

**MPHA Policy Resolution  
Emergency Contraception  
May 2006**

**WHEREAS**, nearly one-half of all pregnancies in the United States are unintended at the time of conception,<sup>1</sup> which translates into as many as 47,000 unintended pregnancies annually in Minnesota<sup>2</sup>; and

**WHEREAS**, there is evidence that access to emergency contraception is not associated with risky sexual behavior;<sup>3</sup> there is evidence that advanced prescriptions are not associated with changes in usual contraceptive behavior,<sup>4</sup> and evidence that over-the-counter access to contraceptives is associated with proper use<sup>5</sup>; and

**WHEREAS**, women who have unintended pregnancies are more likely to report depression and physical abuse, are less likely to receive adequate prenatal care, and are more likely to continue risk behaviors such as alcohol consumption and smoking that place the fetus at a health risk<sup>6</sup>; and

**WHEREAS**, women with unintended pregnancies may be less likely to have healthy pre-conceptual behaviors<sup>7</sup>; and

**WHEREAS**, children born of unintended pregnancies are at greater risk of low birth weight, and of not being breastfed<sup>8</sup>; and

**WHEREAS**, health care practitioners have been prescribing and dispensing high-dose estrogen since the 1960s to be used as emergency contraception, and there now exists a safe and effective medication (Plan B) packaged specifically to be taken orally within 120 hours after intercourse<sup>9</sup>; and

**WHEREAS**, emergency contraception poses no danger to an already established pregnancy<sup>1</sup>, and the mechanism of action is to prevent ovulation, prevent fertilization, or prevent the implantation of a fertilized egg, thereby being defined as contraception (not abortion), and whereby emergency contraception has no medical contraindications for women<sup>10</sup>; and

**WHEREAS**, ready access (within 120 hours) to emergency contraception is essential to effective use because of its time-sensitivity, thereby reducing the chance of pregnancy by up to 89%,<sup>11</sup>; and

**WHEREAS**, there have been attempts by health care practitioners in Minnesota and across the United States to limit access to legally prescribed and dispensed contraceptives, based on personal beliefs and moral viewpoints, which have caused emotional trauma, endangering women's health and violating their legal rights; and

**WHEREAS**, each year, 25,000 American women become pregnant following an act of sexual violence and the prompt use of emergency contraception could prevent as many as 22,000 of those pregnancies<sup>12</sup>; and

**WHEREAS**, best estimates indicate that if emergency contraceptives were widely available in the United States, 1.7 million unintended pregnancies could be avoided and the number of abortions each year could be cut by as much as half<sup>13</sup>; and

**WHEREAS**, a larger percentage of women aged 18 to 44 (68%) are increasingly aware of emergency contraception, but only 6% of sexually active women have used emergency contraception, and whereby only 25% of gynecologists and 14% of family practitioners say that they always or usually include discussion of emergency contraception in routine patient counseling<sup>14</sup>; and

**WHEREAS**, Minnesota law allows for collaborative agreements between physicians and pharmacists to dispense emergency contraception; but there is no state-approved protocol for dispensing emergency contraception over-the-counter at this time<sup>15</sup>; and

**WHEREAS**, thirty-five other countries allow emergency contraception to be sold over-the-counter and eight states in the United States allow pharmacists to dispense emergency contraception without a prescription; and

**WHEREAS**, access to Plan B emergency contraception is determined in part by whether pharmacies stock the medication, and varies from as few as 35% of pharmacies in rural areas to 85% of pharmacies in urban areas<sup>16</sup>; and

**WHEREAS**, in December 2003, the Nonprescription Drugs and Reproductive Health Drugs Advisory Committee (NDRHD) of the FDA recommended overwhelmingly 23-4 to the FDA Commissioner, that Plan B be made available over-the-counter. However, the acting director of the Center for Drug Evaluation and Research, overruled the agency's advisory committees and staff scientists and denied the request<sup>17</sup>; and

**WHEREAS**, national professional organizations, including the American College of Obstetricians and Gynecologists, the American College of Nurse Midwives,<sup>18</sup> and the American Academy of Pediatrics,<sup>19</sup> have attested to the safety of emergency hormonal contraceptives and have advocated for over-the-counter availability; and

**WHEREAS**, the American Public Health Association (APHA) has already approved two policy statements, one regarding emergency contraception access to victims of sexual assault<sup>20</sup> and the other supporting public education about emergency contraception and reducing barriers to access<sup>21</sup>.

