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WOMEN'S HEALTH CARE PHYSICIANS

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Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee member Sarah Prager, MD, MAS.

Access to Emergency Contraception

ABSTRACT: Emergency contraception refers to contraceptive methods used to prevent pregnancy in the first few days after unprotected intercourse, sexual assault, or contraceptive failure. Although the U.S. Food and Drug Administration approved the first dedicated product for emergency contraception in 1998, numerous barriers to emergency contraception remain. The purpose of this Committee Opinion is to examine barriers to the use of emergency contraception, emphasize the importance of increasing access, and review new methods of emergency contraception and limitations in efficacy in special populations.

Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations:

- Counsel patients that a copper intrauterine device (IUD) is the most effective form of emergency contraception. Obstetrician–gynecologists and other health care providers should consider integrating copper IUD emergency contraception provision into their practices and allowing same-day provision of IUDs.
- Prescribe ulipristal acetate when possible because it is more effective than levonorgestrel at all times up to 5 days after unprotected intercourse and in women of all weights.
- Write advance prescriptions for emergency contraception, particularly for ulipristal acetate, to increase awareness and reduce barriers to immediate access.
- Use a visit for emergency contraception as an opportunity to provide information about all contraceptive methods and to initiate a regular method, when possible.
- Counsel all women at risk of pregnancy about emergency contraception and provide patient education materials and reminders in electronic health records, which prompt clinicians and staff to address emergency contraception during visits.
- Support public and clinician education clarifying that emergency contraception will not terminate an established pregnancy.
- Use social media to conduct campaigns regarding access to emergency contraception.
- Provide a referral for a woman who desires emergency contraception if her health care provider, pharmacy, or institution has an objection to providing it.
- Collaborate with pharmacies and other retail outlets to avoid misinformation and ensure timely access to emergency contraception.

Background

Emergency contraception may be used to prevent pregnancy after an unprotected or inadequately protected act of sexual intercourse. Emergency contraception is effective in preventing pregnancy within 120 hours after unprotected intercourse, but it is most effective if used as soon as possible, especially within 24 hours (1). The most common emergency contraceptive method is oral progestin-only pills (levonorgestrel), but use of the antiprogestin ulipristal acetate or a combined regimen (high doses of ethinyl estradiol and a progestin) also are effective (1). A copper IUD is the most effective form of emergency contraception for medically eligible women and is highly effective to prevent pregnancy if inserted up to 5 days after unprotected intercourse (1–3). The copper IUD also provides highly effective ongoing contraception. Additional data on mechanism of action, efficacy, adverse effects, and clinical considerations can be found in the American College of Obstetricians and Gynecologists' Practice Bulletin No. 152, *Emergency Contraception*.

Progestin-only emergency contraception is better tolerated and more efficacious than the combined regimen. In the United States, two levonorgestrel-only regimens are available: 1) a single-dose regimen (1.5 mg levonorgestrel) and 2) a two-dose regimen (two tablets of 0.75 mg of levonorgestrel taken 12 hours apart). The levonorgestrel-only regimens are available without a prescription to women of any age. However, the antiprogestin—a 30-mg tablet of ulipristal acetate—requires a prescription. Ulipristal acetate is more effective than levonorgestrel in preventing pregnancy after unprotected intercourse at all time points within 120 hours (4).

Recent evidence indicates that levonorgestrel and ulipristal acetate may be less effective for women who are overweight (body mass index [BMI] of 25–29.9) or obese (BMI of 30 or greater), although levonorgestrel may lose efficacy at a lower weight threshold than ulipristal acetate (1, 5, 6). Overweight and obese women should be advised that levonorgestrel may be less effective at preventing pregnancy, but they should not be refused or discouraged from using emergency contraception because of their weight. Regardless of a woman's body weight, the copper IUD is the most effective form of emergency contraception, followed by ulipristal acetate.

Barriers to Access

In spite of levonorgestrel-only emergency contraception being made available over the counter without age restriction in 2013, many barriers still remain. These barriers are varied and broad-reaching and are not solved simply by removing the prescription requirement for one type of oral emergency contraception. These barriers apply to obstetrician–gynecologists and other health care providers, as well as to patients, and are presented in the following sections.

Misconceptions

Confusion With Medication-Induced Abortion

Emergency contraception is sometimes confused with medication-induced abortion. Medication-induced abortion is used to terminate an existing pregnancy. All types of emergency contraception are effective only before a pregnancy is established, and, therefore, are not abortifacients (1).

Effect on Sexual Behavior

Another misconception is that making emergency contraception more readily available promotes risky sexual behavior and increases the rates of unintended pregnancy (7). Ready access to emergency contraception is not associated with less hormonal contraceptive use, less condom use, or more unprotected sex (1, 8).

