What emerged from my analysis is that drug deregulation occurs within a loosely defined "health-industrial complex" with industry, professional bodies and the federal and provincial governments holding different responsibilities. Identifying the sources of ideological practices

that shape sexual health work becomes particularly difficult with regards to drug deregulation, due to the different types of organizations involved.

5.2 Manufacturing Risk: Drug Assessment Criteria

The National Drug Scheduling Advisory Committee of the NAPRA has a mandate to provide advice to provincial pharmacy regulators regarding the place of sale of drugs within the different access schedules legislated by the *Food and Drug Act*. The Committee published its records of decisions as committee minutes on its website and described the ten “factors” that they assess all drugs against to determine the relative “risks” to individuals if they have different forms of access – behind, or over-the-counter. When emergency contraception became available in Canada in 2001, the Committee used these “factors” to recommend non-prescription, behind-the-counter, conditions of access. When Health Canada deregulated the drug in 2005, Schedule II conditions were attached.

The 2001 NDSAC minutes only cited the specific factors they cited as being association with emergency contraception. I will analyze the four “factors” cited by pharmacists to maintain restrictions on emergency contraception, “after applying factors #1,2,8 and 9” (National Drug Scheduling Advisory Committee, 2001).

The first reason cited, or “factor 1” was that the medical condition requiring the initial use of medication because “normally identified by the practitioner, in addition that chronic, recurrent, or subsequent therapy must be monitored by the pharmacist” (National Drug Scheduling Advisory Committee, 2002, p.1). As outlined in literature published in 2001, the only eligibility requirement for emergency contraception is having had unprotected heterosexual-reproductive sex – a condition best identified by the woman requesting the drug that does “not require any professional expertise” (Grimes et al, 2001).

Seven of the eight women I spoke with, and myself self-diagnosed the need for emergency contraception due to previous contraceptive failure. Given that emergency contraception pills are taken within 12 hours of one another and the instructions were characterized as easy to use by all of the women I spoke with, and in the literature, it is unlikely that women require their use monitored by a pharmacist over time. Studies suggest that repeated use of emergency contraception is safe and should not be characterized as chronic. These reasons should not be used to keep emergency contraception from women and represents paternalistic and invasive surveillance of women by pharmacists, and their employers, the corporate pharmacy industry. Surveillance was organized in many sites through the application and activation of these “factors” so as to set up using emergency contraception as a risky practice. Furthermore, pharmacist activities like screening and counselling, as well as the collection and storage of sexual health data serves to reinforce the new gatekeeping role.

The second reason assessed or “factor 2” is related to the time-sensitive feature of using emergency contraception within five days of unprotected sex. Factor 2 states the drug “must be readily available under exceptional circumstances when a prescription is not practical” (National Drug Scheduling Advisory Committee, 2002, p. 2). Visiting a doctor’s office during regular hours of business presents a barrier to access for some women, as they may need the drug in the evening or on the weekend, when a doctor may not be available. Time was a major consideration in obtaining, and then taking, emergency contraception as indicated by all of the women I spoke with. Adding in a new gatekeeper, the pharmacist, delayed access for a couple of women by a few hours and the NAPRA did not anticipate such an additional time delay. All the women I interviewed understood that emergency contraception worked best the sooner it was taken and all reflected that access at the pharmacy counter over a physician enabled rapid access at unusual times during the week – during lunch hour, after work, or at 3 am. The reality of living in

northern Ontario or in rural or remote areas presents many challenges to access. Not all pharmacies are open 24 hours. Furthermore, a refusal to dispense emergency contraception in a small town where there is no other pharmacy is not just a barrier, it represents a harmful practice. This factor represents a legitimate consideration in determining drug access and likely should have been a consideration for a full shift to over-the-counter, non-prescription access.

The third assessment criteria, “factor 8”, refers to the use of a drug that requires “reinforcement or an expansion of the directions for use, through pharmacist-patient dialogue” (National Drug Scheduling Advisory Committee, 2002, p. 2). Erdman and Cook identified a contradiction in the clinical literature regarding the need for such dialogue since the treatment is the same for all women and, “Emergency contraception is simpler to administer than many medications...which require tailored dosages based on patient characteristics or therapeutic response” (Erdman and Cook, 2005, p. 145). There was little evidence in 2001 that women required specific direction or further information on how to take emergency contraception properly. The packaging information included with the medication describes when and how to take the medication. Seven of the eight women I spoke with were comfortable with the instructions on the use of the medication; and studies published after the NAPRA decision on Schedule II status attest to ease of use when there are clear instructions on the packaging labels. This characterization of emergency contraception sets up pharmacists as the clinical authority on assessing for unprotected sex without presenting credible information that women require more dialogue or direction.

The last reason cited by the NAPRA on emergency contraception, “factor 9”, refers to medications that have new ingredients and may have unknown or under-studied properties. Research on emergency contraception has been conducted for decades and it is often touted as one of the most widely studied medications. This is not to say that more scrutiny on the practices

of research on sexual and reproductive health is undeserved as it is due to the material, social and historical context of contraceptive development and promotion. However, this is not a new medication with unknown ingredients and this factor was simply poor evidence being used to establish pharmacists as having the authority to recommend the drug's use to women. Yet using this reason for behind-the-counter status on emergency contraception is capricious and not grounded in clinical evidence.

All told, one of the four reasons cited by the pharmacy regulatory committee directly applied to the reality of emergency contraception access. Behind-the-counter conditions created new barriers and different kinds of wait times, however, the women interviewed for this study found emergency contraception easier to access through a pharmacy. The other three reasons that were used to assess the drug as “risky” set up a future role for pharmacists with regard to sexual and reproductive health screening and counselling. The pharmacy body did not take into account the women using the drug, how the practical reality around the implementation of this practice, like safeguarding privacy and confidentiality in pharmacies and at the pharmacy counter, the collection and retention of sexual health information, nor the unequal power relation between pharmacists and women and the harmful practice of refusal to dispense the drug. The decision to frame emergency contraception as risky, requiring professional monitoring and control appears harmful and sexist when reviewing the evidence presented by pharmacists.

5.3 Faulty Knowledge: Federal Rationale for Behind-the-counter Access

Clinical discourse: Eligibility standards and mechanism of action

Similar to the role of the pharmacists on the National Drug Scheduling Advisory Committee, modifications to the *Food and Drug Act* requires that the federal government assess any drug for benefits and costs to the status quo against a set of “factors” to re-classify a drug

from one Schedule of the *Act* to another. The rationale developed by the government for levonorgestrel omitted most of the citations of studies reviewed, the name and/or credentials of the author who is a bureaucrat employed by Health Canada and the process used to review data produced during the clinical review trials, as well as post market surveillance data and information. As others have noted (See Silversides, 2005 and Lexchin, 2004) this information should be released for individuals or even other governments to review, however, Health Canada safeguards pharmaceutical industry information and does not release any information disclosed to the agency during clinical trials by manufacturers that may address safety concerns nor any apparent or real conflicts of interest within the rationale. Thus, it is difficult to ascertain how Health Canada arrives at scheduling decisions, as much information related to how the drug works, along with the process by which the government arrives at these decisions, is not released to protect corporate interests and information used to obtain the specific patents for drugs. The rational is analyzed to understand the ideological practices that informed the government as it shifted access to emergency contraception.

The initial portions of the RIAS introduced levonorgestrel and included four pages of clinical information about the development of the drug, its history of use, its safety record, its use around the world and the way the drug works on a woman's body. The document does not discuss the women who use the drug, nor their eligibility - unprotected sex - until mid-way through the document. The government's risk assessment methods were considerably different from pharmacists at the NAPRA some of the safety factors listed by government were in direct opposition to the factors assessed by the pharmacists on the NAPRA.

For instance, Health Canada found that emergency contraception did not require ongoing supervision, that instructions for the drug's use were clearly included in the packaging information, thus negating the need for pharmacist-patient dialogue and that monitoring women

over time was not required. The other area where the government differed from the NAPRA assessment of emergency contraception was in how it was acknowledged that women could self-diagnose their need for emergency contraception (Government of Canada, 2005, p. 861). Lastly, the government found that emergency contraception does not “mask other ailments” (*Ibid*), does not protect against sexually transmitted infections and that this information be added to the packaging labels in a prominent manner (*Ibid*).

Health Canada used clinical language to describe the mechanism of action, or how the drug works on the body, as “preventing the release of an egg, its fertilization, or *preventing the fertilized egg from attaching to the wall of the uterus*” [emphasis added] (Government of Canada, 2005, p. 858). Evidence in 2005 did not attest to emergency contraception interfering with the implantation of a fertilized egg; to the contrary, research emerged in the 1990s showing that levonorgestrel functions to “interfere with prefertilization events. It reduces the number of sperm cells in the uterine cavity, immobilizes sperm and impedes further passage of sperm cells into the uterine cavity. In addition, levonorgestrel has the capacity to delay or prevent ovulation from occurring” (Croxatto et al., 2001, p. 111 and Croxatto et al., 2003, p. 68).