**Therefore, be it resolved that the Minnesota Public Health Association:**

1. Opposes any efforts to restrict access to the provision of emergency contraception by individuals, organizations, groups or government.
2. Urges hospitals, hospital associations and health systems to adopt as the standard of care the requirement that emergency contraception be offered to any individual legally requesting a prescription, including, but not limited to victims of sexual assault.
3. Urges that prescriptions for contraception and emergency contraception are authorized and filled, and that timely access to these are not denied to individuals seeking to legally obtain them, by healthcare practitioners or pharmacists based on moral or ethical reasons.
4. Supports efforts to encourage pharmacies across Minnesota to stock emergency contraception in order to make it available when needed.
5. Supports state and national efforts to make Plan B emergency contraception available over-the-counter as recommended by the FDA's Non-prescription Drugs and Reproductive Health Drugs Advisory Committee.
6. Supports widespread public awareness campaigns and social marketing efforts to increase awareness about emergency contraception.
7. Supports widespread education of nurses, doctors, pharmacists, health educators and other health professionals working with adolescents and adult women on emergency contraception as a form of contraception, doing this via continuing education offerings and through pre-licensure education programs.
8. Encourages the implementation of collaborative agreements between pharmacists and health care practitioners who may prescribe drugs, as outlined in Minnesota Statute 151.01, Subdivision 27 (6), in order to improve access to emergency contraception.

**References**

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<sup>1</sup> Henshaw SK. Unintended pregnancy in the United States. *Family Planning Perspectives*. 1998; 30: 24-29.

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- <sup>2</sup> MDH. Healthy Minnesotans – Public Health Improvement Goals 2004.
- <sup>3</sup> Raine TR, Harper CC, Rocca CH, Fischer R, Padian N, Klausner JD, Darney PD. Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs: a randomized controlled trial. *JAMA*. 2005;293:54-62.
- <sup>4</sup> Jackson RA, Schwarz EB, Freedman L, Darney P. Advance supply of emergency contraception: effect on use and usual contraception—a randomized trial. *Obstetrics & Gynecology*. 2003;102:8-16.
- <sup>5</sup> Raymond EG, Chen P-L, Dalebout SM. “Actual use” study of emergency contraceptive pills provided in a simulated over-the-counter manner. *Obstetrics & Gynecology*. 2003;102:17-23.
- <sup>6</sup> Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, National Academy Press: Washington, D.C. 1995
- <sup>7</sup> Hellerstedt WL, Pirie PL, Lando HA, Curry SJ, McBride CM, Grothaus LC, Nelson JC. Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *American Journal of Public Health*. 1998;88:663-6.
- <sup>8</sup> D’Angelo DV, Gilbert BC, Rochat RW, Santelli JS, Herold JM. Differences between mistimed and unwanted pregnancies among women who have live births. *Perspectives in Sexual and Reproductive Health*. 2004;36:192-7.
- <sup>9</sup> Stewart F, Trussell J, Van Look PFA. Emergency contraception. IN: Hatcher RA, Trussell J, Stewart F, Nelson AL, Cates Jr W, Guest F, Kowal D (eds). *Contraceptive Technology*. New York: Ardent Media, Inc. 2004.
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- <sup>11</sup> Rodrigues, I et al., *Effectiveness of Emergency Contraceptive Pills Between 72 and 120 Hours After Unprotected Intercourse*, American Journal of Obstetrics and Gynecology, 2002.
- <sup>12</sup> Stewart, F. & Trussell, J. Prevention of pregnancy resulting from rape. *American Journal of Preventive Medicine*. 2000; 19: 228-229.
- <sup>13</sup> *Emergency Contraception: The Need to Increase Awareness* Guttmacher Report, Volume 5, #4, October 2002.
- <sup>14</sup> Kaiser Family Foundation, *2001 National Survey of Women’s Health Care Providers on Reproductive Health*.
- <sup>15</sup> Minnesota Pharmacy Practice Act, Chapter 151 – Pharmacy
- <sup>16</sup> NARAL Pharmacy Survey: Availability of ECPs by area code, Minnesota, 2005.
- <sup>17</sup> The Guttmacher Report on Public Policy, *Advocates Question Plan B Age Restriction After FDA Again Delays Decision*, November 2005.
- <sup>18</sup> American College of Nurse Midwives Policy Statement, “*Emergency Contraception: Expanding Access and Education.*”
- <sup>19</sup> American Academy of Pediatrics Policy Statement, PEDIATRICS Vol. 116 No. 4 October 2005, pp. 1026-1035 (doi:10.1542/peds.2005-1877)
- <sup>20</sup> APHA Policy Statement #2003-16, “Providing Access to Emergency Contraception for Survivors of Sexual Assault.”
- <sup>21</sup> APHA Policy Statement #2003-15, “Support of Public Education about Emergency Contraception and Reduction or Elimination of Barriers to Access.”