Safety of Repeated Use

Data are not available on the safety of current regimens of emergency contraception if used frequently over a long period. However, oral emergency contraception may be used more than once, even within the same menstrual cycle (1). Information about other forms of contraception, and counseling about how to avoid future contraceptive failure, should be made available to women who use emergency contraception, especially to those who use it repeatedly. Women who continue to have sexual intercourse in the same cycle in which they have used oral emergency contraception are at risk of unintended pregnancy (5). A visit to obtain emergency contraception should be used as an opportunity to provide information about all contraceptive methods and to initiate a regular method of contraception when possible.

Financial Barriers

Women's financial resources and insurance coverage may limit access to contraceptive methods. Women who lack health insurance, disposable income, or coverage for over-the-counter medications may not have access to any method of emergency contraception (9). The Affordable Care Act has increased the number of women who can access prescription contraception without cost sharing, but most insurance plans require a prescription to cover over-the-counter emergency contraception, and women may face barriers obtaining coverage of all methods. Approximately 12.8 million women (13%) aged 19–64 years were uninsured in 2014, including low-income women in states where Medicaid has not been expanded (10). Out-of-pocket costs for oral emergency contraception average between $25 and $60, and copper IUD costs can be more than $500, depending on insurance (11–13). Some state Medicaid programs and some private insurers cover over-the-counter emergency contraception without a prescription (14). Expansion of coverage for over-the-counter emergency contraception would increase access for women.

Education and Practice Barriers

Although use of emergency contraception has increased, many women and clinicians remain unfamiliar with the method or are unaware that a physical examination or testing is not needed before oral emergency contraception is provided. Women often are reluctant to or unaware that they can ask for an advance prescription, or they do not anticipate needing it and then have difficulty obtaining a prescription for oral emergency contraception when needed (15, 16). Health care practitioners often discuss or provide emergency contraception only on request or when a woman reports an unprotected sexual encounter (15). Some believe that routine counseling about emergency contraception is too time consuming, or they have a misperception that the patient might be unable to use the method properly (11). In a 2010 survey of obstetrician–gynecologists, only 16% reported having recommended use of the copper IUD for emergency contraception (17). Limited availability of health care providers trained in IUD insertion may contribute to this insufficiency, as well as clinic flow and reimbursement concerns.

Health System Barriers

Women in underserved communities may face additional challenges. Some communities simply lack a nearby facility or clinician willing to provide emergency contraception. In other communities, hospitals, clinics, and pharmacies that are religiously affiliated might present a further barrier to access (7). Legislation and lawsuits seeking to enforce compliance with state laws requiring that emergency contraception be offered to sexual assault survivors have been brought against emergency departments affiliated with religious institutions (18). Currently, these barriers can effectively eliminate all emergency contraception provision in some communities.

Pharmacy Barriers

Pharmacists and pharmacies may impose barriers to women seeking emergency contraception pills in a variety of ways, such as refusing to dispense prescribed emergency contraception, refusing to stock the method, convoluted and inaccurate phone call directions, delays in speaking with a knowledgeable staff member, or being asked unnecessary embarrassing questions (9, 19). One study found that pharmacists gave inaccurate information regarding the correct age threshold for over-the-counter access by adolescents, especially in low-income neighborhoods (20). Pharmacists could be instrumental in improving access to emergency contraception, and several states allow pharmacists to dispense prescription oral emergency contraception without a physician's prescription under certain conditions (16, 21). Some pharmacies may not stock ulipristal acetate because of low demand for this fairly new product.

Special Populations

Access to emergency contraception remains difficult for adolescents, immigrants, non-English speaking women, survivors of sexual assault, those living in areas with few pharmacies, those who are incarcerated, and poor women. Barriers most frequently cited by adolescents are confidentiality concerns, embarrassment, and lack of transportation to a health care provider or pharmacy. Although more than one half of pharmacies offer Spanish language services, expansion of Spanish and other language services could improve timely access to emergency contraception (11).

Up to 5% of sexual assault survivors become pregnant (22). Emergency contraception should be provided to victims of sexual assault, requiring its immediate availability in hospitals and other facilities where sexual assault victims are treated. In 2013, the U.S. Department of Justice issued the second edition of *A National Protocol for Sexual Assault Medical Forensic Examinations* (23). These guidelines strengthened prior recommendations requiring that emergency contraception be made available, either directly or by referral, to victims of sexual assault, even to those victims treated in a hospital with a religious or other restrictive affiliation. Only 17 states have laws requiring that emergency contraception be made available to victims of sexual assault, and even fewer have a means of enforcing these recommendations (24). Legislation for and enforcement of these recommendations should exist in every state.

Nearly one third of newly arrested women are eligible for emergency contraception, but few jails and prisons screen for recent unprotected intercourse or offer emergency contraception when appropriate (25). Adding this screening to the intake process could identify women who would benefit from emergency contraception and reduce unintended pregnancies in incarcerated women.

Conclusion

Emergency contraception remains an important option for pregnancy prevention and is the only method effective after a sexual encounter. Although progress has been made toward improving access, barriers remain. Obstetrician–gynecologists and other health care providers should be sensitive to these barriers and work toward their elimination.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/EmergencyContraception.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the

organization's website, or the content of the resource. The resources may change without notice.

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