Emergency Contraception: Steps Being Taken to Improve Access

Advocates for emergency contraception are engaged on a number of fronts to ensure that women have access to the method within the brief time frame during which it is most effective. The simplicity of their administration and their long record of safety and efficacy have led many to conclude that emergency contraceptives should be made available over-the-counter. But making the regimen widely available faces challenges in the marketplace, as well as opposition from antiabortion and "profamily" groups that erroneously equate postcoital contraception with abortion. In fact, newly available data demonstrate that emergency contraception already has played a significant role in reducing the abortion rate in the United States.

By Heather Boonstra

Second of Two Articles

In the previous issue of *The Guttmacher Report,* the first article in this series on emergency contraception explained what the method is and how it is used, and reviewed efforts to raise awareness of emergency contraception among consumers and providers alike. This second article looks at what is being done to resolve the significant logistical and political barriers that currently prevent women from having timely access to the method.

Pathways to Access

If taken within 72 hours of intercourse, emergency contraception can reduce the risk of pregnancy by at least 75%. This gives women a relatively short time frame in which to locate and contact a provider to prescribe the pills and to find a pharmacist to fill the prescription. Any delay and the chance of pregnancy increases: Emergency contraceptives are most effective when used within the first 24 hours following unprotected intercourse.

How difficult it is to meet these challenges, even in the best of circumstances, is illustrated by an evaluation of the Emergency Contraception Hotline published in the February 2000 issue of *Obstetrics & Gynecology,* which found that one in four calls to the hot line did not result in a prescription within the 72-hour time frame. This result is worrisomely low in light of the fact that the hot line refers callers to a group of physicians who registered to be listed on the hot line's directory of providers. Furthermore, all calls were made during regular business hours, rather than on weekends and holidays when unprotected sex often occurs and when most clinics and doctors' offices are closed.

In light of the inherent challenges to obtaining emergency contraceptives within the narrow window of opportunity, advocates are working on a number of fronts to shorten the steps to getting the regimen. One tactic is encouraging hospitals to offer emergency contraceptives to women who have been sexually assaulted. Another is motivating physicians to offer advance prescriptions and telephone prescriptions to their patients. And yet another is making emergency contraceptives available directly from pharmacists. But perhaps the greatest impact would result from making emergency contraceptives available over-the-counter.

Emergency contraception in hospitals. An estimated 32,000 women become pregnant each year because of rape or incest. The American Medical Association regards pregnancy prevention as an essential component of treatment for women who have been sexually assaulted. Nevertheless, many hospitals do not routinely counsel women about or dispense emergency contraceptives: Of Pennsylvania hospital emergency rooms surveyed by the Clara Bell Duvall Reproductive Freedom Project in 2000 and 2002, only 46% followed well-established protocols for counseling and providing emergency contraceptives; 10% did not even discuss emergency contraception as a treatment option.

Recognizing the need to improve emergency care, advocates from within the sexual assault and reproductive health communities are working together to secure the passage of legislation requiring hospitals that receive public funding to provide women who have been sexually assaulted with accurate, unbiased information on emergency contraception. Five states have adopted such policies: Illinois requires only that information be provided; South Carolina requires provision of emergency contraceptives; and California, New York and Washington require that both information and services be provided. In Congress, the Compassionate Care for Female Sexual Assault Survivors Act was introduced in April 2002 by Reps. Connie Morella (R-MD) and Louise M. Slaughter (D-NY). It would deny federal funds to a hospital that does not promptly provide postcoital con-

traceptive information and services to women who have been sexually assaulted.

Advance and telephone prescriptions. The American Medical Women's Association and the American College of Obstetricians and Gynecologists—recognizing that all sexually active women are at risk of contraceptive emergencies—are encouraging their member doctors to discuss emergency contraception and offer advance prescriptions to sexually active women during their routine visits. The hope is that women will fill the prescription and store the pills in case of future need.

In addition, advocates are suggesting that physicians give prescriptions over the telephone, thereby eliminating the need for an office visit. Because the regimen consists of low levels of the same hormones found in ordinary birth control pills, and because of the short duration of exposure, emergency contraceptives are considered to be safe for nearly every woman; a physical examination is not required. Planned Parenthood Federation of America (PPFA) is encouraging its affiliates to allow new and established patients to receive prescriptions for emergency contraceptives and instructions for their use over the telephone. The North Carolina affiliate, for example, working in accordance with PPFA standards and guidelines and with Family Health International, launched a toll-free number in February 2001 that women can call to receive counseling and a prescription. Since that time, prescriptions have been provided to more than 6,400 women from over 400 towns and cities throughout the state.

