

WHO recommendations on self-care interventions

Making over-the-counter emergency contraceptive pills available without a prescription



What is self care?

WHO's definition of self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health worker.

What are self-care interventions?

Self-care interventions are tools that support self-care. These include evidence-based, quality medicines, devices, diagnostics and/or digital products that can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health workers (1).

WHO guideline on self-care interventions for health and well-being (1)

- There will be an estimated shortage of 10 million health workers by 2030, mainly in low- and middle-income countries (LMICs) (2).

- In 2021, about four and a half billion people were not fully covered by essential health services (3).
- During humanitarian emergencies, including pandemics, routine health services are disrupted and existing health systems can be overstretched.

For certain health services, incorporating self-care interventions can be an innovative strategy to strengthen primary health care, improve universal health coverage (UHC) and help ensure continuity of health services which may otherwise be disrupted due to health emergencies.



In 2022, WHO revised the global normative guidance on self-care interventions for health and well-being, with each recommendation based on extensive consultations and a review of existing evidence (1).

Family planning/contraception

- Family planning/contraception is a life-saving intervention with well recognized health, social and economic benefits.
- Access to family planning/contraception reinforces people's rights to determine the number and spacing of their children.
- Hormonal and non-hormonal modern contraception methods include male and female condoms, injectables, pills (including emergency contraceptive pills), vaginal rings, diaphragms, implants, intrauterine devices and permanent methods (tubal ligation, vasectomy).

Emergency contraceptive pills (4)

Emergency contraception (EC) refers to methods of contraception that can be used to prevent pregnancy after sexual intercourse. These are recommended for use within 5 days of unprotected sex but are more effective the sooner they are used after the act of intercourse. Emergency contraceptive pills (ECPs) prevent pregnancy by delaying or preventing ovulation. They do not induce an abortion if the woman is already pregnant.

Learn more:

These formulations of emergency contraception are included in the:

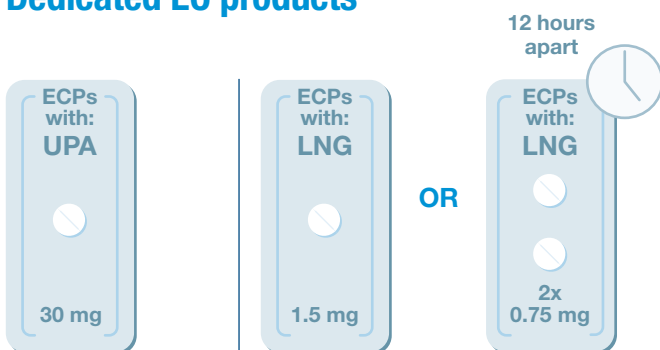
- [WHO essential medicines list \(5\)](#).
- [Family planning: a global handbook for providers \(6\)](#).

Safety: All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman (6).

Effectiveness: The effectiveness of each ECP varies according to individual circumstances, including the type of ECP chosen, the day of the menstrual cycle, and the length of time between unprotected intercourse and initiation of ECPs. The effectiveness of ECPs may be reduced with additional acts of unprotected intercourse in the same cycle, use of other medications (e.g. enzyme inducers), and higher body weight or body mass index (BMI) (7). ECPs with ulipristal acetate (UPA) and levonorgestrel (LNG) are more effective than using COCs or POPs for EC (6). ECPs with UPA are more effective between 72 and 120 hours after unprotected intercourse than other ECPs (4).

WHO recommends any of the following drugs for EC:

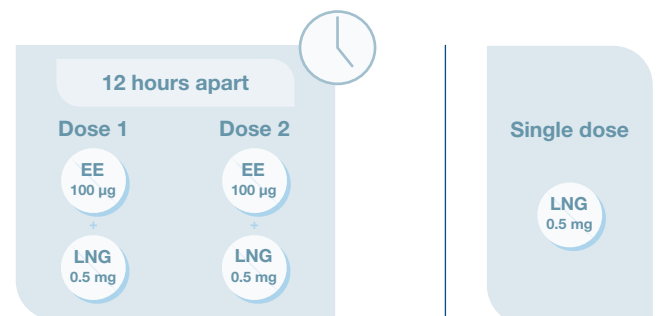
Dedicated EC products



ECPs with UPA, taken as a single dose of 30 mg.

