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29 September 2015

The Secretary
Medicines Classification Committee
Ministry of Health
committees@moh.govt.nz

Dear Andrea Kerridge

Re: Agenda 54th Meeting Medicines Classification Committee

5.1.1 Oral Contraceptives – proposed reclassification from prescription medicine to restricted medicine

I write to support the application of Green Cross Health and the Pharmacy Guild of New Zealand for the reclassification of selected oral contraceptives (ethinylestradiol with norethisterone, ethinylestradiol with levonorgestrel, norethisterone, levonorgestrel and desogestrel) from prescription medicine to restricted medicine when supplied for oral contraception by a registered pharmacist who has successfully completed a training course in accordance with an approved protocol.

I am a retired sexual health physician and this is a personal submission. I remain an active member of RANZCOG (Honorary Fellowship), RACP (Australasian Chapter of Sexual Health Medicine), New Zealand Family Planning (Honorary Vice President and Life Member) and ALRANZ (Past President).

My experience includes 12 years as a Student Health doctor, 34 years as a Family Planning doctor and 17 years as an abortion operating doctor when I took a particular interest in the reasons for contraceptive failure. In 2002 I was involved in the training of pharmacists in Wellington and Palmerston North for the supply of emergency contraception. I have attended a number of conferences where the benefits and risks of over the counter supply of contraceptives have been discussed, most recently in Edinburgh in October 2012 when the results of the London (Southwark and Lambeth) programme were presented. (Reference: Parsons J. et al. Evaluation of a community pharmacy delivered oral contraception service. *Journal of Family Planning & Reproductive Health Care* 2013; 39: 97-101.)

My considered opinion is that the benefits outweigh the risks.

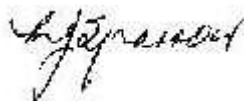
To address some of the concerns raised at the previous meeting:

- (1) The high number of unintended pregnancies indicates a need for improved access to all methods of contraception, including oral contraception.
- (2) The amount of pharmacist time can be managed, as demonstrated by the successful introduction of emergency contraception in 2002.
- (3) The fact that not all pharmacies would be resourced to provide such a service is not a reason to stop those who can.
- (4) Fragmentation of records, while not to be disregarded, is less important than the risks associated with unintended pregnancies.
- (5) The fact that poor and young women may not have a general practitioner is no reason to deny them access to a very safe medicine at a critical time in their lives.
- (6) Prescribing by nurses is an excellent idea but some women will prefer to obtain supplies from a pharmacy.
- (7) Collaboration between doctors and pharmacists, with the consent of the patient, is to be encouraged. This should include pharmacists initiating a prescription for first time users, according to agreed protocols, as well as providing repeat prescriptions. Attending a pharmacy for emergency contraception may well be an opportune time to initiate oral contraception.
- (8) In my opinion greater consideration must be given to the views of women, their unmet needs and their preferences. These are just as important as the views of primary healthcare practitioners.
- (9) The support from RANZCOG, a major medical representative body, is significant although in my opinion prescription need not be confined to repeat prescriptions. I believe it would be safe to recommend a 3-month prescription for initial supply and a 6-month prescription for repeats.

The prevention of unintended pregnancies is an important goal with economic and public health benefits. This moderate proposal from the applicants is not the only answer to the problem of unintended pregnancies but it is a step in the right direction.

I attach separately the MCC Public Consultation Cover Sheet.

Yours sincerely



Dame Margaret Sparrow DNZM MBE