Even if providers agree to proactively offer prescriptions to women, however, women may find it difficult to fill prescriptions within the 72-hour time frame. There is ample anecdotal evidence indicating that individual pharmacists have refused to fill prescriptions for emergency contraceptives, presumably on the grounds that to do so would facilitate abortion. Other pharmacies—including Wal-Mart, one of the nation's leading drug retailers—do not carry emergency contraceptives as part of their regular stock. A survey of 170 of New York City's pharmacies, for example, conducted by the New York City Council Investigation Division in June and July 2002, found that only about half of all pharmacies citywide carried emergency contraceptives. When queried, many of the pharmacies said that they do not stock the method because demand is low. This may be the result of a vicious cycle: Many women do not know that a postcoital method of contraception exists, and many doctors do not mention it to their patients. As a result, women are not coming in with prescriptions to fill, and pharmacies do not feel the need to keep a supply of the drug.

Pharmacy provision. Notwithstanding the problems that already exist with pharmacies, many advocates are looking to them as the primary way to facilitate access to emergency contraceptives, because they are often conveniently located and open on evenings, weekends and holidays (when contraceptive accidents are most likely to occur). In 1997, Washington State became the first in the nation to allow emergency contraceptives to be provided directly by pharmacists through voluntary "collaborative drug therapy agreements." These agreements allow physicians or nurse practitioners to delegate their authority to prescribe specific medication to pharmacists. By June 2001, pharmacists in Washington were providing emergency contraceptives at a rate of about 1,200 prescriptions per month. More than 35,600 prescriptions have been provided since the program began, preventing an estimated 2,000 unintended pregnancies.

The success of the Washington program has inspired other states to follow suit. California and Alaska recently changed state policy to allow pharmacists, within a collaborative agreement with a health care provider, to dispense emergency contraceptives. Despite these developments, replicating the Washington program has not been easy, says Kirsten Moore, president of the Reproductive Health Technologies Project. "At the policy level, it's an approach that often becomes embroiled in a battle between physicians and nonphysicians over scope of practice."

Moreover, the way collaborative agreements work in practice challenges Americans' notions of how pharmacies operate. Whereas in many other countries, nonprescription drugs of all kinds must be requested from a

COUNTRIES WHERE EMERGENCY CONTRACEPTION IS AVAILABLE WITHOUT A PRESCRIPTION

Albania	Mauritius
Belgium	Namibia
Benin	Norway
Cameroon	Portugal
Denmark	Republic of the Congo
Finland	Senegal
France	South Africa
Gabon	Sri Lanka
Guinea	Sweden
Israel	Switzerland
Ivory Coast	Togo
Lithuania	Tunisia
Madagascar	United Kingdom
Mali	

Source: **The American Society for Emergency Contraception, current as of November 7, 2002.**

Improving Access: The French Experience

The abortion rate for France is already one of the lowest in the world: At 12 per 1,000 women aged 14–44, it is half the U.S. rate. Even so, when emerging evidence in the late 1990s suggested that the rate was stabilizing instead of continuing to decrease, the French government responded swiftly—in part, by providing better access to emergency contraception.

Emergency contraception has been available in France since the early 1970s, and a product specifically packaged for postcoital use became available in May 1999. Just one month later, the French government decided to switch the drug to nonprescription status, making it available on request from pharmacists, who in France are gatekeepers for all medications. (France does not have an over-the-counter status equivalent to that in the United States.) Women who purchase emergency contraception from pharmacies can have 65% of the cost reimbursed to them under national health insurance; the method is available for free from family planning clinics.

The French government has taken extraordinary steps to ensure that adolescents in particular have access to the method. After 18 months of debate, the national assembly passed a law in December 2000 allowing public and parochial high school nurses to provide emergency contraception. In January 2002, French officials issued a decree allowing minors to obtain emergency contraceptives from a pharmacy at no charge and without requiring authorization from a parent; pharmacists are required to counsel young women and provide them with information about other forms of birth control.

Since 1999, over 1.5 million treatments have been sold in France, 97% without a prescription. There have been no reports of adverse events. Moreover, experts note that widespread availability of emergency contraception has spurred a renewed interest in all methods of contraception. "There is a more open discussion—among pharmacists, nurses in school, across all society—about what to do to prevent pregnancy and sexually transmitted diseases," says Elizabeth Aubeny, president of the French Association for Contraception. "And the more you talk about contraception, the more women use it and the fewer abortions there are."

pharmacist, the United States does not have an equivalent "behind-the-counter" status.

Over-the-counter availability. Many advocates contend that the best and most systematic way of ensuring that women have access to emergency contraceptives when they need them is by making the regimen available directly to consumers without a prescription, as it is in many countries (see chart, page 11). The smooth transition in France from prescription to nonprescription status is concrete evidence of the positive effect of access on women's health (see box).

Advocates for a switch from prescription to over-the-counter status contend that emergency contraceptives have all the characteristics of a nonprescription drug. Requiring a physician's prescription "makes no sense," says David Grimes, vice president of biomedical affairs at Family Health International. "Emergency contraception poses no serious risks. It is nontoxic; there is no danger from overdose or potential for addiction; and dosage is the same for all women."

