Canadian study reviewed the success of a pilot programme for providing EC at pharmacy without a prescription. Almost 7000 prescriptions were obtained and 21% of women stated that if they had not obtained EC in this manner, they would not have obtained it elsewhere. The Canadian government recently introduced a bill to remove EC from its current ‘prescription-requiring status’ making it available ‘over the counter’, thereby further removing barriers to access by women of all ages. According to the UK guidelines, the cost of licensed EC products available at pharmacies range from £5.99 with a prescription to £24.00 for an over-the-counter (OTC) product. To make matters worse, OTC products are limited to patients over 16 years of age. Imposing these restrictions on EC severely limits access to the products in the population least likely to see a physician and most likely to benefit from their use.

The medical eligibility criteria for EC are quite broad. According to the WHO guidelines, there are no absolute contraindications to EC use, which supports the safety of providing EC as an OTC product. If a prescription is required, advanced issue of a prescription for EC does not cause an increase in the use of EC (i.e. patients do not abuse EC as a form of regular contraception). Indeed, they are likely to use EC when needed, and may also more likely to use standard contraception preferably.

Hormonal EC needs to be made accessible to all women equally, especially to adolescents. This is most likely to occur in an environment where they can access EC at a convenient time, in a convenient location, at a convenient price (preferably free of charge). Only then might we start to see the financial and social benefits of primary prevention of unwanted pregnancies in this age group.

Melissa Mirosh, MD
Chief Resident in Obstetrics and Gynecology,
University of Saskatchewan

Olefeni Olatunbosun, FRCS(OG), FACC
Professor and Chair, Department of Obstetrics, Gynaecology & Reproductive Sciences, University of Saskatchewan, Royal University Hospital, 103 Hospital Drive, Saskatoon SK S7N 0W8, Canada

References


Reply

Madam

As mentioned in my original article there is only one study1 that shows a direct correlation between intercourse treatment interval and effectiveness of emergency hormonal contraception (EHC). Neither the subsequent World Health Organization (WHO) paper in 2002 nor another large study2 have shown this correlation. The 1998 WHO paper quoted by the correspondent was carried out in women within 72 hours of intercourse and only four women used EHC-72 hours. In the 2002 paper the authors clearly state: “There was no evidence of an interaction between regimens and timing of treatment within 72 hours or after 72 hours. For the three regimens combined, women treated after 72 hours had a higher pregnancy rate than those treated within 72 hours but the difference was not significant”.

Another study looking at the Yuzpe regimen between 72 and 120 hours3 also had small numbers and, therefore, wide confidence intervals so it is difficult to know the true efficacy.

The 2002 paper shows that the 1.5 mg levonorgestrel sal gel dose regimen is as safe and effective as a split dose gel; it therefore seems logical that the simpler dosing should be the one of choice. I agree that EHC should be ideally used as soon as possible and that this may be best achieved by ensuring that any woman who may, at sometime in her life, be at risk, has some easily available. After all, don’t most people have simple painkillers at home and sometimes in their handbags in case they should get a headache? This is despite both aspirin and paracetamol (acetaminophen in North America) having a considerably greater list of contraindications and side effects than levonorgestrel.

My mention of the intrauterine device (IUD) was precisely to remind clinicians that they should not be constrained by myths. Fitting an IUD in a nulliparous woman is a common practice in our service and as a result with all methods, is related more to the adequacy of counselling and practical expertise of the fitter than with the parity or age of the woman.

Contraception in the UK is free when on a National Health Service prescription. When bought from a pharmacy without prescription, the cost of EHC is indeed high. I agree that the age restriction has no medical basis. I was delighted to see that Canadians now have access to EHC without prescription. I hope it is at an affordable price. It was very disappointing that the USA Food and Drug Administration (FDA) did not feel able to make an equally enlightened decision despite the advice they received.

EHC is safe and should be broadly and affordably available to all who need it. However it is not the answer to unwanted pregnancies and must be part of a much wider effort to increase knowledge, accessibility, affordability and usability of all methods of contraception and prevention against sexually transmitted infections.

Anne Webb, MBChB, MFFP
Consultant in Family Planning and Reproductive Health Care, Abacan Clinics for Contraception and Reproductive Health Care, 40-46 Dale Street, Liverpool L2 5SF/UK. E-mail: anne.webb@pct.northliverpool.nhs.uk

References


Service standards: chaperones and record keeping

Madam

We are grateful for the responses from McVicker, Murray and Robinson1,2 but without wishing to over-polemic this debate we would like to clarify the problems a little more within women within 72 hours of intercourse and only four women used EHC-72 hours. In the 2002 paper the authors clearly state: “There was no evidence of an interaction between regimens and timing of treatment within 72 hours or after 72 hours. For the three regimens combined, women treated after 72 hours had a higher pregnancy rate than those treated within 72 hours but the difference was not significant”.

Another study looking at the Yuzpe regimen between 72 and 120 hours3 also had small numbers and, therefore, wide confidence intervals so it is difficult to know the true efficacy.

The 2002 paper shows that the 1.5 mg levonorgestrel sal gel dose regimen is as safe and effective as a split dose gel; it therefore seems logical that the simpler dosing should be the one of choice. I agree that EHC should be ideally used as soon as possible and that this may be best achieved by ensuring that any woman who may, at sometime in her life, be at risk, has some easily available. After all, don’t most people have simple painkillers at home and sometimes in their handbags in case they should get a headache? This is despite both aspirin and paracetamol (acetaminophen in North America) having a considerably greater list of contraindications and side effects than levonorgestrel.

My mention of the intrauterine device (IUD) was precisely to remind clinicians that they should not be constrained by myths. Fitting an IUD in a nulliparous woman is a common practice in our service and as a result with all methods, is related more to the adequacy of counselling and practical expertise of the fitter than with the parity or age of the woman.

Contraception in the UK is free when on a National Health Service prescription. When bought from a pharmacy without prescription, the cost of EHC is indeed high. I agree that the age restriction has no medical basis. I was delighted to see that Canadians now have access to EHC without prescription. I hope it is at an affordable price. It was very disappointing that the USA Food and Drug Administration (FDA) did not feel able to make an equally enlightened decision despite the advice they received.

EHC is safe and should be broadly and affordably available to all who need it. However it is not the answer to unwanted pregnancies and must be part of a much wider effort to increase knowledge, accessibility, affordability and usability of all methods of contraception and prevention against sexually transmitted infections.

Anne Webb, MBChB, MFFP
Consultant in Family Planning and Reproductive Health Care, Abacan Clinics for Contraception and Reproductive Health Care, 40-46 Dale Street, Liverpool L2 5SF/UK. E-mail: anne.webb@pct.northliverpool.nhs.uk

References


Editor’s Note

This letter has been forwarded to the Chair of the Clinical Standards Committee.

Journal of Family Planning and Reproductive Health Care 2004; 30(4)