Public Health Association
AUSTRALIA

Emergency Contraception
Policy Position Statement

Key messages: Affordable provision of effective contraception is an essential health service and is cost-effective in reducing the impact of unintended pregnancies on individuals, the health system and society.

Key policy positions:

1. A comprehensive National Sexual and Reproductive Health Strategy is required.
2. Priority policy changes required include:
    - Reducing the impact of unintended pregnancies through effective contraception as a public health goal.
    - Ensuring all people of reproductive age receive education that is free of discrimination, enabling the choice of contraceptive options that are safe, reliable, affordable and acceptable.
    - Improving education of health care professionals and funding of services to enhance professional competency, reduce barriers to provision and support the use of emergency contraception
3. Consumers' access to safe, affordable emergency contraception, including the copper intrauterine device, should be improved. This may require specialised settings and/or funding arrangements.

Audience: Federal, State and Territory Governments, policy makers, program managers, other professional and non-government groups.

Responsibility: PHAA Women's Health Special Interest Group

Date adopted: 23 September 2021

20 Napier Close Deakin ACT Australia 2600 – PO Box 319 Curtin ACT Australia 2605
T (02) 6285 2373 **E** phaa@phaa.net.au **W** www.phaa.net.au

Emergency Contraception

Policy position statement

PHAA affirms the following principles:

1. The National Women's Health Strategy of 2020-2030 sets a priority for 'equitable access to timely, appropriate and affordable [sexual and reproductive health] care for all women,' and the promotion of sexual and reproductive health resources, including emergency contraception (EC) options.
2. Moreover, the United Nations Sustainable Development Goals (SDGs) make specific reference to family planning in Goal 3 and 5. A comprehensive National Sexual and Reproductive Health Strategy should honour our commitment to the SDGs and be monitored against agreed indicators.
3. A comprehensive National Sexual and Reproductive Health Strategy would deliver the best outcomes including improved awareness of and access to EC.
4. All reproductive-aged people should receive evidence-based information about EC methods and how to access them. This should be free from discrimination and bias, and from a variety of sources.
5. EC methods should be available at no cost to the patient and governments should therefore ensure universal access; particularly for priority groups such as adolescents and people from under-served communities. This may require specialised settings and/or funding arrangements.
6. All EC methods including the including levonorgestrel and ulipristal acetate emergency contraceptive pills and the Copper-bearing intrauterine device (IUD) should be offered as part of routine EC provision (if not contraindicated) [1].
7. Health care professionals should be aware of the suitability and benefits of all EC methods and be confident in discussing these methods with their patients.
8. Health care professionals should be trained to insert and remove IUDs and other long-acting reversible contraception (LARC) devices. Those health care professionals who are not trained to insert IUDs should have access to local referral pathways to ensure affordable and timely referral.
9. Service providers including clinicians and pharmacists have an ethical obligation to minimise disruption to patient care. A conscientious objection to contraception should never be used to impede access to care. If the provider is unwilling to provide EC, they must provide an effective referral to an accessible provider who is known to not object to the use of EC.

PHAA notes the following evidence:

10. Reducing the rate and impact of unintended pregnancy through effective contraception use is a public health goal.
11. EC provides a safe and effective opportunity to prevent pregnancy after unprotected intercourse [2]

12. The method of action for EC pills involves the prevention of fertilisation of an egg by delaying ovulation or, in the case of a Copper-bearing IUD, prevention of a fertilised egg from implanting in the uterus [3]. EC does not cause an abortion or harm to a very early pregnancy [3].

13. EC methods can be used by all people with a uterus (unless contraindicated), including those who are breastfeeding, and have no impact on long term fertility [3, 4].

14. The Copper-bearing IUD is the most effective form of EC [5]. Currently, the Cu-IUD is not subsidised on the Pharmaceutical Benefits Scheme and few consumers are aware of its use as an EC method [6]

15. The ulipristal acetate ECP is the most effective oral form of EC [7], but is more expensive than levonorgestrel ECP and less frequently stocked in pharmacies.

16. Limited available data suggest that EC uptake is relatively low in Australia [8, 9], knowledge gaps remain [6, 10], and information about all options are not always provided by health professionals [11-14]. However, there are no routinely collected contraception usage data - including EC - that are reliable and comprehensive in Australia.

17. The majority of people who access EC do so in an emergency. The availability of EC directly from pharmacies does not increase 'risk' behaviour (e.g. unprotected sex) or misuse [15]. Patients value the increased accessibility, discreteness and convenience of over-the-counter EC, making pharmacies a preferred point of access for many patients, including adolescents [15].

18. Pharmacists discuss ongoing contraception in only one-third of EC dispensing encounters in Australia [16]. Pharmacists trained to provide comprehensive contraceptive counselling and/or refer patients to a contraception provider can improve access to effective ongoing contraception [17, 18].

19. Implementing this policy would contribute towards achievement of UN Sustainable Development Goals 3: Good Health and Wellbeing, and Goal 5: Gender Equity. Specific Sustainable Development Goal targets relate to emergency contraception include:

    - SDG 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
    - SDG 5.6: Ensure universal access to sexual and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

PHAA seeks the following actions:

20. A comprehensive National Sexual and Reproductive Health Strategy should be developed to raise awareness of EC by health professionals and the community. The strategy should honour our commitment to the Sustainable Development Goals and be monitored against agreed indicators.

21. Accurate information about the full range of contraceptive options including all EC methods should be provided during contraceptive consultations.

22. State, Territory and Federal Governments should ensure that all school health curricula include detailed information about the full range of contraceptive options including EC methods.