Moreover, the regimen is easy to follow without the supervision of a health care provider. A study published in the August 2002 issue of *Obstetrics & Gynecology* of over 660 women (including many young and minority women and women of low literacy) was designed to evaluate how well women understood a prototype over-the-counter package label for emergency contraceptives. The vast majority (85%) understood key messages about indications for use, contraindications, instructions, possible side effects and management of serious complications, and almost all women (97%) understood that the first pill should be taken within 72 hours or as soon as possible after unprotected intercourse in order to prevent pregnancy.

The over-the-counter campaign got a boost in February 2001 when more than 80 medical, public health and advocacy groups signed a citizen's petition urging the Food and Drug Administration (FDA) to lift the prescription requirement. In February 2003, the manufacturer and distributor of one brand of emergency contraceptives, Plan B, will be taking its case to the FDA and filing an application for over-the-counter status. The company hopes a decision by the FDA will be reached in 2003.

Political Controversy

The goal of making emergency contraception widely available is not shared in all circles, and there are some interest groups who are openly hostile to the method. Key opponents are groups identified with the antiabortion and "profamily" movement—such as the United States Conference of Catholic Bishops, the Family Research Council and Concerned Women for America—who regard the drug as tantamount to abortion. Most ignore the fact that all hormonal contraceptive methods, depending on when during the menstrual cycle a

woman initiates the method, act by delaying or inhibiting ovulation, inhibiting fertilization or inhibiting implantation of a fertilized egg, which in medical terms is considered to mark the beginning of pregnancy. Emergency contraception has no effect once a pregnancy has been established.

Over and above this ideological opposition to abortion (and, in some cases, birth control), others may worry that the widespread availability of a postcoital method would lead many women to use it repeatedly and abandon more reliable methods of contraception. However, studies in the United States and Scotland have found that women who have emergency contraceptives at home do not use the regimen in lieu of ongoing methods of contraception. "There is no evidence that the availability of postcoital contraception will encourage women to take greater risks," says Felicia Stewart, adjunct professor and co-director of the Center for Reproductive Health Research & Policy at the University of California in San Francisco. "Participants in studies who have their own supply overwhelmingly choose to use 'plan ahead' methods regularly and keep postcoital contraception for emergencies—because they know that when used correctly and consistently these regular methods offer better pregnancy protection."

Perhaps the most deeply rooted controversy around ready access to emergency contraceptives involves adolescents. In many ways, a backup birth control method is especially important for sexually active teens, who may have sex only sporadically, and also are more likely than older, married women to experience contraceptive failure. Furthermore, 25% of sexually active teens do not use any method at first intercourse, and many find it difficult to take oral contraceptives every day or to consistently use intercourse-related methods, such as the condom or diaphragm.

As important as a backup method may be for this group, however, some fear that educating young people about emergency contraception encourages promiscuity. Again, there is no evidence that access to emergency contraceptives has any discernible effect on teen sexual activity. According to a study published in the May 2002 issue of *British Medical Journal,* English teens who had received instruction about emergency contraception showed an improved understanding of the method, but had no change in sexual activity, when compared with counterparts who had not received such instruction.

Abortions Averted

Advocates for widespread access to emergency contraceptives may never be able to satisfy the method's most ardent critics. For many Americans, however, the benefits of making emergency contraception widely available, once understood, are likely to be compelling. A hypothetical scenario calculated in the late 1980s projected that if emergency contraceptives were widely available in the United States, 1.7 million unintended pregnancies could be avoided each year, and the annual number of abortions could be cut by 800,000. Now, newly released data indicate that emergency contraceptive use already has played a significant role in reducing the U.S. abortion rate. In 2000–2001, The Alan Guttmacher Institute conducted national surveys of all U.S. abortion providers and of more than 10,000 women having abortions. The studies, published in the November/December 2002 and January/February 2003 issues of *Perspectives on Sexual and Reproductive Health,* together demonstrate the increasing significance of emergency contraceptive use. An estimated 51,000 abortions were averted by women's use of emergency contraceptives in 2000; moreover, emergency contraceptives accounted for up to 43% of the decrease in total abortions between 1994 and 2000.

"Wider access to emergency contraception is perhaps the single most promising avenue for reducing this country's high rates of unintended pregnancy and abortion," says Stewart. "The regimen is used in the most risky of all settings, when many women, if they were to get pregnant, would have an abortion. If women heard about emergency contraception from their doctors and saw it in pharmacies, many would use the method and wouldn't have to experience an unintended pregnancy. This would make a concrete difference in women's lives." ⊕

This is the second of two articles on issues relating to emergency contraception supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in these articles, however, are those of the author and The Alan Guttmacher Institute.

Errata:

The August 2002 issue included estimates from the American Social Health Association of the incidence and prevalence of sexually transmitted diseases (page 8). We failed to state that the estimates represented only cases contracted through sexual contact; overall estimates for HIV and Hepatitis B are higher when cases transmitted through other means are included.

The October 2002 issue indicated that California was the first state to codify *Roe vs. Wade* (page 11). In fact, California was the first to do so in close to a decade. Several states adopted similar laws in the early 1990s or shortly after the 1973 decision.