

Emergency contraception: Mostly successes, but still some threats

Following the World Health Organization (WHO) paper in 1998,¹ it was clear that progestogen-only emergency contraception (POEC) causes less nausea-related side effects than the Yuzpe regimen. The study also showed a reduction in effectiveness of both treatments with time. Although the effectiveness of the Yuzpe regimen was lower than in other studies, which caused some debate, it was clear that POEC was no less effective. POEC has gradually become the oral emergency contraception (EC) of choice in countries where it is available.

In France POEC got a prescription only medicine (POM) licence in spring 1999 and almost immediately was awarded a pharmacy (P) licence. In the USA, where EC has only recently been licensed in any form, POEC was available from late 1999.

Prior to a POM version becoming available in February 2000 in the United Kingdom (UK), the move towards POEC had started, mainly in specialist services, either by the use of multiple progestogen-only pills or by importation of the two tablet version from other European countries where it was available.

For some years the WHO has stated² that the only contraindication to EC was pregnancy, as it is incapable of dislodging an established pregnancy. In 1995 a joint statement³ was issued in the UK requesting that oral EC be available as a P product, but no pharmaceutical company was willing to move forward at the time. With the publication of the WHO paper¹ this changed.

At around the same time patient group directions (PGD) were being introduced for a variety of situations to enable nurses to issue POMs, and pharmacists became interested in doing something similar. The Manchester-Trafford-Salford Health Action Zone (M-T-S HAZ) was the first place to pilot this, starting at the end of 1999. Following training, named pharmacists could issue free, oral EC without reference to a doctor, only needing to refer on those who fell outside the PGD or wished an intra-uterine device (IUD). Subsequently, various other areas of the country, including Lambeth-Southwark-Lewisham, have also taken on the idea.

Prior to the launch of the P product a lot of preparatory work was carried out by both the Royal Pharmaceutical Society of Great Britain (RPSGB) and the pharmaceutical industry to enable a smooth introduction of this product. The aim was to provide all pharmacists with the necessary information to enable them to feel confident not only about the pharmacological and usual dispensing issues, but also about the sensitivities of dealing with issues relating to sexual health which inevitably stir up strong feelings in some people.

The RPSGB called together a group of experts representing doctors, pharmacists, clients and the Department of Health to look at all the issues, and through the Centre for Pharmacy Postgraduate Education (CPPE) they developed a structured training package.

At no time will POEC do any harm, although there are times when it will have no effect, either because it is not needed (e.g. one missed pill in the middle of a combined pill packet), or because it cannot dislodge an already implanted pregnancy. There are times when a woman may

be better served by using an IUD, so local links are vital for pharmacists to enable them to refer women on. Although pharmacists may wish to ask various questions, when pared to the bone the most important question is 'Are you on any other medication?' This will elucidate anyone on liver enzyme inducing drugs, which would render POEC less effective. This is a question pharmacists regularly ask anyway.

There were some initial concerns about pharmacists being able to deal with issues around sex. However, they have sold condoms for years and regularly deal with clients discussing diarrhoea, incontinence and stoma care so have plenty of experience with sensitive issues.

Pharmacists received a booklet that included all necessary pharmacological information and the 'Guidelines for Doctors' written for the Faculty of Family Planning and Reproductive Health Care. They were also invited to attend a meeting run by the local postgraduate tutor in their area, including input from a local doctor with expertise in EC. A workbook was sent out in advance to encourage the participants to think through all possible problems, and any questions were dealt with at the meeting as well as working through various scenarios.

Usually POM to P transitions are uneventful, but uniquely there was a debate in the House of Lords where an attempt was made to block the legislation permitting the change. The transcript makes very interesting reading, and in the end the opposers of the POM to P transition lost, 95 to 177.

The P product became available in February 2001. By mid 2001 the overall sales of EC had risen only modestly; the P product formed 25% of the sales with the POM version taking up 68% of sales, and the rest being made up by sales of the old oestrogen-progestogen product. A decision was therefore taken to withdraw the combined product (Schering PC4) from the 1st of October 2001.

The provision of POM product via pharmacists using PGD, in some of the earliest areas to use them, has been formally reviewed. It showed that 99% of women were very satisfied or satisfied with the service they received, and 91% of women were comfortable or very comfortable with the level of confidentiality afforded them. The pharmacists felt that this was a service begging to happen. In the M-T-S HAZ the numbers have gradually increased to 1500 requests a month. The local contraceptive services have noticed a reduction in EC requests, but also an increase in ongoing contraception requests. Nearly 20% are requests from women living outside the HAZ and there is a move to roll out the model throughout the North West Region.

The training programme designed through the CPPE was very well received. There were over 200 meetings which about a quarter of all pharmacists in England attended.

The most recent National Omnibus Survey showed that 91% of women aged 16-50 years had heard of oral EC, and 11% had used it in the last 2 years.⁴

The Family Planning Association (fpa) have noticed an increase in the number of phone calls from pharmacists, and have noticed a reduction in enquiries from clients on Mondays. Despite anecdotal reports that the P product is selling well in Liverpool, a comparison of requests for EC

to the Abacus Centres for Contraception and Reproductive Health between spring 2000 and spring 2001 did not show a difference. Forty percent of requests were still occurring on Monday and there were no obvious changes in other days of the week. The overall number of requests for EC, which had been increasing year on year, appear to have steadied off in the last 2 years. There is no provision of EC through PGD in Liverpool yet.

So far it looks like everything is fine but (and there always is a 'but', especially with issues around sexual health) despite the Attorney General stating in 1983 that 'post-coital treatment does not constitute a criminal offence within either sections 58 or 59 of the Offences Against the Person Act 1861', the anti-choice group, Society for the Protection of the Unborn Child, have been given permission to proceed with a high court action to halt P provision of EC. If this were to succeed there could be obvious implications to the legality of EC in all situations, as well as to other methods of contraception.

We still have to continue informing and educating all those who have, or may have, any need for contraception. Women need to be aware of their choices and have easy and acceptable access to them, thus enabling informed choices. Part of this information/education process involves us, the providers, getting involved locally or nationally to ensure that a small minority, however vocal, cannot impose their

views on the majority who obviously are able and willing to access contraception.

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