Framing emergency contraception as having post-fertilization effects is a stigmatizing, exclusionary tactic taken up by some anti-choice groups who view contraception and abortion services as contentious. It constructs emergency contraception as less like contraception and more like an abortion. The false information in government literature on the drug’s definition sets up the role for more information, assessment, counselling and referrals by pharmacists quite nicely; emergency contraception was framed as a risky drug that requires professional monitoring. This also served to leave the drug open to contestation about its physiological function, lumping it in with medical abortion drugs, and thus permits anti-choice factions to dispute its role as a contraceptive. By including an incorrect definition of the drug, not grounded in the literature

published at the time about emergency contraception, the government took up this myth and further exacerbated the stigmatization about emergency contraception and its use. Furthermore, the incorrect definition of the drug was included on the drug's packaging labels. The drug's labels are screened by the NAPRA and Health Canada and thus the information distributed with emergency contraception included the incorrect definition in the early period of deregulation. The false definition of the drug was also included on the manufacturer's website where it remains to current day. I conclude that the false characterization of emergency contraception as having post-fertilization effects has real implications for women. For instance, as I indicated previously, there was some confusion amongst the women I spoke with about how the drug works on their bodies. Recall that this may have affected some of the women who participated in this research as they obtained information about the drug from a number of sources – friends, health professionals, the internet and at school. These women dealt with their lack of knowledge in different ways. The results of the spread of faulty information by the state gives credibility to the myths or “problems” with emergency contraception resulting in stigmatization, confusion, and perhaps the drug's under-use.

Most of the women I spoke with had a poor knowledge of the ideas of implantation, fertilization and the biological aspects of reproduction that emergency contraception interfered with. One woman had to pause and reflect on how the drug works on her body, “I never questioned the knowledge I was fed...you know I never actually really thought about that” (Diana). When asked, others believed it caused symptoms similar to a miscarriage or that it caused a miscarriage. Between all of the women, some were not interested in knowing the function of the drug as long as it prevented unwanted pregnancies. Other women did want more accurate information and yet the official texts were misleading women and others, therefore the

inaccurate definition of the drug on the part of government contributed to retaining restrictions on emergency contraception.

As an activity of ruling, “consultations” occurred in June 2003, a letter was sent via email about the proposed regulatory change to provincial deputy ministers of health, the provincial drug managers, deans of pharmacies, registrars at the pharmacy associations, industry and regulatory associations, professional and consumer associations, the Canadian Food Inspection Agency, Industry Canada, Standards Council of Canada and, “other interested parties...related to pharmacy” like a few women’s organizations. Largely, the recipients were part of the ruling regime like health professionals and academic organizations related to pharmacy. The proposal was published the following year in 2004 in the *Canada Gazette* to make “public” the proposed amendment to the *Food and Drug Act*. The government requested feedback on the proposed amendment within 75 days and these responses are published in the RIAS. Many feminist organizations appear to have been excluded from the consultation, as were academic departments that conduct research on women and health. With only 75 days to submit responses, the consultation meant that many organizations and individuals that work on access to contraception were excluded from the process. This final RIAS was published in May 2005 and is the document that I analyze in this section.

The RIAS revealed there was more opposition to the amendment in terms of real numbers – 152 responses were opposed to deregulation with 145 in favour, however when examining the composition of these responses, there was a diversity of groups and opinions amongst those in favour. More organizations, or groups of people, supported the amendment while more individuals were opposed, with about 50 organizations or associations and 95 people in support of the change representing 145 different responses; these included those from district health

organizations, women's health groups and provincial or national associations representing physicians, pharmacists and nurses (Government of Canada, 2005, p. 863).

The consultation portion of the RIAS was difficult to analyze; most of the time, the federal government deferred responsibility to a number of social organizations that represent a "health-industrial" complex that included, state, industry and professional bodies like the drug manufacturer, the national professional regulatory body, provincial governments, provincial pharmacy authorities or the national pharmacy professional association, the Canadian Association of Pharmacists.

During the consultation, supporters of deregulation recommended that information on the product labels include multiple languages, contact information where women could seek further information from community organizations or telephone numbers. Health Canada pointed to the manufacturer as responsible for product label information even though the NAPRA indicated they reviewed the draft product labels for emergency contraception in 2004. As for including information about community resources for women, Health Canada acknowledged that this was possible and could be "made available by parties other than the manufacturer by means other than the product label." This is a vague response to the important task of increasing women's knowledge about the new way to access the drug, or about how it works. Information on the packaging labels for the drug in 2013 lists includes post fertilization events and thus continuing to problematize emergency contraception.

I argue that the decision made to keep emergency contraception behind-the-counter was political and that the government gave up "neutrality" and evidence-based decision making to other, competing social forces. Deregulation was accompanied by little to no funds to increase women's knowledge about the new mode of access to the drug or the way it worked so as to reduce the social relations of stigmatization surrounding its function and use after unprotected

sex. Evidence from the Ontario pilot project study attributed a marketing campaign to increased use of the drug because of an increase in awareness and yet the federal government did not provide funding for educational campaigns on the new modes of access or about general information about the effectiveness of emergency contraception (Dunn et al.). While the government cited the Ontario study but omitted the specific findings on increasing knowledge and awareness from the rationale. Other research revealed a lack of knowledge about how the drug works, as did the women who spoke to me with many confusing emergency contraception's function with that of medical abortion or miscarriage. External research found a lack of knowledge and misperceptions led to some serious consequences, including the belief that use of the drug would be harmful to their well-being, feeling stigmatized by service providers, members of their community and/or family members (Shoveller J, Chabot C, et al., 2007, p. 13). This study from BC concluded that a poor understanding of how emergency contraception works might create further barriers to its effective use.

In the rationale, opponents of deregulation raised the misconception about the drug function as having post fertilization effects, linking the drug with abortion. These anti-choice respondents were opposed to deregulation and demanded that women *be made aware* of how the drug works as an abortifacient as it may have “devastating” consequences for her personally. Health Canada did not reject this notion in its response, rather, they contributed to the misperception and reported that post-fertilization effects would be on the drug label and that pharmacists were being trained to tell women that this was a way the drug could work. Rather than reference women’s legal rights to access, feminist evidence around freedom of choice or evidence-based medicine, Health Canada bent to the so-called “rhetoric of choice.” Instead, the government used poor evidence to evade dealing with the “politics” of women’s health and specifically, the mechanism of action, and did not challenge this anti-choice conception by using

evidence based knowledge. Rather, Health Canada stated that “women will have the information needed to make a *personal, informed* choice” (Government of Canada, 2005, p. 862) a response that I find further contributes to the stigmatization of women and emergency contraception. As I argued in Chapter Three, anti-choice tactics take up activities and ideological practices that are in opposition to the anti-choice goals and the rhetoric of informed choice is being employed but it is not in fact truly informed choice. Indeed, leaving the incorrect mechanism of action in official texts made the federal government complicit in anti-choice tactics. Further, what about the material conditions that need to exist in order to make that choice? What about maintaining the legal status to gain access? Or about those women who do not want to engage in anti-choice discussions about implantation or fertilization?

Clinical discourse: side effects, repeat use

Since oral contraception first came onto the market in the 1970s, there was a “large amount of post-market data available” for Health Canada to review in the rationale. Health Canada outlined that there have been no adverse reactions or safety problems since it began to be used as a prescription drug in Canada since 2000. The rationale continued to develop the justification to remove the prescription requirement for emergency contraception. The government also cited three decades of data regarding the use of oral contraception on a daily basis over the long term as a “long history of safe and effective use.” The rationale to deregulate goes onto summarize clinical evidence that emergency contraception does not cause problems for those with pre-existing heart or liver conditions nor does the use of the drug increase the risk of birth defects or ectopic pregnancy. Emergency contraception was not found to cause any harm to an already established pregnancy. Studies published as early as 2001 indicated the only side effects for emergency contraception were minor, like nausea and vomiting, with the few cases of

serious side effects associated with oral contraception having no “causal association” (Grimes et al, 2001, p. 152) with emergency contraception.

The women who were interviewed for this thesis experienced the side effects of nausea and vomiting; one woman spoke of being ill and ended up speaking with a pharmacist via Telehealth services who told her that she had likely absorbed enough of the medication between time of ingestion and getting ill that the medication likely worked. She did worry enough about this to see her doctor afterwards about whether emergency contraception had worked. At the time of the interview she was still confused about how the drug worked on her body, having had good knowledge about how to access and take the drug but not having a good idea of what it was doing to her.

Many of the questions posed during the consultation by those in opposition to deregulation referred to health issues associated with emergency contraception that demonstrated a lack of knowledge and were a part of stigmatizing practices surrounding emergency contraception. Rather than using feminist or even legal arguments to dispute any of these questions, the government refuted these questions using clinical evidence only.