ECPs with LNG, taken as a single dose of 1.5 mg, or taken in 2 doses of 0.75 mg each, 12 hours apart.

Oral contraceptive pills used for EC

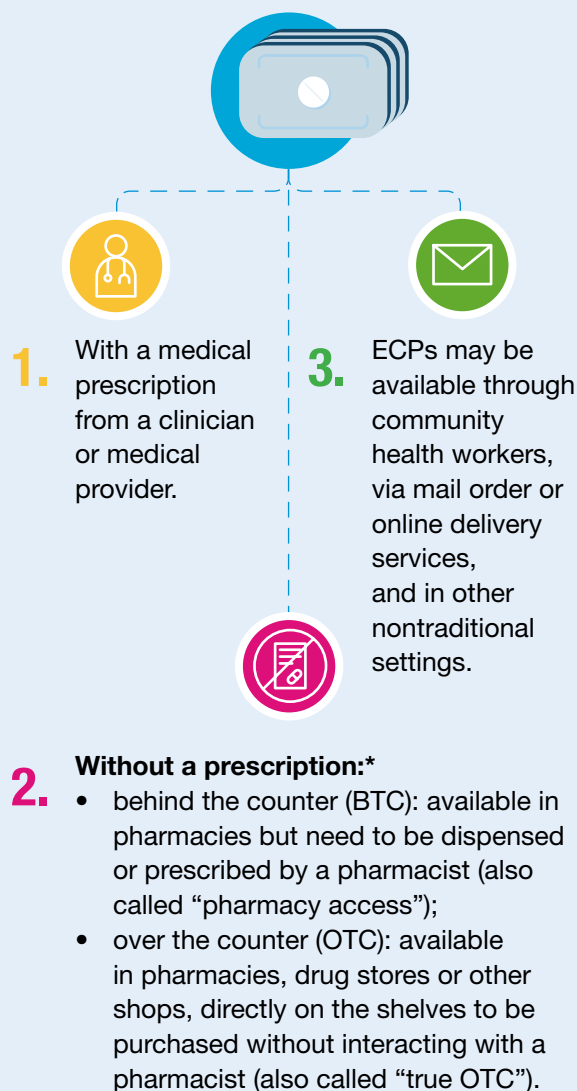


Combined oral contraceptives (COCs), taken as a split dose: one dose of 100 µg of ethinyl estradiol (EE) plus 0.50 mg of LNG, followed by a second dose of 100 µg of ethinyl estradiol plus 0.50 mg of LNG 12 hours later (Yuzpe method).

Progestin-only pills (POPs) can also be used for EC, taken as one dose of 1.5 mg of LNG or norgestrel.

How women access ECPs

ECPs are available through three main modalities.



* In this document, “over-the-counter (OTC)” refers to dispensing without prescription (i.e. both OTC and BTC as defined above), unless specified. ECPs containing LNG are registered and/or available in at least 146 countries; ECPs containing UPA are registered and/or available in at least 75 countries. Women can access LNG ECPs without a prescription, as recommended by WHO, in at least 85 countries, and UPA ECPs in at least 56. COCs and POPs are available globally. Source: ECEC, 2023 (8).

Current challenges to health systems providing family planning/contraception services

- 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method [9].
- Reasons for not using contraception include: limited choice of methods; fear or experience of side-effects; cultural or religious opposition; poor quality of available services; user and health worker bias; gender-based barriers.
- In many countries, the numbers of trained health workers are not sufficient to address the need for contraception.
- Where contraceptive services are available, certain population groups – including young people, poorer segments of the population, sexually active unmarried individuals, and people in rural settings – may face challenges when they seek to access contraception.

Special considerations for ECPs

- ECPs can be especially important for women in vulnerable or marginalized situations – those who have experienced forced or unwanted sex, or women who may not be able to access clinic-based family planning services easily (due to youth, displacement or other factors). These factors make self-care particularly important.
- Unlike other family planning methods, ECPs must be used as soon as possible and within a short period of time after unprotected sex to effectively prevent pregnancy. Self-care – the ability to obtain and use the method without the support of a health worker – can save time and also foster readiness because ECPs can be procured in advance of need.

