



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

ACCESS TO EMERGENCY CONTRACEPTION

The College Position – endorsed by RACGP Council 7 August 2003

The College believes that a high quality emergency contraception service is most likely to be delivered in a general practice. Pharmacy based services are not geared to provide the range of support services required and over the counter access will only address one of the desirable health outcomes for high quality management of unprotected intercourse.

The RACGP is concerned that the public debate on emergency contraception is currently limited to consideration of over the counter provision of Postinor-2.

The RACGP would welcome an inclusive debate of emergency contraception issues to ensure that Australian women can optimise access AND high quality care.

Emergency Contraception

The provision of progestogen only emergency contraception and the provision of a quality emergency contraception service are not synonymous.

While the World Health Organisation established “levonogestrel only as the gold standard in hormonal emergency contraception . . . women who need emergency contraception also have other needs and a holistic sexual health service is essential.”¹

At the practice level, the provision of a high quality emergency contraception service includes

Initial Consultation

- Obtain history: unprotected intercourse within 72 hours of presentation?
- Prior episode(s) of unprotected intercourse in same menstrual cycle?
- Any contraindications to progestogen use?
- Negative urine pregnancy test - if considered necessary to test
- Check BP. Elevated BP is not a contraindication but requires further investigation
- If no symptoms of sexually transmitted infection (STI), delay pelvic examination until follow-up
- Review ECP efficacy, safety and instructions for use.
- Mention that although highly effective, the ECP is not 100% effective.
- Consider the cost. Currently it is cheaper to prescribe the progesterone-only oral contraceptive pill (Microval® or Microlut®) for two doses, however a current Medicare card and health care card (if applicable) must be shown at the pharmacy. Postinor-2® can be supplied via private prescription (~\$20-\$25), obviating the need for unique patient identification.
- Inform the patient that she needs to return to the GP if she vomits within 2 hours of a dose.
- Assist the patient to work out the timing so that the second dose is given at a convenient time.
- Discuss side effects (nausea, vomiting and less common side effects of breast pain, dizziness, tiredness, spot bleeding). These are evidence that the medication is working.

¹ Webb, A *Emergency Contraception: even easier to prescribe, but users still need a holistic sexual health service*, in *BMJ* 2003;326:775-776 (12 April)



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- Stress ongoing contraception in that cycle and discuss long-term contraception needs or encourage return to do so.
- Inform the patient that timing of periods often changes after the ECP.

Follow-Up Visit (2 to 3 Weeks) if practical

- STI screening, discussion of ongoing contraception needs.
- PAP smear if indicated
- Urine pregnancy test if menstruation has not commenced.
- Referral to other agencies if necessary.

A quality emergency contraception service aims to achieve several outcomes:

- Reduced rate of unplanned pregnancy and associated morbidity
- Identification and management of issues related to unprotected intercourse eg possible sexual assault
- Reduction of incidence STDs from current and future episodes of unprotected intercourse with preservation of future fertility. Of particular concern is *Chlamydia trachomatis* which has significant consequences for future fertility and is often asymptomatic.²

Improving Access to Emergency Contraception

The RACGP acknowledges that access to emergency contraception is important and depends both on availability (location and timing) and cost. The RACGP acknowledges the benefit of Postinor-2 and supports:

- PBS listing to improve accessibility to women; particularly those with limited disposable incomes.
- Improved scheduling, triage and practice management processes to ensure that women who require urgent consultations can access GPs
- Better triaging for emergency contraception in Accident and Emergency Units and Family Planning Clinics, particularly in rural areas. However, this needs careful consideration as our A&E Centres are already over-burdened
- Better education of the community on contraception in general and emergency contraception specifically.

**Prepared by the RACGP National Standing Committee on Quality Care
23 July 2003**

² Webb (above)



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ACCESS TO EMERGENCY CONTRACEPTION: Background Paper

Introduction

General Practice and Contraception

“You don’t get much more bread and butter general practice than contraception. With nearly one in twenty consultations being directly related contraception, and no doubt many more including contraception as part of another presenting complaint, we as general practitioners are regularly informing, discussing and advising on contraception.”³

Emergency Contraception

Emergency contraception is contraception used after unprotected sexual intercourse has occurred.

Common methods of emergency contraception currently available in Australia, include:

- Yuzpe method: use of multiple combined oral contraceptive pills. The equivalent of two Nordiol contraceptive pills taken within 72 hours of unprotected sex, followed by an identical dose 12 hours later;
- Insertion of a copper intrauterine device up to five days after unprotected sex;
- Progestogen only emergency contraception⁴.

Progestogen only contraception has been found to be effective and to have significantly reduced side effects over the Yuzpe and IUD options. In July 2002, Postinor-2 became available in Australia, as a commercially packaged emergency contraception regime. Postinor-2 is available on private prescription at a cost of approximately \$25.00. As it is not listed on the Pharmaceutical Benefits Scheme, there are no concessions for women on low incomes.

