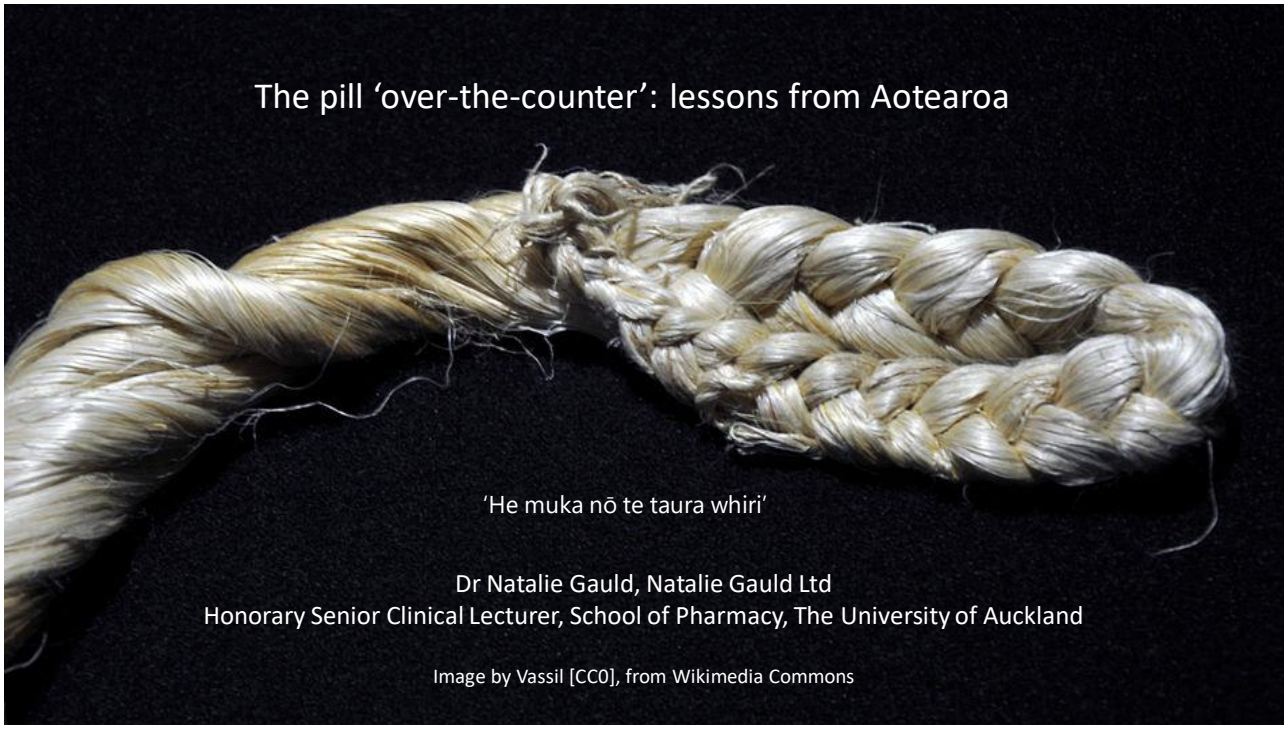
The pill 'over-the-counter': lessons from Aotearoa



'He muka nō te taura whiri'

Dr Natalie Gauld, Natalie Gauld Ltd
Honorary Senior Clinical Lecturer, School of Pharmacy, The University of Auckland

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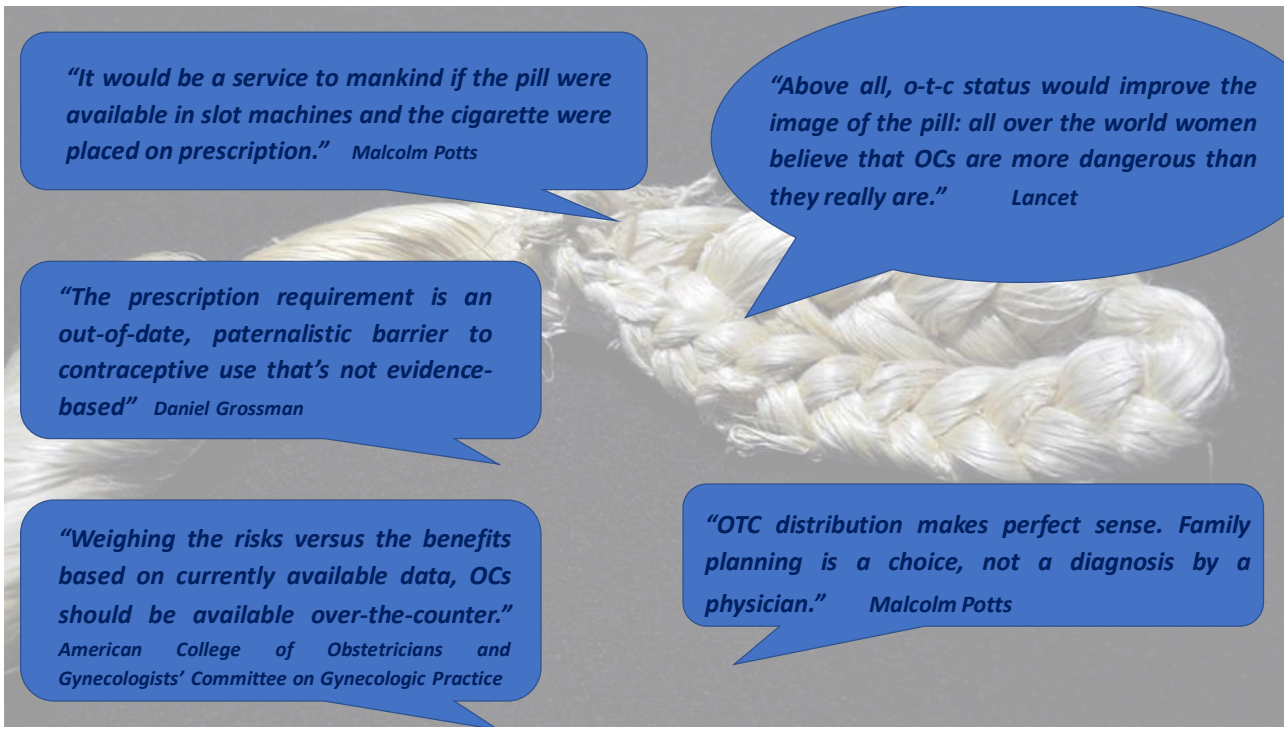
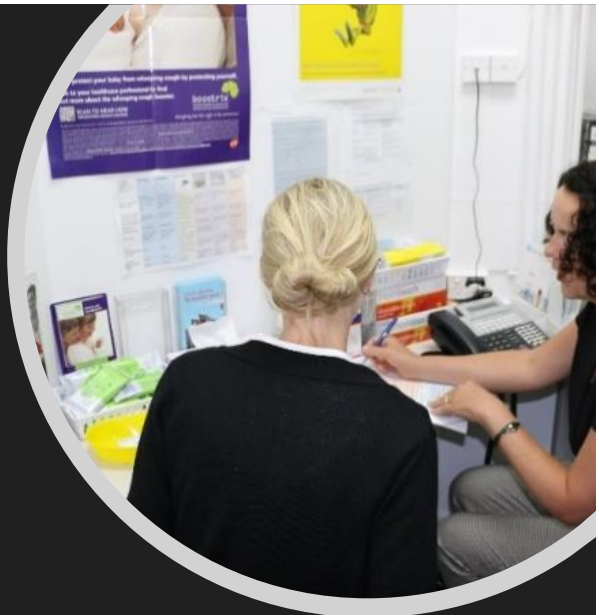