Recommendation

WHO strongly recommends making over-the-counter emergency contraceptive pills available without a prescription to individuals who wish to use emergency contraception (1).

This recommendation is based on the systematic review of the literature relevant to the question “Should ECPs be made available without a clinician’s prescription?” conducted by WHO in 2021 (10).

What dispensing modalities are recommended? (1,10)

Evidence about women's and health workers' opinions about the provision of ECPs without a prescription is limited. A systematic review found that most women value the privacy and control offered by OTC access, but that some are concerned about having limited interaction with health workers in true OTC delivery. While there is widespread support for prescription-free EC, a proportion of women have a preference for behind-the-counter modalities that allow for interaction with a health worker. In general, health workers are less supportive of OTC access and are generally concerned that education or counselling opportunities will be missed in OTC access. This includes counselling about how to use ECPs correctly, and routine sexual and reproductive health (SRH) services (use of other contraceptives, and screening for cervical and breast cancers and sexually transmitted infections [STIs]).

Blended delivery modalities, in which users can choose where and how to access ECPs, may be most responsive to a range of user preferences.

Implications of over-the-counter availability of ECPs – what the evidence tells us

Information and correct use: The limited evidence suggests that women who obtain ECPs without prescription have adequate information to take it correctly. Future research should investigate this further, to assess whether correct knowledge of EC translates to correct use in OTC modalities. Research in LMICs is also needed.

Impact on abortion rates: While studies have not found that pharmacy access to ECPs has an effect on lowering abortion rates overall, two studies found that such access lowered abortion rates specifically for younger women (19 and younger) (10).

Resources and costs: The ability to access ECPs without a prescription is likely to save money, but it is also possible that OTC products will no longer be covered by health insurance or other schemes. The evidence suggests that providing ECPs OTC may

be cost saving for the health sector (for both private insurance and public payers). Data on the cost impacts for patients and families is limited, but it is likely that this intervention may be cost saving for end users too (as they will not have to pay to see a doctor, travel to a clinic, or take time off work for a clinic appointment and lose wages) while introducing no negative sexual and reproductive health and rights (SRHR) outcomes. Government subsidies should be retained when distribution is transferred to an OTC approach.

Feasibility: An increasing number of countries already offer ECPs without a prescription, indicating that this intervention is feasible.

Equity: OTC availability of ECPs removes the need to see a health worker and/or to get third-party permission (from a parent, partner or spouse) in many countries. Thus, it is likely to increase access, reduce discrimination and support human rights, especially among adolescent girls and young women, and among individuals of diverse sexual orientation and gender identity and expression. In particular, given the unique barriers faced by younger women accessing prescription-only ECPs in many settings, increased access to OTC ECPs may be particularly beneficial for younger women.

Acceptability: Support for OTC ECPs among end users varies within and across countries. Overall, end users support OTC access to ECPs because it offers improved access/availability; convenience; more-flexible hours; confidentiality, privacy and anonymity; reduced cost; greater control for women; and less opportunity for judgement from a health worker. End users who do not support OTC ECPs are concerned about a lack of privacy, increased cost, and lack of personal contact with a health worker for support and information.

Health workers are concerned about potential increase in risky behaviour, misuse and repeated use of ECPs, and communication, and think that OTC delivery might preclude delivery of education and counselling. Some health workers have expressed religious or moral concerns about OTC delivery; these concerns were more common among health workers who believed ECPs were a form of abortion (10).



Limitations

ECPs have been available without a prescription in numerous countries for over two decades. Yet there is little published research about the implications of such availability globally, and almost none in LMICs. More research is needed about women's knowledge about ECPs in different settings, their ability to use it correctly, and their needs for information. Questions also remain about the use of ECPs in both pandemic and humanitarian settings.

Learn more:

- WHO self-care guideline (1)
- WHO emergency contraception fact sheet (4)
- Family planning handbook, Chapter 3 (6)
- Training Resource Package for Family Planning module on emergency contraception for pharmacists (11)
- European Consortium for Emergency Contraception Wheel (12)

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