Emergency Contraception Pills and the Need for Advance Prescriptions

Unintended pregnancy is associated with late initiation of prenatal care, low birthweight, domestic violence and poor child health and development. Oregon survey and birth certificate data indicate that more than half of all Oregon pregnancies are unintended, and that over 40% of those unintended pregnancies end in abortion. Emergency contraception could potentially prevent half of unintended pregnancies. This CD Summary discusses emergency contraception (EC) and several strategies for increasing women’s access to EC.

**WHAT IS EMERGENCY CONTRACEPTION?**

EC has been available since the early 1970s. Emergency contraceptive pills prevent pregnancy the same way that daily birth control pills do—by delaying or preventing ovulation, inhibiting fertilization or preventing implantation of the fertilized ovum. They are not to be confused with birth control pills—by delaying or preventing ovulation, inhibiting fertilization or preventing implantation of the fertilized ovum. They are not to be confused with birth control pills. The pregnancy Risk Assessment Monitoring System (PRAMS) is a DHS Office of Family Health survey of new mothers. In 1998–99, PRAMS found that 30% of new mothers reported not having heard of EC. The women most likely to have not heard about EC (in multivariate analysis) were mothers with less than a high school education, with an annual family income below $30,000, and whose pregnancies were unintended (see table). These demographic characteristics describe a group of women for whom education about the availability of emergency contraception should be a priority.

The original regimen approved for EC contained a combination of estrogen and progestin. However, in 1999, the FDA approved a progestin-only regimen (two doses of 0.75 mg of levonorgestrel taken 12 hours apart) under the brand name Plan B. Plan B is more effective and has fewer side effects (particularly much reduced nausea and vomiting) than the original regimen, and should therefore be the EC regimen of choice for most situations. In addition, although it was suggested that the original regimen be prescribed with an antiemetic, the low incidence of nausea and vomiting with Plan B means that prescription of an antiemetic together with Plan B is not routinely indicated.

EC pills can reduce the risk of pregnancy by 75–89% (without EC pills 8% of women with unprotected mid-cycle intercourse would become pregnant; with EC pills only 2% would become pregnant). EC therapy is most effective when taken in the first 24 hours after intercourse. Although effectiveness decreases with time after intercourse, it may be effective in some cases up to five days after intercourse.

**IMPROVING ACCESS TO EC**

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a DHS Office of Family Health survey of new mothers. In 1998–99, PRAMS found that 30% of new mothers reported not having heard of EC. The women most likely to have not heard about EC (in multivariate analysis) were mothers with less than a high school education, with an annual family income below $30,000, and whose pregnancies were unintended (see table). These demographic characteristics describe a group of women for whom education about the availability of emergency contraception should be a priority.

One way to increase access to EC is for providers to supply female patients with advance prescriptions for EC at routine visits. Some providers have expressed concerns that advance prescriptions may lead to reliance on EC as a birth control method. However, a randomized trial found that women who had emergency contraceptive pills in their home were not more likely than the control group (who had to go to a doctor to obtain EC) to use it more than once.

Another strategy to improve access to EC is to make it available directly from pharmacists. Since 1998, Washington State has allowed pharmacists, under the aegis of a collaborative drug therapy agreement, to evaluate a patient’s need for EC and provide counseling, referrals and EC pills, if appropriate. Over 50,000 women have accessed EC from Washington pharmacists since 1998, and surveys of physicians and patients have shown strong support. Pharmacist-dispensed EC may have caused the subsequent decrease in abortions and unintended pregnancies in Washington. California enacted a similar law in 2001. Although there was discussion during the Oregon 2001 legislative session about how to allow pharmacist dispensing of EC, no bill was passed relating to this topic.

**WHAT PROVIDERS CAN DO**

Providers should inform their patients about EC as an option in case of contraceptive failure or unprotected sex. Providers should not rely on their patients asking for EC, and any woman of reproductive age should be asked if she knows about EC, and offered EC information and a prescription if appropriate. Health-care providers at college health clinics can educate students about EC and expedite access. Emergency-department providers can inform rape victims about EC. EC can safely be prescribed over the phone without an exam, since neither possible pregnancy nor any STD is a contraindication for EC. To improve awareness about EC, providers can prominently display brochures and pamphlets about EC in their waiting rooms. Special effort should be given to educating low-income women and women with less than a high school education about EC.

Providers can order Plan B and/or preprinted prescription pads directly from the manufacturer, Women’s Capital Corporation (1-800-330-1271; info@go2planB.com). Their web site (http://www.go2planB.com [“Tools for Clinicians”; “Pharmacy Directory”]) lists some of the retail pharmacies that stock Plan B.

Additional information about EC is available from DHS’ Office of Family Health at 503/731-4507.
Influenza Departs Oregon

This past season influenza type A (H3N2) viruses predominated in Oregon with the first case reported during the 9th week (ending 12/01/01) of the influenza epidemiologic year by staff of the Providence Portland Medical Center Infectious Disease Laboratory and the last case was reported in week 27 (ending 04/06/02) by Clinical Epidemiologists of Legacy Health System. In addition to these two sources, reports were received from the Oregon State Public Health Laboratory (OSPHL). Considering all sources of culture-positive reports, this season’s tally came to 115 isolates—five type B isolates and 110 type A. Last season’s tally climbed to 133 isolates by this same time—52 type A and 81 type B. Onsets of illness peaked at 14 during week Feb. 10–16.

Review of OSPHL reports for the last 10 seasons dating back to 1991–92 reveals a continuing trend toward less vindictive influenza viruses. The number of “R/O flu” specimens examined for influenza virus came to 377 with 44 (12%) positive. The number of cultured specimens ranked third with only two seasons having lower totals. The same third place ranking emerged when comparing the number of isolates and percentage positive. The one feature seeking recognition was the duration of 19 weeks—which ranked as the third longest; the 1994–95 season lasted 20 weeks and the 1992–93 season 26 weeks.

Highlights of the season in the U.S. consisted of identification of reassortment H1N2 viruses and viruses of the B/Victoria lineage not seen here since 1991. The H1N2 viruses did not pose any threat as the current vaccine proved as effective against them as the circulating H1N1 and H3N2 viruses. The appearance of the viruses of the B/Victoria lineage led to the change in the B component of the vaccine recommended for the next season.

This season, Oregon surveillance efforts were bolstered by 22 sentinel practitioners. On average 1.5% of patients seen each week had influenza-like illness (ILI). ILI peaked at 3.0% during the week of February 3–9.

Thanks to all who participated in our surveillance activities, including the sentinel reporters! Resumption of surveillance for the 2002–2003 season will be announced in the fall on these pages. In the meantime, we have a wealth of influenza info, including recommendations for the coming season, on our influenza website: http://www.oshd.org/acad/docs/influenza.htm.

Lockdown — NOT

May 16th's entertaining and dramatic episode of ER unfortunately portrayed the public health response to a smallpox outbreak inaccurately. In particular, we public-health types in Oregon do not envision a scenario in which we would advise the “lockdown” of an emergency department.

Were smallpox to be reintroduced we would advise isolation of febrile patients and rapid vaccination of household and face-to-face contacts. Contacts would be discharged from the emergency department and contacted daily to see if they had developed a fever and therefore required isolation.

Please note the distinction between isolation of febrile patients, which we would employ, and quarantine, which we would not employ. Quarantine involves large-scale restriction of movement and cohorting of ill and well people together; it may well increase the exposure of many to disease, would be difficult to enforce, and has historically been ineffective. History has shown us that smallpox is controllable by contact tracing and ring vaccination.