Health Canada appeared to try to quell any notions that removing a prescription requirement would lead to so-called “excessive” use (Government of Canada, 2005, p. 859) and argued that the repeated use of emergency contraception is a risky practice by listing, “several reasons why levonorgestrel 0.75 mg is not a logical choice for ongoing contraception” (Government of Canada, 2005, p. 859). What followed were inaccurate reasons cited by the government like emergency contraception being less effective than any other form of contraception. When comparing percentiles about contraception failure rates, the contraceptive patch, oral contraceptives, contraceptive injections and the contraceptive ring all fail about nine per cent of the time; condoms 18 per cent of the time; female condoms 21 per cent; and lastly,

emergency contraception, if used within 72 hours, has a failure rate of 11 percent (Centers for Disease Control and Prevention, 2013).

Another reason the government listed was that the long-term use can lead to “prolonged medical bleeding”, which is contradicted by Health Canada’s earlier statement where long-term use was cited as safe and effective. Prolonged bleeding appears undocumented in the literature (Grimes et al, 2001) and it is generally a side effect of oral contraception. Since oral contraceptives are composed of different combinations of hormones and have different patterns of use than emergency contraception, used daily over a large span of a woman’s reproductive years, this side effect should not be listed for emergency contraception. Lastly, nausea and vomiting “would deter from its routine use” (Government of Canada, 2005, p. 859). I conclude that the government crafted a cautionary message against repeated use over the long-term, despite the evidence in the literature at the time of deregulation and within the different sections of the government rationale that women could use the drug repeatedly with little side effects or problems.

As I indicated in the preceding section, the government rationale was lacking in many ways, including not using the approaches like evidence-based medicine, legal or feminist frameworks which creates barriers to use and thus contributing to increased risks of unwanted pregnancy. Here, what became visible within the RIAS, was that the government is seeking to establish itself as a source of knowledge on emergency contraception to set up the social relation of women complying with the clinical authority - discourse. Furthermore, the government broadened the ideal of a responsible contraception user, who plans her methods of contraception in advance of unprotected sex that endorsed a limited use of emergency contraception to include only certain, logical conditions, which requires women to submit to a particular definition of the drug, its side effects, treatment and associated processes.

Despite the ability of women to self-diagnose a need for emergency contraception safely and effectively, Health Canada began to establish that emergency contraception is more safe when provided by a medical authority with the ability to screen and educate women. Women were rarely mentioned and the document excluded most of the material and social conditions under which women access emergency contraception that will be discussed in the next section.

5.4 The Absence of Women and the Social and Material Conditions of Access

As demonstrated by women in the previous chapter, access to emergency contraception relied upon many activities. Much of women's sexual health work involved interactions with different people - like a friend, boyfriend or boss; finding information about the drug; consideration of time; transportation and location of the pharmacy; negotiation for access with those working at the pharmacy; strategies to reduce or alleviate the social relations of stigmatization experienced while waiting in line; speaking to a pharmacy assistant; speaking in a glass box with a pharmacist; or, navigating referrals to another pharmacist. All of these tasks describe some of the social and material conditions of access; some of which the government identified in its rationale but largely failed to address, or even considered addressing, any of them. What is important to remember here is that the women who participated in this thesis identified a range of issues around access to emergency contraception, not just timing and cost, the two issues raised substantively by the government as reasons to deregulate.

Thus when the federal government outlined in the RIAS that it intended to increase access by placing emergency contraception behind-the-counter, it failed to establish that access to emergency contraception involves more than simply creating a new space where the drug was available for longer hours. Moral surveillance, stigmatization, transportation, cost, timing, language of service, the gender of pharmacist, communities, culture, knowledge of how to get the

drug and knowledge about how the drug worked and interactions with various people all were aspects of women's sexual health work and affected access to emergency contraception.

So while the government identified time and costs as affecting access, the information in the rationale seemed like an attempt to carve out a new role for pharmacists. The absence of an overt commitment to evidence based medicine, feminist scholarship or even legal analysis enabled anti-choice discourses to infiltrate and dominate government ideological practices. The government steers clear of an overt political or legal position on the availability of emergency contraception and this absence affirms the bureaucrats privileged certain forms of knowledge, developed outside of lived experience, in order to obtain compliance from women.

By not identifying many of the social or political consequences of access to emergency contraception, or unwanted pregnancy, or by associating emergency contraception with abortion by providing a scientifically incorrect definition of the drug, the government became complicit in spreading anti-choice rhetoric. Refusing to engage in the social, material and political realities that women have to grapple with, the federal government even failed to establish the legal means by which women have a right to use these drugs without interference, bias or stigma. What this does is leave women in a vacuum of access that enabled the "creep" of other ideologies. How do we enable the bureaucracy to inform and imbue so-called neutral, clinical health policy decisions, that are never really neutral as the provision of health services is always imbued with different ideologies, as this example shows with the actual politics of sexual and reproductive health? In omitting discussions of choice, decision-making, power, capacity, experience, do we undermine the choices women make around controlling their reproduction?

Furthermore, Health Canada did not outline any of the social benefits of a woman being able to control her fertility. Unwanted pregnancy is not viewed as harmful nor is the rationale grounded in any legal, feminist notions of freedom to access the drug. The reliance a faulty the

clinical discourse situated women's experiences and other social forces that seek to deny access to sexual and reproductive services outside of the bureaucratic rationale and regulatory process overall. These ideological practices enabled the exclusion of the social and political conditions of women's access from the discussion entirely.

Time

The government discussed three facets of the social and material conditions of access to emergency contraception – equality of access, time and costs. Some provinces deregulated access to emergency contraception before the federal initiative that resulted in the drug not being equally available to women across the country. The second reason raised by bureaucrats was that women will have easier and faster access to emergency contraception through pharmacies due to the longer operating hours when the drug may be needed, like on the weekend or after business hours (Government of Canada, 2005, p. 858). All of the women who shared their experiences cited longer hours of pharmacies as assisting with increased access.

Costs

The cost of emergency contraception was listed within the government rationale as one of the benefits/costs related to deregulation. Women in my research found emergency contraception expensive and costs increased from the initial pilot phase of deregulation, discussed in Chapter Three, by \$10 to \$20 in 2007 when these interviews were conducted. The federal government indicated there was strong support for “continued coverage” under provincially-run or private insurance plans. The rationale acknowledged that women may have to pay the entire cost of emergency contraception and that prices may increase due to a fee for counselling attached to the medication, depending on provincial and corporate-pharmacy policies.

I have already outlined the specific fees that may be attached to emergency contraception, with the information derived from two pilot projects of pharmacists dispensing emergency

contraception. Costs increased for women and the women I spoke with mostly found the cost prohibitive. The RIAS addressed this feature briefly as the only risk to behind-the-counter status for emergency contraception and the federal government points out that coverage for the counselling fee was not under its jurisdiction and would be “negotiated” by provinces and territories.

Indeed, the cost of the medication was a barrier to access, especially for five of the eight women I spoke to that have limited financial resources or may not have regular employment, like younger women or students, or if women had to pay extra costs like transportation or ask for time off work to get the drug. These examples revealed that cost is an important consideration for most women, regardless of where they live or their class. How did Health Canada determine that women required counselling when accessing emergency contraception? How was this transfer of services accomplished - from physicians in a publically funded, non-profit system, to pharmacists in a for-profit setting? Why were these costs deferred to women?

While the public drug benefits system does not cover women’s emergency contraception, the federal government indicated there would be a “negligible” effect on provincial systems if coverage was extended for pharmacist visits. The federal recommendation in the rationale was non-binding and this section illustrated a pattern in the RIAS of the federal government shirking concerns brought up during the consultation by deferring to the provinces or professional regulatory bodies to rectify any barriers related to the social and material conditions of access. For instance, examples include education, cost, fees for counselling services, privacy and confidentiality. The tension between federal and provincial division of labour in delivery of health care gave both levels of governments an easy excuse to not engage in any of the facets of social and material conditions of access as they simply indicated it was not their responsibilities. Furthermore, the federal provincial division of labour affected women since each woman in this

study cited reasons like cost, lack of privacy and confidentiality provisions and the evolving relationship between the pharmacist and women.

Many respondents raised increased prices as an issue during the consultation that supported deregulation and these people were concerned that private or provincial drug benefit plans would not cover the cost of the medication. Health Canada did not raise the evolving nature of health service provision from publicly funded physician visits to “pay for service” at the pharmacy counter. Public drug plans, as administered by the provinces, set guidelines on coverage in collaboration with provincial pharmacy regulators. The rationale does not discuss the increased costs due to professional fees that were added to the base price of the drug. Nor does Health Canada point to the federal Patented Medicines Price Review Board that establishes the costs of medications nationally.

