Public Health Association
AUSTRALIA

Enhancing Awareness, Affordability and Access to Emergency Contraception

Policy Position Statement

Key messages: The provision of affordable, 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.

1. A comprehensive national sexual and reproductive health strategy is required.
2. Priority policy changes include:
    - Reducing the incidence of unintended pregnancies through effective contraception as a public health goal.
    - Ensuring all people of reproductive age receive evidence-informed education that is free of discrimination, enabling the choice of safe, reliable, affordable, and acceptable contraceptive options.
    - 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 and affordable emergency contraception, including the copper intrauterine device, should be improved with specialised settings and/or funding arrangements.

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

Responsibility: PHAA Women's Health Special Interest Group (SIG)

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Contacts: Assoc. Prof. Amie Steel amie.steel@uts.edu.au; Dr. Abela Mahimbo abela.mahimbo@uts.edu.au Women's Health SIG Co-convenors

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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. The United Nations Sustainable Development Goals (SDGs), to which Australia is a signatory, make specific reference to family planning in Goal 3 – Good Health and Wellbeing and Goal 5 – Gender Equality. 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 affordable EC.
4. EC methods should be available at no cost to those <26 years. Governments should additionally ensure universal access to EC, particularly for priority population groups and underserved communities.
5. 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.
6. All EC methods, including, levonorgestrel and ulipristal acetate emergency contraceptive pills and the copper-bearing intrauterine device (IUD) should be offered as part of routine EC.
7. Health 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 professionals, including pharmacists, have an ethical obligation to minimise disruption to patient care. A conscientious objection to contraception should never impede access to care. If any provider is unwilling to provide EC, they must be required by law to provide an effective and timely 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.[1]
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 fertilisation or a fertilised egg from implanting in the uterus.[2] EC does not cause an abortion or harm to a very early pregnancy.[2]
13. EC methods can be used by all people with a uterus (unless contraindicated), including those who are breastfeeding, and they have no impact on long-term fertility.[2,3]

14. The copper-bearing IUD is the most effective form of EC.[4] Currently, the copper-bearing IUD is not subsidised by the Pharmaceutical Benefits Scheme and few consumers are aware of its use as an EC method.[5]

15. The ulipristal acetate EC pill is the most effective oral form of EC,[6] but is more expensive than the levonorgestrel EC pill and less frequently stocked in pharmacies.

16. There are no routinely collected contraception usage data – including for EC - that are reliable and comprehensive in Australia. The limited available data suggests that EC uptake is relatively low in Australia,[7, 8] knowledge gaps remain,[5,9] and information about all EC options is not always provided by health professionals.[10-13]

17. The availability of EC directly from pharmacies does not increase 'risk' behaviour (e.g., unprotected sex) or EC misuse.[14] Patients value the increased accessibility, discreetness and convenience of over-the-counter EC, making pharmacies a preferred point of access for many patients, including adolescents.[14]

18. Pharmacists discuss ongoing contraception in only one-third of EC dispensing encounters in Australia.[15] Pharmacists trained to provide comprehensive contraceptive counselling and/or refer patients to a contraception provider can improve access to effective ongoing contraception.[16, 17]

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

    - SDG 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including 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 include raising the awareness of EC choices by health professionals in the community. The strategy should honour our commitment to the SDGs and be monitored against agreed indicators.

21. EC methods should be available at no cost to those <26 years including the copper-bearing IUD.

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

23. 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.

24. Doctors and nurse practitioners, registered nurses, midwives, Aboriginal and Torres Strait Islander health workers and pharmacists, should have access to resources and training on EC, and on how to impart evidence-based knowledge about contraceptive options to their patients, inclusive of adolescent, Aboriginal and Torres Strait Islander, LGBTQI, disabled person-safe care and care for people who have been sexually assaulted.

25. Adequate remuneration and government subsidies are required to appropriately incentivise health providers for contraceptive consultations, prescriptions, and insertion and removal of long-acting reversible contraception (such as copper-bearing IUDs). Registered nurses, midwives, Aboriginal and Torres Strait Islander health workers, doctors and pharmacists need to be able to access Medicare rebates and the PBS to provide contraception.

26. Subsidies for all EC methods are required and should be free for those <26 years. 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 in all primary care settings, beyond sexual assault services.

27. Pharmacies should always keep all EC methods in stock, including an ability to dispense copper IUDs with a referral route to a local inserter. Pharmacists should possess competent knowledge of EC methods, to ensure patients have choice and access to the method of EC they prefer.

28. Community pharmacists should be utilised to improve access to EC. This may require specific legislation, funding arrangements, pharmacists continuing professional development, update of pharmacy curricula, and enhanced referral pathways through collaborative practice arrangements.

29. National data about EC use should be routinely collected and used to monitor the uptake of EC and progress against agreed performance indicators.

PHAA resolves to:

The PHAA will work with key stakeholders to improve the acceptability and awareness 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 SDGs.

23. Ensure that legislation designed to protect a health provider's right to conscientious objection does not support discrimination or the disruption to patient care and includes the monitoring of compliance to uphold all patient's reproductive rights.

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 that includes copper IUDs, which are experienced by health care professionals.

26. Employing evidence-based strategies to reduce the barriers to accessing EC and effective ongoing contraception experienced by consumers.

(Adopted 2018 and revised 2021 & 2024)

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