Over the Counter Availability of Progestogen Only Emergency Contraception

The National Drugs and Poisons Schedule Committee has approved the first stage of levonorgestrel (Postinor-2) being available over the counter (OTC) under the supervision of a pharmacist. This recommendation is now open for consultation prior to the Committee's final decision in October. If accepted, then emergency contraception (EC) will be available without prescription from 2004.

There has been a flurry of media interest: including a front-page article in The Age on 27 June 2003 (www.theage.com.au) The AMA and ADGP have argued that this is a retrograde step. Public health agencies have generally received the news favourably.

College Considerations

The management of emergency contraception is a microcosm of the tensions and pressures that impact on the general practice/health care system in that it focuses attention on:

- Access and equity to care in a timely manner for all patients
- Quality of care provided by the practitioner
- Continuity of care provided in an important area
- Environment in which care is provided
- Role of the pharmacist in EC

³ Calabresi, L Contraception: we’ve come a long way, in AFP Vol 31, No 10 (October 2002) p. 1

⁴ Foran, Terri, Emergency contraception, in AFP Vol 31, No 10 (October 2002)



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The consideration of the RACGP position requires an alignment of each of these concepts into a working model that supports high quality care for women at a vulnerable time.

Issues for Consideration

Access and Equity

The College's Task Force in Women's Health acknowledges that emergency contraception medication is available in more than 80 countries, that it is effective⁵ and that there is evidence to support over the counter availability on the grounds of recent trials that showed women provided with supply of emergency contraception medication were less likely to become pregnant than those told about it.

The WHO trial (1998) found that effectiveness is optimised if emergency contraception medication is provided within 72 hours of intercourse⁶. Subsequent studies, however, have indicated that benefits still accrue beyond 72 hours⁷. In forming a view on access, it is necessary to consider whether individual GPs and general practice in some areas would have difficulty in meeting the 72-hour timeline.

Alternate sources of emergency contraception that could improve accessibility are hospitals, A & E and Family Planning Clinics; all with established medical management systems. This would increase availability, especially in rural areas. It would also allow tracking to ensure that women were not using emergency contraception as their principal means of contraception.

These centres, like GPs, have medico-legal risk insurance.

Postinor-2 is not available through PBS and, therefore, will be limited to women can afford to pay the full price of the drug. In some instances, where cost is a factor, GPs can offer alternatives. The RACGP supports consideration of Postinor-2 being included on the PBS.

Quality of Care

GPs do not just dispense EC: they diagnose and support effective patient management and decision making. A consultation with a GP will canvas the specifics of the situation to eliminate sexual assault and STDs, will consider alternate forms of contraception and will provide follow-up with other services or with the GP.

Furthermore the GP will be able to advise on the impact of EC, that it is not 100% effective, the options available.

The Task Force on Women's Health has supported OTC emergency contraception with the following conditions that would address some of the quality care issues:

- the pharmacist needs a private room/space to discuss emergency contraception with the woman/couple

⁵ Webb, 2003 (above)

⁶ Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regime of combined contraceptives for emergency contraception in *Lancet* 1998; 352:428-433

⁷ Ellertson C, Evans M, Ferden S, Leadbetter C, Spears A, Johnston K, et al. Is 72 hours too late? Extending the time limit for starting Yuzpe regimen emergency contraceptive pills. *Obstet Gynecol* 2002 (In print). Rodrigues I, Grou F, Joly J. Effectiveness of emergency contraception pills between 72 and 120 hours after unprotected sexual intercourse. *Am J Obstet Gynecol* 2001; 184: 531-537



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- the pharmacist needs to canvas whether the sexual contact was consensual (ie this is not the result of sexual assault), sexually transmitted disease risk and that there is a process in place for follow up if necessary.
- Where cost is significant barrier, referral to GP or A&E to access Yuzpe method etc.

NSC:QC members have strengthening the second condition, to:

- the pharmacist should advise women to see her GP or Family Planning Clinic as soon as possible to discuss contraception, STDs etc

For further details, see the College's position on Emergency Contraception management at <http://www.racgp.org.au/folder.asp?id=703>

The NSC:QC consider that these conditions may not be within the capacity of community pharmacy as outlined below.

Continuity of Care

GPs have an ongoing relationship with patients: the majority of patients attend the same GP or the same practice consistently: the doctor patient relationship is real and quite different to the pharmacist/client relationship.

Environment of Care

The relationship between a pharmacist and a client is quite different and affected by the overwhelming trappings of the commercial environment of the pharmacy. This raises the issue of effectiveness of the pharmacy environment for sexual health management:

- currently pharmacists do not have adequate training in STD advice, post pill follow up and pregnancy and psychological counselling. This would need to be addressed prior to implementation.
- Pharmacist will need to establish specific medical records systems to support this initiative (see comment below).
- Medical indemnity: pharmacists will require specific indemnity to cover the occasional and serious impact of undiagnosed STDs, pregnancy etc
- Health promotion messages will need to be unambiguous. ie Postinor-2 is not a valid alternative to regular planned contraception. It is only a crisis option. Perhaps there should be a warning that if this option has been required 3 or more times the woman would be strongly advised to seek professional medical advice about contraceptive options. Also, it is not emergency STD prevention.