The impacts of this type of information production by the bureaucrats responsible for deregulation had grave consequences. This is due, in part, to the knowledge produced about emergency contraception being detached from women’s experiences; pregnancy risks, side effects, safety regimens, international literature reviews, are all described with little reference to the body it is acting upon. This keeps emergency contraception and its access soundly in the biomedical gaze because politicians and policy makers are too cautious of delving into the politics of sexual and reproductive health.

5.5 Ruling via Stigmatization: Pharmacist Practice, Counselling and Education

Conditions at Point of Sale

Proponents of deregulation identified a range of potential barriers or posed questions seeking further information. In all cases, Health Canada’s responses deferred all responsibilities to another organization for solutions to the barriers.

For instance, one issue raised in the consultations related to the lack of jurisdiction the federal government had over conditions at point of sale. Prior to Health Canada changing the drug from prescription to non-prescription in the *Food and Drug Act*, it sought assurances from the national regulator, the NAPRA, that it be kept behind-the-counter. Since most of the organizations consulted were a part of pharmacy practice, this issue being raised is of no surprise as most individuals who were consulted have a stake in a pharmacist's new role with women.

In the bureaucratic response to this, the federal government acknowledged its lack of jurisdiction over conditions at point of sale and cited the 2001 NAPRA recommendation that if Health Canada were to change prescription status for emergency contraception, it be kept behind-the-counter.

Counselling and education

Five responses to the consultation disagreed with the drug being kept behind-the-counter, along with the intervention of a pharmacist in screening and counselling women. These respondents felt emergency contraception should be freely available without restrictions. Rather than outline the criteria by which NAPRA made the decision for behind-the-counter status, the federal government simply acknowledged that it did not have jurisdiction over conditions at point of sale. Again, as stated previously, this type of response enabled the government to not take part in any of the politics around access to emergency contraception and increasing pharmacist's scope of practice, and bowed to the lobbying that was clearly occurring behind the scenes by health professional associations at the time of regulation.

Pharmacy practice and training guidelines

Pharmacists obtained wider scopes of practice, and the Canadian Pharmacists Association, as the federal government explained was "poised and ready" with extensive training guidelines to counsel and assess women. Most prominent in the government rationale was that it

privileged certain types of information like some clinical “facts” that had glaring errors and organizations like the Canadian Pharmacists Association and the NAPRA that set up pharmacists to benefit from their own recommendations. These organizations set national clinical standards for practice and care and had clinical guidelines already developed on the use of emergency contraception prior to deregulation. Indeed all three sponsoring organizations, the Canadian Pharmacists Association, the Society of Obstetricians and Gynaecologists of Canada and the drug manufacturer, Palladin Labs, had called for and been a part of the initial Committee meetings of the NAPRA and the sponsors of the schedule change for emergency contraception in the early part of 2000. Where were women within all these processes?

Consent, privacy and confidentiality

A number of those organizations and individuals in support of deregulation raised issues related to the practice of pharmacy including that the privacy and confidentiality of women should be guaranteed, there were also suggestions that pharmacists should receive uniform training and that “standards of care” be implemented with ongoing monitoring to ensure the professionals were meeting these standards. Another concern related to the need for social activism and accountability measures to ensure that all provinces have policies to deal with pharmacists that refuse to dispense emergency contraception to women and that referrals to other pharmacies should be guaranteed where possible.

What becomes apparent is that the federal government was engaged in a neoliberal accountability exercise in drafting its rationale as it continually identified pharmacy practice, guidelines, training, ethics, privacy and confidentiality as the responsibility of provincial pharmacy bodies. Health Canada did not acknowledge these issues like barriers to access, unlike cost, and as I heard from women, privacy and confidentiality and data collection and storage were issues some grappled with while seeking emergency contraception.

The last issue identified by supporters of deregulation during the consultation was about information sharing, in that guidelines and other materials developed by pharmacists should be shared with other health professionals at no cost. In response, Health Canada stated that these national guidelines were available online at the Canadian Pharmacists Association website. Yet in 2007, when I began to interview women about their experiences in seeking emergency contraception, I visited the website and training materials were available, if a membership fee had been paid to the association.

Since I could not access the material used to train pharmacists on how to screen and counsel women, this shows a lack of commitment to transparency at many levels, a key finding of this thesis. The process of the review of clinical trial data remains unpublished, the citations of the data or research reviewed by government is not identified, and the NAPRA decision to recommend Schedule II status was made following an in-camera meeting of the Committee. Rather than grounding access in state-legal means, like sexual and reproductive rights or the liberty to control one's body, the government deferred direct questions related to deregulation to other organizations.

An organization that represented a provincial pharmacist association and another that represents pharmacy industry wrote to propose that Health Canada should grant pharmacists the authority to prescribe emergency contraception and these groups pressed for costs of the drug to be covered under public and private drug plans, for payment from government for pharmacists' fees for services, training and pharmacists being able to refuse to dispense the medication. These distinct issues were grouped together in the opposition section and Health Canada's response was brief and indicated changing pharmacists' prescription authority would inhibit access to women by requiring more time. Health Canada did not address the fees for services for pharmacists, or the ability of pharmacists to refuse to dispense drugs. However, for the first time in the RIAS,

Health Canada acknowledged the “shared responsibility” between the federal and provincial governments and organizations in order to provide “access to safe and effective, quality drugs” (Government of Canada, 2005, p. 869).

Moral regulation: Age, surveillance, privacy and confidentiality

The prevalence of moral regulation and stigmatization of emergency contraception was apparent at many different levels, the individual, the community and societally. First, some of the women I spoke with perceived seeking abortions as irresponsible and compared the use of emergency contraception against abortions and thus elevated certain social practices over others representing the stigmatization of many aspects of fertility regulation. A few women experienced the social relation of stigmatization in the use of emergency contraception; one was reluctant to mention using it to a friend and another waited around so no one would see her ask for it.

Another study that spoke with women in BC of Asian or South Asian descent who cited similar concerns – of members of their communities finding out they had used the drug or saw them get it. This study spoke with women who had never used emergency contraception before and revealed some examples of the social relations of stigmatization they projected onto users or repeat-users as, “irresponsible,” “careless,” and that, “they resort to using emergency contraception because their “poor judgment” or “low character,” leads them to “have sex when drunk or high, or to be promiscuous” (Shoveller J, Chabot C. et al, p. 15). These statements were contrasted against empathetic feelings by those women who had used the drug before towards others that used it, which illustrates the differing impacts of stigmatization within communities on individual women.

Since many of the women in the BC study were also uninformed about its mechanism of action, I can identify some patterns. That women can read instructions and follow them, that they tend to know whether they may become pregnant due to unprotected sex and understood how to

access emergency contraception and I broaden my definition of sexual health work to include these activities. On the other hand, the women I spoke with and as other research attests, women have low knowledge of the way the drug works on the body, leading to misperceptions about its use, stigmatization, judgment, embarrassment. These barriers inhibit access and leave women more vulnerable to unintended pregnancy. The process of deregulation and the literature produced by bureaucrats, industry and pharmacists to increase access, framed emergency contraception as a drug that may have an effect on fertilization and dangerous side effects thus, requiring professional assessment and advice. Indeed, the RIAS and its risk management framework used the side effects and potential for “excessive” (Government of Canada, 2005) use by women (really, using the drug repeatedly), as the rationale for pharmacist intervention.

Pharmacists’ expertise was framed as the safe way to ensure that “women are appropriately screened and counseled before receiving it” (Government of Canada, 2005, p. 856). The federal bureaucrats exposed this mediated deregulation by pharmacists as a safe practice that the Canadian Pharmacists Association developed guidelines and extensive training for pharmacists. This language promoted pharmacists to having the authority as the arbiters of women’s need for emergency contraception as the basis for safety to guard against women using emergency contraception “excessively” and to determine if they had unprotected sex.

To summarize, the bureaucratic rationale to deregulate the drug began by showing the drug’s safe use over decades that it was easy to administer and use, and that women would be better and more equally served in Canada by direct access at the pharmacy counter. The bureaucrats began to construct a rationale to justify pharmacist intervention as the safe approach to loosening restrictions for emergency contraception as women required assistance. I uncovered some subtle and overt misconceptions on the part of government that included neoliberal and sexist ideological practices. It appears that in drafting its justification in the RIAS in 2005 the

government anticipated anti-choice opposition to the deregulation of the drug and was appealing to these groups by merely responding to repeated uninformed questions posed in the consultation section of the document. Responding to anti-choice queries in the description and consultation sections of the rationale gave substantial merit and credibility to this ideological discourse. Finally, it is distressing to see the real lack of evidence presented to justify pharmacist intervention in sexual health education and counselling.

Federal policy decisions, clouded by shoddy review of the clinical literature, using a process unidentified to women who are affected by the outcomes and containing outright inadequate information about the biological function of emergency contraception, served to benefit professional interests over women's. In privileging the medical discourse, and limiting discussions about women and their bodies, does this approach serve politicians as well as pharmacists? By not engaging in a candid discussion about women, reproductive freedom and choice, politicians or bureaucrats cannot be held responsible by feminists or anti-choice groups for this policy decision. Really, this approach facilitated by risk management that ends up in no one being accountable for conditions of access.