NZ environment

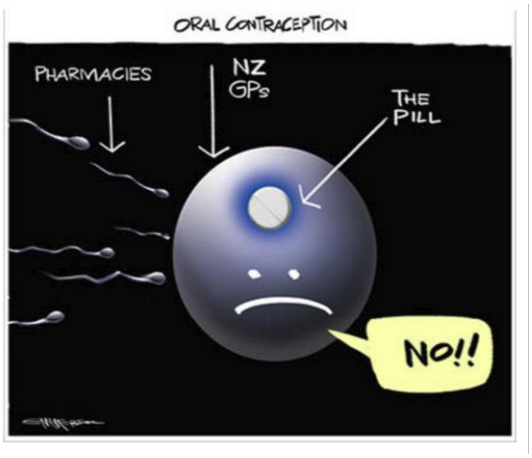
- Emergency contraceptive reclassified 2001
- Reclassifications of oseltamivir (Tamiflu®), sumatriptan, trimethoprim for cystitis, vaccines
- Positive research results
- Teen pregnancies ≥50% higher than Australia, especially in Māori (with contraceptive use gaps) and Pasifika



UN. Adolescent fertility rates. World Bank Group, 2016. Hohmann-Marriott BE. Aust N Z J Obstet Gynaecol 2018;58(2):247-50. Clark T, et al. NZ Med J 2006;119(1228). Adolescent Health Research Group. Sexual and reproductive health and sexual violence among New Zealand secondary school students. The University of Auckland, 2016.

It wasn't fast

- First application 2014
- Approval: February 2017
- Available in pharmacies from November 2017



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How did women in NZ get widened access to oral contraceptives through pharmacy?

Repeated applications to reclassify from Green Cross Health and Natalie Gauld Ltd

Input from experts including Assoc Prof Helen Roberts; pharmacists; general practitioners; women

Supportive submissions from RANZCOG

Consultation with medical and pharmacy organisations

Supportive submissions included: ALRANZ, Dame Margaret Sparrow, University of Auckland pharmacy students, pharmacy organisations, University pharmacy academics

Evidence from overseas models, NZ reclassifications, and a careful model

The model

POPs – desogestrel, levonorgestrel, norethisterone

COCs – ethinyloestradiol ≤ 35 µg with levonorgestrel or norethisterone

Woman must have seen a doctor in the last 3 years for the same contraceptive

Training through the Pharmaceutical Society of NZ

Screening tools - questions and advice

Inform the GP unless patient opts out

Documentation kept

Information sheet for women

Full recheck annually or new pharmacy

Australian comparison

- Continued supply since 2013
- Immediate need and if prescriber is unavailable only
- Restrictions, eg supplied in last 6 months
- All oral contraceptives
- Not initiation
- No changes
- Pharmacist but no additional training
- No screening tool/patient information specific to pharmacist-supply
- Single full pack
- PBS benefit

Pros for NZ model

- Opens access for many
- Women want it
- Not self-selection, not pharmacy assistants, only pharmacists with additional training
- Helps maximise risk-benefit

Cons for NZ model

- No initiation
- Not funded – inequities
- Usually can't change o/c
- Some o/cs excluded
- Not LARCs
- Consultation cost is typical
- New graduates can't do it

Research needed

- Is this the best model?
- Does it increase access?
- Does it increase inequities?
- Is it working for Māori and Pasifika?
- How safe is pharmacist-supply versus doctor-supply?
- Do women like it?
- Do women still see the GP enough?
- Is micro-credentialing necessary?
- Does it help the health system?
- What improvements are needed? Funding, wider access?
- How about LARCs?

Kia Ora
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