23. Health professionals, including doctors and nurse practitioners, registered nurses, midwives, and pharmacists, should have access to resources and training on EC, and on how to impart knowledge

about contraceptive options to their patients, inclusive of adolescent-safe care and care for people who have been sexually assaulted.

24. Adequate Medicare rebates and pharmaceutical benefits are required for contraceptive consultations, prescriptions, and insertion and removal of long-acting reversible contraception (such as Copper-bearing IUD) that do not lead to financial disincentives for health care professionals or those seeking contraception. The role of registered nurses and pharmacists in these rebates and benefits need to be further explored.
25. Subsidies for all EC methods are required. Specialised settings/funding arrangements should be implemented for priority groups, including adolescents, people from under-served communities and those who have been sexually assaulted, as a matter of urgency.
26. Pharmacies should keep all EC methods in stock at all times and possess competent knowledge of these methods, to ensure patients have choice and access to the method of EC they prefer.
27. The community pharmacy workforce should be utilised to improve access to the Copper-bearing IUD and ongoing contraception after EC pills. This may require specific legislation, funding arrangements, pharmacist continuing professional development and/or the update of pharmacy curricula, and enhanced referral pathways through collaborative practice arrangements.
28. National data about EC use should be routinely collected.

PHAA resolves to:

The PHAA will work with key stakeholders to improve the acceptability of and access to EC methods and will advocate for:

22. A comprehensive National Sexual and Reproductive Health Strategy that includes EC and addresses the domains identified in the Melbourne Proclamation and the Sustainable Development Goals.
23. Abolishing legislation that supports discrimination and disruption to patient care based ideological beliefs and understandings of gender, pregnancy and contraception.
24. Standardised education and in-service training for health care professionals that includes EC methods and guidance on how to provide affirming, person-centred care to different patient populations, inclusive of identification of reproductive coercion and sexual assault.
25. Reducing the barriers to providing LARC experienced by health care professionals.
26. Employing evidence-based strategies to reduce the barriers to EC and effective ongoing contraception experienced by consumers.

Adopted 2018, revised 2021

References

1 Faculty of Sexual and Reproductive Healthcare. FSRH Guideline: Emergency Contraception. December 2017 update. https://www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017/: FSRH; 2017. [Accessed.

2 Lee JK and Schwarz EB. The safety of available and emerging options for emergency contraception. *Expert Opinion on Drug Safety* 2017;16(10):1163-71.

3 FSRH. Faculty of Sexual and Reproductive Health Guideline Emergency Contraception. London: Faculty of Sexual & Reproductive Healthcare; 2017. https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/emergency-contraception/. [Accessed.

4 WHO. Medical eligibility criteria for contraceptive use. Geneva: World Health Organization; 2010. Report No.: 9241563885. [Accessed.

5 Cleland K, Zhu H, Goldstuck N, et al. The efficacy of intrauterine devices for emergency contraception: a systematic review of 35 years of experience. *Human Reproduction* 2012;27(7):1994-2000.

6 Dorney E, Botfield JR, Robertson S, et al. Acceptability of the copper intrauterine device as a form of emergency contraception in New South Wales, Australia. *The European Journal of Contraception & Reproductive Health Care* 2020;25(2):114-9.

7 Glasier AF, Cameron ST, Fine PM, et al. Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *Lancet* 2010;375(9714):555-62.

8 Richters J, Fitzadam S, Yeung A, et al. Contraceptive practices among women: the second Australian study of health and relationships. *Contraception* 2016;94(5):548-55.

9 Wilkins R, Warren D, Hahn M, et al. Families, incomes and jobs, volume 6: A statistical report on waves 1 to 8 of the Houshold, Income and Labour Dynamics in Australia Survey. The University of Melbourne: Melbourne Institute of Applie Economic and Social Research; 2011. [Accessed.

10 Hobbs MK, Taft AJ, Amir LH, et al. Pharmacy access to the emergency contraceptive pill: a national survey of a random sample of Australian women. *Contraception* 2011;83(2):151-8.

11 Collins JC, Schneider CR and Moles RJ. Emergency contraception supply in Australian pharmacies after the introduction of ulipristal acetate: a mystery shopping mixed methods study. *Contraception* 2018.

12 Downing SG, Payze C, Doyle-Adams S, et al. Emergency contraception over-the-counter: practices and attitudes of pharmacists and pharmacy assistants in far North Queensland. *The Australian & New Zealand Journal Of Obstetrics & Gynaecology* 2011;51(6):527-31.

13 Higgins SJ and Hattingh HL. Requests for emergency contraception in community pharmacy: An evaluation of services provided to mystery patients. *Research in Social and Administrative Pharmacy* 2013;9(1):114-9.

14 Hussainy SY, Stewart K and Pham M-P. A mystery caller evaluation of emergency contraception supply practices in community pharmacies in Victoria, Australia. *Australian journal of primary health* 2015;21(3):310-6.

15 Buckingham P, Amos N, Hussainy SY, et al. Pharmacy-based initiatives to reduce unintended pregnancies: A scoping review. *Research in Social and Administrative Pharmacy* 2021.

16 Collins JC, Schneider CR and Moles RJ. Emergency contraception supply in Australian pharmacies after the introduction of ulipristal acetate: a mystery shopping mixed-methods study. *Contraception* 2018;98(3):243-6.

17 Clement KM and Mansour DJ. Improving uptake of the copper intrauterine device for emergency contraception by educating pharmacists in the community. *The journal of family planning and reproductive health care* 2014;40(1):41-5.

18 Cameron ST, Glasier A, McDaid L, et al. Use of effective contraception following provision of the progestogen-only pill for women presenting to community pharmacies for emergency contraception (Bridge-It): a pragmatic cluster-randomised crossover trial. *The Lancet* 2020;396(10262):1585-94.