Another concern brought up by those opposed to the amendment inquired about the US's decision to deny women over-the-counter access. This debate is still ongoing in America and relates to denying young women access to emergency contraception without parental consent.² The RIAS stated that at the time of deregulation debates in America, the US indicated there was a lack of statistics related to use of the drug by those under the age of 16 and denied women over-the-counter access. Rather than dispute that all women, regardless of age, are free to access

² At the time of writing, a group of people, including parents of young women, sued the politically appointed head of the Federal Drug Administration for the right of all women to access the drug. The Obama administration appealed the first Federal Court ruling that had struck down the administration's decision to limit access to those over 16.² The American government appealed the decision, with much criticism from women's organizations, and the appeal was struck down, again in early June 2013. Finally, the government relented and now, women in America of all ages can access emergency contraception

contraception, Health Canada explained that deregulation in Canada was different than in the US since the transaction was being monitored, “behind-the-counter status would give timely access and professional advice” (Government of Canada, 2005, p. 867). Here, it becomes evident that the government was prepared to deregulate access to emergency contraception so long as women continue to be monitored about their use. The insertion of pharmacists in sexual health screening and counselling becomes a part of the accountability exercise to ensure access occurs in a “responsible” manner.

The last concern raised by one opponent to deregulation that Health Canada decided merited a response, was that an “objecting” pharmacist should not be obliged to refer to another provider, leaving women without access to the drug. Rather than frame this as an issue of ethics with potential professional or legal ramifications or even identifying the harm this would cause women, the federal government deferred responsibility again by simply stating that this was the responsibility of professional associations. Furthermore, rather than dispute that all women, regardless of age, are free to access contraception, Health Canada explained that deregulation in Canada was being monitored by pharmacists.

Summary

Deregulation of emergency contraception occurred in a shifting terrain, where a woman’s relationship with state-paid health services shifted to a for-profit business, with a pay for service model. Women’s experiences in access did not inform the decision to deregulate the drug and leave it behind-the-counter. Rather, the decision was informed by successive years of lobbying by professional associations, who used the rhetoric of deregulation being beneficial to women to add fees to this transaction.

The “factors” analyzed by the ruling regime, in this case a tri-partite arrangement that included the government, drug manufacturer, professional associations / pharmacy regulatory bodies, provides the rationale for deregulation that were not informed by the good evidence available in 2004 and 2005 that the drug was easy to select and take by women. The ruling regime developed a narrative that emergency contraception was safe and effective, and relied upon a false definition of the drug that contributed to confusion about its mechanism of action, and left emergency contraception in a tenuous position, open to contestation by anti-choice factions.

For some of the women I spoke with, incorrect information about how the drug works meant they also had some confusion about emergency contraception and associated it with abortion, leading to feelings of guilt, stigmatization or judgment. Poor knowledge can be identified as a barrier to use of emergency contraception. While the drug was safe and easy to take, by the ruling regime’s very definition, the practice of taking emergency contraception still required pharmacists’ surveillance to ensure women did not use the drug repeatedly, that they were “properly” screened and counseled, and established a paid gatekeeper for access to ensure the drug was being used “safely”.

By refusing to delve into the political sensitivities of emergency contraception and sexual health, the ruling regimes wind up enabling conservative, anti-choice and sexist perceptions of women to orient the official “text.” The regime clung to the notion that they wanted to improve timely access to the drug, while failing to address a number of the social and material conditions of access. Not only did they fail to provide solutions or point to changes that could be made over time, the federal government did not even bother to problematize the barriers to access for women, or even, document these conditions. Instead, they shirked responsibility, pointing to other organizations, bodies, people, levels of government as responsible, rather than recognize

the coordinating/mediated role the federal government can assume with regards to women's health. Rather than discuss some of the sexism and paternalism present in questions coming from the consultations within the regulatory statement, the federal government deferred responsibility to other social forces as having jurisdiction over things like cost, coverage, pharmacist censure due to non-referral, pharmacy practice, information on the drug label, education to women, education to health professionals. This leaves access open to contestation. Lastly, there was evidence in the texts analyzed of paternalistic, sexist and anti-choice discourses. In choosing to answer certain questions posed by anti-choice factions, and in forcing women to be informed about issues they do not want to be informed about or using terminology like "pro-life" to describe those groups opposed to deregulation, we see evidence of anti-choice rhetoric within the ruling relations and reproduced in the bureaucratic account.

This is an issue that points to the tenuous position of the federal government in creating access to drugs. As I suggested earlier, the people that produced the RIAS, the federal bureaucrats, failed to provide a sufficient rationale for behind-the-counter status, and they set up the drug as requiring professional screening and counselling by highlighting "major side effects", providing misleading information about the mechanism of action, thereby justifying "safety" surveillance by pharmacists.

The text-mediated information contained within the government rationale to deregulate emergency contraception cedes responsibility to other forces within the ruling regime, organizations that could be said to represent the health-industrial complex, with provincial governments and regulatory bodies to address the myriad of barriers raised during the consultations. Here it begins to become clear that the federal government is shifting its policy and related regulation so as to catch up to what the practice has become locally – with three provinces already enabling non-prescription access to emergency contraception. This game of catch up

comes with its own neoliberal accountability activities to ensure “process” is followed and risk, measured.

The ruling regime was assisted by the federal - provincial division of labour regarding drug availability that forced women to submit to the biomedical gaze vis-à-vis an interaction with the pharmacist. The reason why this is of concern is because pharmacists profit from this new interaction. Furthermore, the ruling regime did not explain the nature and extent of the impacts of pharmacies determining their own training materials, education materials for women and document collection practices. Thus, what the current system implies, is that federal devolution of responsibility over access to emergency contraception, point of sale, collection of private information about sexual health, and the educational materials that teach women how to self administer the drug, occurred without a specific policy or procedure in place to guide these interactions to ensure that women have the power to make a free and informed choice about contraception.

Chapter 6

6 Conclusion: Sexual Health Work and Emergency Contraception

I started this research project many years ago with the idea of exploring other women's experiences in obtaining emergency contraception to see how we could ultimately improve access to the drug. My wider investigation looked at how the processes of deregulation affected access for women and in doing so, uncovered their strategies, emotions, negotiations with pharmacists, their families, friends, colleagues and others. Unwanted pregnancy remains an experience shared by women around the world regardless of class, ethnicity, religion, age, or legal status and what is shared amongst each woman is the need to regulate her fertility. The activities of sexual health work or the "doing of health" reveals the social relations that could have remained invisible using other research methods. Activities such as decision-making, rushing to get emergency contraception, navigating stigmatization, costs, seeking information from different sources, appearing responsible-compliant, being patient and waiting were all aspects of women's sexual health work. I have argued that this work exposes the ideological discourses embedded in some of the organizations and individuals involved in access and deregulation which shaped women's sexual health work. The research exposes the hidden and visible ideological practices of the drug ruling regime - or the health-industrial complex of state, industry and professional organizations.

While this work is being published in 2014, it began in 2007, and emergency contraception's status changed to over-the-counter by Health Canada in 2008. In reality today, anecdotal evidence from some women as well as activist websites suggests that emergency

contraception remains behind-the-counter, kept in drawers, or unavailable at certain pharmacies. Women still have to ask for the drug in some cases and may be denied the medication or experience similar forms of moral regulation or the social relations of stigmatization as some of the women in my study experienced. This makes the 2005 to 2008 period of limited deregulation even more pertinent for women as recent anecdotal evidence suggests that the ideological discourses that impeded access continue to linger around women using emergency contraception today. The behind-the-counter conditions appear to be maintained by some pharmacists or pharmacies; thus, the widened scope of practice pharmacists were granted by the federal government for sexual health counselling and education remain attached to the drug even though eligibility criteria were abolished. In spite of much evidence that attests to unwanted pregnancy remaining a problem for women in Canada and that emergency contraception can be used effectively by women, pharmacists may be maintaining their gatekeeping practices around emergency contraception.

I want to begin this conclusion by reminding the reader what worked for women as they went to the pharmacy to obtain emergency contraception. First, three women had positive experiences when speaking to female pharmacists. While these three women referenced the gender of the pharmacist, the tone and style of the conversation was neutral, professional, friendly and respectful. Second, being served in a timely and efficient manner was obviously beneficial for women since all of the women knew the drug worked best the sooner it was taken. Some of the women took issue when they had to wait in line, and especially after they expressed their need for emergency contraception to someone working at the pharmacy. Third, when a woman's privacy was respected, and the transaction proceeded in a confidential manner, the social relations of stigmatization diminished. Lastly, having a previous relationship with the

pharmacist mattered to two women and one of these specifically sought a pharmacy that offered services in French.

