Prevention is better than cure — especially in the field of sexual and reproductive health. Australia’s teenage pregnancy rates (17.3 per 1000 women in 2003) and abortion rates (19.7 per 1000 women in 2008) are high compared with other Western countries. Such rates are not inevitable, and recent contraceptive strategies were developed to help in reducing them.

One such strategy was the rescheduling in Australia of the emergency contraceptive pill (ECP) containing levonorgestrel to Schedule 3 (over-the-counter) status, making it available from pharmacists without a prescription. Improved access to the ECP is a crucial issue, given that the sooner it is taken after unprotected intercourse, the more effective it is. By rescheduling the ECP, it was hoped that women would be able to obtain it more easily within the narrow time frame recommended, especially after hours and on weekends, when it is more difficult to access a general practitioner. A second-generation antiprogestin ECP, ulipristal acetate (30 mg), has now been released and is thought to be a more effective option up to 120 hours after unprotected intercourse.

Our recently published Australian population study of over 600 women aged 16 to 35 years found that although 95% had heard of the ECP and 26% had used it, just under half (48%) were aware that the ECP was available over the counter. In addition, under half (45%) thought it was safe for the health of women, most (61%) erroneously believed that it would damage a pre-existing pregnancy, and 32% that it was an abortifacient, similar to mifepristone — all findings consistent with overseas studies.

Women’s attitudes towards the ECP revealed various views and beliefs influencing their use, including moral and religious reasons, fear of side effects, and unrealistically low perceptions of pregnancy risk. Unsurprisingly, women with good knowledge of the ECP were more likely to report having used it. Some women (12%) thought they were unlikely to become pregnant, even when having unprotected intercourse at the most fertile time of the menstrual cycle.

Although our linked study found that pharmacists believe further information provision following ECP dispensing is their responsibility, most women (84%) prefer to receive information from a doctor rather than a pharmacist. This offers an important opportunity for GPs to help patients prevent unintended pregnancy and abortion. GPs could include discussion of the ECP in all general consultations with women of reproductive age regarding contraception or reproductive issues, such as cervical cancer screening. Ideally, GPs should seek opportunities to discuss the ECP within an overall contraceptive strategy and with all female adolescents during routine health care visits. GPs can play a critical role in informing and educating women about their risks of becoming pregnant, the use of contraceptives generally and how to use them correctly and consistently. They can also counsel about risky sexual behaviour and the higher risk of an unplanned pregnancy resulting from such behaviour. They could encourage women to keep an advance supply of the ECP at home, if appropriate.

Access to such ECP options would be more widely available if it were to be subsidised or free for women who are socioeconomic disadvantaged (eg, health care card holders).

As well as the prevention of unplanned pregnancy, assistance with pregnancy termination may be necessary and should always be available if women are unable to continue with a pregnancy. There are parts of Australia where sex education is inadequate, access to contraceptive advice or support is lacking, and hospitals do not provide pregnancy termination services. This can lead to problematically late presentations for abortion.

In Australia, the removal of the requirement for ministerial approval for the importation and supply of mifepristone means that doctors can now apply to the Therapeutic Goods Administration for approval to provide this drug to their patients for medical termination of pregnancy. Mifepristone is widely used in many countries, including the United Kingdom, the United States, France, New Zealand, Sweden and China and has been shown to be a safe, effective and highly successful treatment for the termination of early pregnancy.

Already, women are being offered greater options when making the decision about an unintended pregnancy — they can choose to continue with the pregnancy, to place the baby for adoption, or if they opt for termination, a limited number of clinics, such as Marie Stopes International Australia, are now able to provide medical termination with mifepristone as an alternative to referral for surgical abortion.

This option could, and probably should, be more widely available, but a greater emphasis on prevention is clearly needed. At the very least, a sustained public information campaign should address the misconceptions we have uncovered, and publicise the availability of effective contraceptive options. At most, a more comprehensive national sexual and reproductive health strategy should be implemented.

Competing interests
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Emergency contraception and medical abortion are options, but education about them is vital

Unintended pregnancy in Australia: what more can we do?
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