Furthermore, the development of these services within pharmacies is likely to increase the cost of provision of emergency contraception medication, and thus may increase availability but decrease affordability.

Role of the Pharmacist in EC

Extending the role of the pharmacist has long term implications for primary health care delivery: the Australian community (and the medical profession) has not yet debated the legitimate role of pharmacists.

Developed by the RACGP National Standing Committee on Quality Care.

23 July 2003

Emergency Contraception Resources

<http://www.racgp.org.au/folder.asp?id=703>



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These documents are an independent statement about Emergency Contraception developed by the RACGP in collaboration with the Drug and Therapeutics Information Service (DATIS).

Summary

*Emergency Contraceptive Pill (ECP) levonorgestrel 750 microgram
Managing risk associated with unprotected sexual intercourse*

This document is an independent statement about Emergency Contraception developed by the RACGP.

Information about the "morning after pill" has been available since the 1970s. However the term tends to be misleading and there is agreement for the recommendation to redefine this form of contraception as emergency contraception (EC). Difficulties in using emergency contraception appropriately include the lack of a product packaged specifically for this purpose, the lack of training provided on correct use, confusion over its form of action and concern with some as to whether it is an abortive agent.

An opportunity for GPs and other medical services to more easily offer women emergency contraception now presents itself. Postinor-2® – a progesterone only emergency contraceptive pill (ECP) is now available.

Over the last two years the RACGP Taskforce in Women's Health has held discussions with the Australian Public Health Association and with Family Planning NSW. The Taskforce has reviewed the evidence and had practical experience in using a progesterone only emergency contraceptive. At present this is 25 levonorgestrel tablets given twice with a 12 hour interval between doses.

The Taskforce recommends to GPs that the term emergency contraception be used as it is more than a morning after pill as it is most effective if used within 72 hours of intercourse. Emergency contraception can be used when no contraception was used and if other forms of contraception such as condoms have failed. Emergency contraception needs to be offered to women after non-consented sexual experiences (sexual assault).

The material in this paper has been organised to inform GPs about the latest evidence. The opportunity now exists for GPs to inform patients about emergency contraception, to offer it to all women at risk of unwanted pregnancy and at this time to be giving confidential and supportive care particularly when the woman has had an unwanted sexual encounter.

Practice Points

Discuss the emergency contraceptive pill (ECP) with all women when contraceptive methods are discussed at the clinic visit.

Consider prescribing ECP in advance, with a prescription for ECP issued in conjunction with any prescription for contraception. Written materials should be supplied with any prescription for ECP.

Initial Consultation

- Obtain history: unprotected intercourse within 72 hours of presentation?
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- Check BP. Elevated BP is not a contraindication but requires further investigation
- If no symptoms of sexually transmitted infection (STI), delay pelvic examination until follow-up
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- Assist the patient to work out the timing so that the second dose is given at a convenient time.
- Discuss side effects (nausea, vomiting and less common side effects of breast pain, dizziness, tiredness, spot bleeding). These are evidence that the medication is working.
- Stress ongoing contraception in that cycle and discuss long-term contraception needs or encourage return to do so.
- Inform the patient that timing of periods often changes after the ECP.

Follow-Up Visit (2 to 3 Weeks) if practical

- STI screening, discussion of ongoing contraception needs.
- PAP smear if indicated
- Urine pregnancy test if menstruation has not commenced.
- Referral to other agencies if necessary.

Issues Surrounding Prescribing and Use

It is important that the interaction between the woman requesting emergency contraception and the GP is a positive experience.

- Some GPs are not comfortable with the concept of emergency contraception. It is essential that these doctors provide a referral option for the patient.
- Respect the patient's sense of urgency.
- Avoid making assumptions and/or judgements about the patient and her behaviour.
- Avoid lecturing or "talking down".
- Consider issues faced by women from non-English speaking backgrounds.
- Respect the difficulties faced particularly by young women and disadvantaged women in the effort to reach the GP.
- The young patient may be concerned about confidentiality.
- Consider mandated notification issues depending on the young patient's age.
- Discuss sexually transmitted infections.
- Offer referral for additional support if needed.
- The best experience for the patient is one in which the GP:
 - gently and systematically gathers the facts
 - explains emergency contraception and provides written information
 - discusses with the patient if she needs more information and/or a prescription for long-term contraception. ie does not assume that the patient is ignorant of the issues involved.
 - is "youth-friendly" and non-judgmental
- A poor experience may result in the woman never again seeking ECP.



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