Transformation in health service delivery is a phrase commonly used to describe a range of changes to the health systems operating in Canada. For the most part, this transformation is intended to describe activities that save money in the face of an increasingly “cash-poor” state administered health system. Federal cash transfers to provinces to pay for services will decrease over the next couple of years as the national policy has changed its funding formula from being tied to rates of inflation towards a fixed rate for transfers, decreasing over time. However, I have provided evidence that the type of transformation that needs to occur is in delivering people-centred care, based on the best evidence available at the time, by a mixture of health professionals trained in privacy, ethics, and communications to deliver good health and health education. While having the space to make personal decisions and access fair, health services free from state or industry oppression, exists theoretically in Canada, materially these conditions change depending on who you are, where you live and what you are looking for.

Real transformation is required at the pharmacy in order to make the space for women to obtain emergency contraception freely, in advance of when they are pressed for time and really need the drug. To me, and in light of the evidence presented in this thesis, it seems obvious that women should be able to obtain emergency contraception in advance of sex, without having to explain her sexual practices, menstrual cycles or her use of other forms of contraception. Being able to ask a health professional for free advice about contraception, sex, menstruation, sexually transmitted infections and other types of knowledge is also a good practice; and this advice should be freely available from many social services and not legislated and forced upon women. Furthermore, sexual health education should happen in many social sectors and include open discussions about the function and use of emergency contraception and other forms of

contraception, including abortion services. While feminist conceptions of informed consent, body literacy and understanding how contraception works in order to make good decisions to maintain one's health is indisputable, I am reluctant to suggest that we rely on grass-roots or activist campaigns as the sole means for education. Drawing from my definition of reproductive freedom as reproduction being individual and social at once, this is insufficient. Knowledge production and translation needs to occur between individuals and through communities and social agencies and requires some solid evidence and materials, funds to re-produce materials in many languages, and to adapt materials for different people and cultures. This proposal is supported by the evidence provided by women that they seek health information from a range of sources. Thus, I am arguing that materials and education should be offered voluntarily at many levels, and via many different social institutions and individuals, in a myriad of ways.

6.1 The Ideal Contraception User and Women's Sexual Health Work

Ideal: "Responsible" women

In seeking emergency contraception, women were consciously performing as responsible under the biomedical gaze promoted by these ruling regimes, all the while resisting the ideological discourses that weighed upon these interactions. This resistance occurred in different ways, by laughing with me during the interview when recounting a rather ridiculous situation, with hostility to the pharmacist, through direct negotiation, by portraying themselves as a responsible contraception user and using scientific language to denote knowledge about emergency contraception. The ideal contraception user is a woman who plans to use contraception in advance of sex, does not use emergency contraception repeatedly, does not seek abortions, appears responsible, knowledgeable and patient and who bases her decisions on rational information sought out from people in the health profession and governments. The ideal

user effectively acts as a norm against which to measure other women's standards of behaviour, contributing to the social relations of stigmatization and moral regulation and surveillance around the drug; this model user is shaped by ideological discourses like neoliberalism, sexism and compliance with the clinical authority. I contrast the "responsible" contraception user against women's actual sexual health work, where some of the activities of women intersect directly with behaviour or activities of the ideal user; this brings into view the types of work required to negotiate access to emergency contraception.

Reality: "Responsible" sexual health work

Exploring women's experiences in seeking emergency contraception brings into view the different tasks and activities involved in managing one's fertility. None of the women in the study wanted to become pregnant. Thinking about unprotected sex and the possibility of becoming pregnant were common for all of the women who participated in this research and all but two women reported using contraception before sex took place; these six women experienced some form of contraceptive failure. Most of the women used condoms that broke and three others were using hormonal contraception, in the form of the pill or the contraceptive patch. All but one woman had taken emergency contraception before, having procured it from their physicians, or obtained it again under deregulation from a pharmacist a second or third time as discussed in this research. Thus, women were actively working to reduce their risks of unwanted pregnancy by using contraception regularly well before sex took place. Two women did not use contraception in advance of sex and used emergency contraception afterwards in order to prevent potential pregnancy. While the use of emergency contraception should not be tied to the ideal behaviours outlined earlier, in practice, most of the women were already seeking to reduce the potential of pregnancy by using other forms of contraception that failed, requiring emergency contraception for back up protection. Thus, performing as an ideal, "responsible" contraception user was a task

most of the women could manage as they were already using emergency contraception as their “Plan B™”, since “plan a – other contraception” had failed. However, it is remarkable that women felt the need to impart to pharmacists that they were “responsible” in order to gain access to emergency contraception, this suggests the use of emergency contraception is seen as problematic.

Learning about obtaining emergency contraception directly at the pharmacy was an important task, and women tended to obtain information from those that they are most comfortable speaking about emergency contraception with, overwhelmingly from friends first, then from their doctors, on TV and/or in school. Women noted that they knew emergency contraception was available behind-the-counter because of discussions with friends, with whom they were comfortable speaking with about sex and sexuality. Pharmacists were a source of information about how the drug worked on a woman’s body and as I discussed, two women wanted more detailed information about the medical function of emergency contraception; one woman found it by speaking to two pharmacists, the other did not get the information she needed as she was too embarrassed to ask. Being able to seek advice and information from the pharmacist is a good practice and information on sexual health should be provided in a private, comfortable, positive space, free from surveillance or stigmatization.

Making the decision to get emergency contraception happened at different moments in time; for instance, right after sex, later the same day, in the early hours of the morning, the day after sex took place and a full two days after unprotected sex. For all but one woman, the side effects were minimal and they took the drug effectively, having self-diagnosed their need for emergency contraception due to unprotected heterosexual, reproductive sex. Direct access from a pharmacist was cited by all of the women as reducing the amount of time it takes to get the drug. Some of these women suggested that wait times at the pharmacy counter could be minimized by

prioritizing all requests for emergency contraception over any other prescriptions due to the time limitations for using the drug effectively.

Some negative aspects of mandatory pharmacist screening and counselling were reported by women that included the following activities: answering questions and being quizzed about the drug and/or her menstrual cycle; negotiating access by appearing responsible; reporting other contraceptive usage; using clinical language like “levonorgestrel”; waiting in a line; being placed in a glass booth to wait to the side; feeling anxiety over refusal or others finding out; being referred to a second pharmacist and having to go through screening all over again. Within these tasks, I broaden the understanding of the work it takes to get emergency contraception, including identifying activities that women performed as being responsible, conforming to ideal conceptions of requesting women, like being patient or asking for the drug with its clinical name. What these activities mean was that women were aware they were being assessed and “acted” responsible according to the conception of an ideal user, even though any request for the drug should be seen as acting “responsibly”, with responsibility here used to denote a woman’s control over her fertility, so as to reduce the risk of unwanted pregnancy.

Peggy’s quote, “What does this do?” a question she asked two pharmacists, reveals that while she was comfortable taking the drug to reduce the risk of pregnancy, she wanted more information about how the drug worked. Knowledge about how the drug functions was important to understand for some women to reduce the social relations of stigmatization about emergency contraception and the drug’s association with abortion. Better knowledge about the function of emergency contraception likely contributes to increasing the use of the drug with a corresponding decrease in the risk of unwanted pregnancy. Thus, greater knowledge would greatly impact use and may reduce the rates of unwanted pregnancy or abortion however, this research remains to be conducted.

6.2 Ideological Practices Ruling Women's Sexual Health Work

Recall that the industry around contraceptives is fragile and open to political coercion: history informs this social relation in the discovery of new commodities, driven by neoliberalism. Marketing and maintaining a good corporate brand were the central organizing feature in the development of contraception and emergency contraception; indeed companies shied away from involvement in any contraceptive project for fear of real reprisal, whether it be at the cash-register or with violence, threats, protests or even death by anti-choice forces. In attempting to keep “politics” out of “medicine”, I am convinced that the state defers to conservative, anti-choice sentiments. I depicted this malaise in the rationale for deregulation in both using the word pro-life and in reproducing the larger ideological practices of sexism and neoliberalism. In addition, the division of labour between jurisdictions in Canada around pharmacy practice meant that the process of deregulation relies too much on one type of organization – professional associations – who were lobbying for new roles, and increased fees. What appears to have been missed by the government in their analysis, are the consequences of privatizing sexual health education and the transformation of the relationship between women and her physician to neoliberal capitalist medicine and health care.

Neoliberal capitalist health care and sexism were two of the most influential discourses I identified in the social relations of access to emergency contraception. Sexism was pervasive, both in forcing women to speak to their eligibility for the drugs, in documenting their sexual health practices, in making her wait, in quizzing or testing her. Indeed, the very process is grounded in paternalistic practices made to ensure women comply with the biomedical gaze. A feature of the deregulation of drugs in Canada means that the state, industry and professional

associations work in concert with one another and this health-industrial complex, oriented around the expansion of capitalism, and effectively leaves those affected by deregulation outside of the process.

This serves two broader goals, first the façade of risk management and the reliance on rational, clinical discourses contributed to a void in official texts about women. Going through the processes of deregulation – assessment, consultation and recommendation for a change in a drug's availability was moot for emergency contraception since the government and pharmacists had decided upon behind-the-counter conditions well in advance of the federal effort to deregulate. The vacuum here becomes present as it is where individuals are absent, or kept outside of formal means of the process of deregulation, which places the entire process under scrutiny. These neoliberal accountability processes, to mitigate risks and reduce liabilities on the part of industry, health professionals or the state, ultimately meant that no one was responsible for the conditions of access for women. Lack of responsibility for ensuring access and keeping the tone of the decision-making rationale “clinical” means that no blame can be laid on pharmacists, government or politicians by anti-choice forces. Deregulation reveals that state-provided and citizen-funded shared health care is being slowly eroded and carved off for profit in a piecemeal fashion.

Professional associations and regulatory bodies used the language of women's rights and good health but their activities reveal they participated in fixing fees for services all the while touting that increased access meant fulfilling the state's obligations to women. Rights taken up by professional associations and population agencies are thus reified from women's actual contraceptive access. Neoliberalism informed many elements in these transactions, including the privatization of sexual health education on emergency contraception, increased

professionalization/specificity, widening pharmacists' scope of practice; increasing the costs of the drug; and setting up gender as "problematic" or "the other" to the biomedical gaze.

The federal-provincial division of labour is problematic as it relates to drug scheduling. First, it was difficult to decode and deconstruct ideological and administrative conceptual organization and practices in drug deregulation. Second, many responsibilities in drug deregulation were devolved to the health-industrial complex, that includes provincial and federal governments, health professional organizations and industry. What this means, and in this mix, is that not only do we lose the ability to trace the roots of decision-making and thus identify transformative activities and those responsible for access, but we do not place the social relations of access at the centre of the process. Women were removed from most of the official texts and professional associations worked to increase their function and pay, that involved the construction of idealized behaviours in order to determine women's eligibility. Meetings occurred and decisions were made with only health professionals and industry present, and this resulted in an inaccurate definition of the medical effect of emergency contraception, that misleads women and others about the way the drug works. In the absence of any current federal policy grounded in women's good health, the federal government fails to orient the provinces around wider goals and activities, and does not play a coordinating, leadership role in ensuring access to sexual health services. Indeed, the deregulation of emergency contraception showed that the federal government was catching federal policy up with provincial practices, with three provinces already enabling behind-the-counter access.

Misinformation about emergency contraception was prevalent in government and pharmacist texts that effectively kept emergency contraception behind-the-counter. This ignorance contributed to its stigmatization by pharmacists and government. When I began to identify the social relations of stigmatization, I realized that the inaccurate information on the

side effects, eligibility requirements and post-fertilization effects are some of the reasons why the drug continues to be seen as problematic. This hegemony of the clinical gaze created eligibility standards, framed repeat use as risky and set up professional roles in evaluation and monitoring of women. By shoring up neoliberalism in its quest for new sources to generate capital, gender is constructed in opposition to the health-industrial complex whereby women's needs are seen as problems and external to the project of deregulation and privatization.

Discourse within the government rationale for a schedule change fails women by forcing them to comply with particular treatment regimens, and sets up a norm against which all behaviour is measured. In industry and bureaucratic analyses, both pharmacists and bureaucrats assessed the drug as "risky" which set up a future need for a broader role for pharmacists with regard to sexual health assessment and counselling. This included the development of the clinical authority for pharmacists that tied screening for side effects associated with long-term use of oral contraceptives. These side effects, like blood clots, angina, and the like are being taken up as clinical criteria so as to position pharmacists as the best people to monitor women so as to justify being paid for it.

6.3 Shared Responsibility for Social Conditions

First and foremost, I revisit my earlier argument about reproductive freedom, since it provides the framework by which I can move forward. First, in the earlier discussion on rights and choice and the need to see the body as both social and individual at once, I argue that simply relying on state-granted rights are problematic for the provision of sexual and reproductive health. It is simple[?] to believe that rights will always exist as long as the state that grants them does; and in assuming this, there is a danger of reifying rights, as we understand that "rights" exist theoretically but not materially. Rights exist for women to get emergency contraception in

Canada but in reality, six of the women I spoke with had a hard time getting the drug. This attests to rights being subverted in different ways by political coercion and moral regulation like in many periods of time in Canada.

What rights do not grapple with are the conditions by which we enjoy those rights, and rights keep us alone, individuals that have no impact on one another or the social forces that we shape and shape our experiences. Reliance on individual notions of control and power denies other social forces any obligation to ensure that the material conditions exist for women to express their need to regulate their fertilities. Reliance on rights enabled the government to write a rationale to deregulate, with little information about women, the scope and scale of the problem of unwanted pregnancy or the potential negative effects of mandatory screening and sexual health counselling by a privately paid professional. Thus, these rights enabled the government to disconnect women's physiological functions from the social relations within which we exist.

The regulatory statement and the process that placed emergency contraception behind-the-counter ignored women, elevated poor clinical knowledge and professional bodies' opinions over the evidence available at the time of deregulation. In the next section, I propose some solutions to remedy some of the problems women experienced in accessing emergency contraception.

6.4 Transforming the Material Conditions of Access

Women

Women can be seen as "conscious agents of reproductive processes" (Petchesky, 1987, ix) and they articulated that they require the social space to make health decisions free from oppression. Emergency contraception should be freely available to women without restrictions or surveillance. This includes learning about sexual health from information that is accurate,

informative and non-judgmental. Women also may require more information about emergency contraception from a number of sources, including health professionals. Key to increasing women's knowledge is ensuring that emergency contraception's definition accurately reflects its function. Women who reported the experience as positive were able to make private requests to pharmacists who provided the medication quickly and asked if more information was required. Creating space and processes by which to enable the exchange of information about sexual health in a non-punitive fashion should exist in Canada in this day and age. Stigmatization, bias, negative assumptions about female sexuality may be alleviated somewhat by accurate information about emergency contraception and factoring in privacy and confidentiality in the provision of women's health services.

Women may require assistance with the cost of the medication as costs increased over the period of deregulation. For those women that are most vulnerable, those with lower incomes in external research tended to obtain their supplies from a physician because the cost of the drug was covered under that arrangement. Targeting industry, federal and provincial governments to recognize the harmful practice of unwanted pregnancy and to subsequently gain real support to cover the costs of services to assist women in reducing their risks of unwanted pregnancy means that contraceptive services should be covered under drug insurance plans, both provincially-run and private benefit plans.

In addition to this, feminists and others need to develop comprehensive and inclusive theoretical perspectives on issues like being free to access equitable health services (or reproductive freedom), federal sexual health policies and the implications of an absence of said policy, and the impacts of the slow and steady creep of privatization of health service delivery and its associated effect on women.

Professional Associations

The Canadian Pharmacists Association, the Society of Obstetricians and Gynaecologists of Canada and the National Association of Pharmacy Regulatory Authority are all social actors that maintain different responsibilities in deregulation, professional certification/regulation and are shaped by the ruling ideological discourses of neoliberalism and sexism. Professional organizations are self-regulating and given that pharmacy practice operates within both state-provided and for-profit health systems, increased attention should be paid to the impacts of devolving health services from one part of the health-industrial complex to another. Some aspects of increasing pharmacists' scope of practice could contribute to the weakening of certain aspects of state-provided health services and should be analyzed as a part of the process of assessing risk. Professional associations have a role to play in Canada to bring forward the best evidence, review this evidence and make recommendations for the type of professional oversight over access to drugs. Assessment criteria to assess risks must take steps to minimize potential conflicts of interest around increasing professional scope of practice. Oversight by women and other people affected by different facets of drug deregulation should transform the process by which drug-risk is measured, so that the focus is on delivering fair health services, equitably, based on the best evidence that takes into account the social and material conditions of access. Indeed, I am arguing that the notions of risk be broadened and different practices should be assessed for individuals, groups and regions to ensure the approach takes into account the people who are accessing medications. Professional associations could learn a lot by reviewing feminist methodologies in analyzing evidence, developing approaches and delivering care.

Federal, provincial and territorial regulatory authorities

Professional regulatory bodies must implement codes of conduct to be monitored with ways to censure pharmacists that do not abide by standards around discrimination, or refuse to

dispense medication or fail to refer to locations that have emergency contraception. Privacy and confidentiality policies and procedures should be further refined with ways for people to access services out of sight of other pharmacy patrons. Furthermore, people should be able to opt out of corporate pharmacies that collect such data like health practices and disclose how it is used and shared for marketing or other means. Pharmacies should be obliged to disclose if they are submitting aggregated data about people to other corporations, like drug manufacturers. Efforts should be made to educate pharmacists about women's specific needs about stigmatization, sensitive health information and effective approaches to communication about sensitive information.

At a federal level, the National Association of Pharmacy Regulatory Authorities is responsible for assessing schedule changes against ten clinical "factors" and recommending the level of availability to the federal government and respective provincial bodies. As such, this organization, in spite of an ideological commitment to reviewing the best evidence, put the needs of its member-pharmacists ahead of women, which appears as a conflict of interest. Different modes of analyzing "risks" and the aforementioned ten clinical factors should be predicated on the social and material conditions of drug access. Accurate versions of the drug definition, its mechanism of action, and side effects should also appear on the product label for emergency contraception. Increasing transparency and oversight arrangements on committees that make decisions should be encouraged as well as exploring other options like feminist approaches as a means by which to increase transparency and to place people at the centre of analysis.

Manufacturers

Drug manufacturers have a responsibility to ensure accurate information about the mechanism of action of the drug appear on the product label, grounded in the best evidence.

Federal, provincial and territorial governments

Emergency contraception should be freely available at no cost to women in all regions of Canada. When Health Canada began to deregulate the drug, all of the available evidence suggested that unrestricted access would reduce the risk of unintended pregnancy. The federal government failed women in its rationale to deregulate emergency contraception to behind-the-counter. First, the federal government needs to develop a current and comprehensive national policy on sexual and reproductive health where women remain at the centre of analysis and entrench said policy in ideas like reproductive freedom to enable access to a number of health services and therapies. Reliance on rights enabled the government to disconnect women's physiological functions from the social relations within which women exist. By taking up sexual and reproductive freedom, the government could commit to policies and practices that put people's needs first in order to address the obligations other social actors have to ensure the material and social conditions of access to emergency contraception.

The specific directorate at Health Canada that oversees the deregulation of medications should be advised by different communities that deregulation processes influence, like women, so as to transform the development of the rationale to deregulate drugs. Health Canada's regulatory statements fail women, and I would suspect many other people, in that it conforms to rational decision-making paradigms, disconnects women's experiences from the realities of the social relations of physiological reproduction, and uses poor science to evade social and material conditions as well as moral or political questions. Furthermore, the means by which to assess the de-listing of services and its impacts on people and the state health care system should be developed. The federal government must commit to transparency in drug deregulation; this would include publishing industry knowledge that is a part of the clinical review trial system. A

commitment to transparency, accountability, and openness would go a long way to shore up the deregulation and scheduling processes.

Furthermore, the government should be committed to using the best evidence available at the time of deregulation in both the rationale to deregulate drugs and their clinical definition of emergency contraception; both documents should be revised as soon as possible. As I argued, ignorance and misconceptions about emergency contraception effectively contribute to its problematic status. Another significant solution is if the federal government would work to increase awareness about emergency contraception, publish resources in multiple languages, and invest in creating some advocacy tools to increase knowledge.

6.5 Developing a Feminist Research Agenda

I would like to bring the discussion back to women's experiences as differential experiences of contraception, reproduction and fertility, and suggest that research from the different standpoints of women should continue to be documented and analyzed using feminist research theories and methods. When I think about the ideal contraception user and the real experiences of women, more work needs to be done to understand what gives rise to these idealized depictions of women, when in actual practice, every woman was responsibly seeking emergency contraception to manage her fertility and reduce the risk of unwanted pregnancy. What could be more responsible than that? There are many areas that require further exploration and explication regarding women and sexual and reproductive health, such as: the impacts of privatization of health services like health education on women; new ways to evaluate and manage "risk" grounded in social sciences or using mixed methods; the development of people-centred approaches to health service delivery; equality of services in rural and remote

communities in Canada; and further research on health professionals' perceptions of women and sexuality.

However, developing new feminist approaches on reproductive freedom could make a major contribution to women's actual access to services. Very little is written on issues like choice, control and freedom, and efforts should be made to make this a research a priority, particularly in Canada. As we know, when institutional and social forces attempt to deny women's access to services or education, women continue to seek the services regardless, sometimes at great risk. Many of the issues identified in this thesis around sexual health work remain unresolved, like the high cost of medication, privacy and confidentiality at the pharmacy counter, the availability of emergency contraception in rural or remote communities, referrals to other professionals or pharmacies, misperceptions and/or sexist conceptions of female sexuality amongst health professionals. Rights do not take this work any further and there is a real need to explore how reproductive freedom could widen access to services and correspondingly, reduce unwanted pregnancies for women.

Developing new ways of thinking about choice, control and decision-making around reproductive and sexual health would foster transformative research on many of the specific topics I listed as researchers delve into ontological and epistemological questions about freedom. Feminists have taken rights as far as they can go – rights are in place nationally and internationally - creating the theoretical space to access drugs and the legal means to pursue any denials of these rights. However, rights do not mean that a woman: will know how emergency contraception works; where she can get it; be able to afford to purchase emergency contraception in the first place; or be provided with the drug in advance so she can use it as required.

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http://www.cihi.ca/CIHI-ext-portal/internet/EN/Quick_Stats/quick+stats/quick_stats_main?xTopic=Hospital%20Care&pageNumber=3&resultCount=10&filterTypeBy=undefined&filterTopicBy=5&autoresh=1

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Appendices

Appendix A: Interview Guide

Emergency Contraception Interview Guide

To start, I would like to go over some of the ethical ground rules for this interview. All information you provide is confidential. Your name will not be included on any of the information that I collect and your identity will not be revealed in any report. With your permission, today's interview will be taped and transcribed. You will be given the opportunity to review the transcript before it is used in any kind of analysis. Your transcript will not be shared and only seen by myself. You may refuse to answer any questions that you prefer not to answer and that's ok. If at any time you want to end the interview we can do that and there are no penalties.

The goal of this interview is to gain information on women's experiences in getting emergency contraception from a pharmacist. This is due to the shift in regulations which allows women to access emergency contraception directly from the pharmacist. I am interested in the experience you had at the pharmacy. This information will enable my understanding on some of the different social relations that occur in this simple exchange for health information and products.

A. Demographics:

- Age
- Place of residence
- Educational level
- Professional status
- Ethnicity
- Marital status/living as a couple
- History of pregnancy/abortion
- Regular contraception?
- One month after emergency contraception use, what contraception was used?
 - no contraception but not at risk, pill, implant or patch, IUD, condom, natural methods, no contraception and at risk
- Number of sexual partners at one month after emergency contraception use?
- Frequency of sexual intercourse in month preceding interview
- Received any contraceptive counselling in the past year?

B. Knowledge:

- Reason for emergency contraception use
- Why use emergency contraception? Do you use another form of contraception?
- Had heard about emergency contraception at that time? What do you know?
 - Did she know about direct pharmacy access and time efficacy?
 - Know how effective emergency contraception is when taken within the first day after unprotected intercourse? Up until 72 hours?
 - How emergency contraception works to prevent fertilization and has little effect on if implantation will take place?
 - Side effects?

- Where did she get information about emergency contraception?
- Discussed emergency contraception with partner before use?
 - After use?
- Characteristics of intercourse after taking emergency contraception until next menstrual period
Protected, unprotected, no sexual intercourse, don't know
- Would use again?
 - Estimated future use?
 - Pregnancy test?

C. Experience with Health Professionals and Services:

- Describe the actual process of obtaining: how you got to the pharmacy, time of day, number of people spoken to, confidential area
- Easy or very easy to obtain?
- Satisfied with the manner in which their request for emergency contraception in pharmacy relating to confidentiality will be handled?
- Felt comfortable or very comfortable about discussing emergency contraception with pharmacists?
- Whether the woman favoured the pharmacy or a clinic for purchase?

D. Attitudes:

- Positive attitude towards emergency contraception availability
- What is the most important factor for access to emergency contraception: availability, counselling, health information, (more concerned about) risks, anonymity/personal responsibility
- Is emergency contraception use better than having an abortion?
- About use of emergency contraception (regular, once, twice, repeat)
- Sense of vulnerability towards pregnancy?
- Concerned about what others may think?
- Getting emergency contraception was an overwhelming task

Appendix B: Ethics Approval Form



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Fax/Téléc. : 705

Research Ethics Board
Office of the Associate Vice-President, Research
L-335-A
(705) 675-1151, ext 3213
(705) 671-3850

This is to certify that the research proposal entitled "*Access to Emergency Contraception*", File 2007-07-04 submitted by Sara Fryer and Carol Suschnig supervisor on July 20, 2007 has passed an expedited review by Laurentian University Research Ethics Board.

Conditions:

Signed Daniel Ok, Acting Chair, LU Research Ethics Board

Signatures of members

Department

Susan James

Midwifery
SDHU

Date: Sept 17/2007

Note: this approval covers only the documents submitted, in the language in which they have been submitted. Any changes to questionnaires or procedures must be re-submitted to the Board, as stated on the form.

Start Date: upon approval
Report Date(s): August 2008

Finish Date: July 2008