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EMERGENCY CONTRACEPTION

A GUIDE FOR SERVICE DELIVERY

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INTRODUCTION

Emergency contraception (EC) refers to contraceptive methods that can be used by women in the first few days following unprotected intercourse to prevent an unwanted pregnancy. Emergency contraceptive methods are effective and safe for the majority of women who may need them, as well as being simple to use.

The available methods for emergency contraception are: increased doses of combined oral contraceptives (COCs) containing ethinylestradiol and levonorgestrel; high doses of progestogen-only pills containing levonorgestrel; and copper-releasing intrauterine devices (IUDs).

The role of emergency contraception in family planning

The need for emergency contraception is clearly demonstrated by the occurrence of unwanted pregnancies and induced abortion, and by high rates of unwanted pregnancy among adolescents in many places. Often it is the inadequacy of family planning services, in terms of availability and/or quality, that has contributed to this need.

The introduction of emergency contraception into family planning programmes and its distribution through clinic and non-clinic channels — along with appropriate advocacy and information/education/communication (IEC) activities — are now being recommended by a number of agencies and organizations in order to prevent unwanted pregnancies and their consequences for women and couples.¹

Preventing unwanted pregnancies and unsafe abortion

In spite of the effectiveness of modern contraceptives, unwanted pregnancies occur in large numbers throughout the world and many women seek termination. It is estimated that 40 to 60 million abortions are performed each year; approximately 20 million of them are carried out in unsafe conditions. This is a reflection of the unmet need for family planning (WHO, 1994).

If emergency contraceptives were easily available, millions of unwanted pregnancies and abortions could be averted. This fact has been demonstrated in European countries where emergency contraceptive pills have been available for many years. For instance, in the Netherlands, which

¹ Consensus Statement on Emergency Contraception. 1995; IMAP/IPPF Statement. 1995. Consortium for Emergency Contraception. 1996.

has the lowest abortion rate of any industrialized country, emergency contraception is widely available as a back-up for other family planning methods.

Any woman of reproductive age is potentially at risk of an unwanted pregnancy, and there are no "typical" profiles of women who have abortions, in terms of age, parity, socio-economic or educational level, type of relationship, or knowledge about contraceptives. Frequently, women who report having had an induced abortion are married or in stable partnerships and have children already, but their socio-economic situation is such that it would be difficult for them to support another child. Single women may seek abortion for fear of social ostracism if they carry a pregnancy to term. The social consequences of an unwanted pregnancy can be especially dramatic for adolescents from the disadvantaged sectors of society and are common reasons for abortion. Limited access to modern contraceptives and the failure or incorrect use of contraceptives play an important role in this picture.

Preventing unwanted pregnancies among adolescents

Many unwanted pregnancies occur during adolescence, when young women and their partners become sexually active before they are fully aware of the need for contraception or have had access to appropriate services. Emergency contraception can be useful in these circumstances.

An unwanted pregnancy has psychosocial and health consequences for the adolescent mother and her newborn baby. How serious these consequences are depends largely on the degree of support provided by the young woman's partner, family, health services and society in general.

Socio-economic and cultural factors influence the age at which young women have their first sexual intercourse and whether or not they are likely to practice contraception. Thus, the frequency with which adolescent pregnancy occurs varies across countries and socio-economic levels. Fertility rates range from 54 to 153 per 1000 women aged 15-19 years in Latin American countries, and from 23 to 236 per 1000 in African countries, with Central Africa being the region with the highest proportion of pregnant adolescents (the mean rate is 207 per 1000 women). By contrast, the fertility rate in developed countries is around 30 per 1000 women aged 15-19 years, with the lowest rates — below 20 per 1000 teenage women — found in parts of Europe and Eastern Asia. As a general rule, rates tend to be highest among the poor and among less educated women — precisely those who are least equipped to cope with the negative consequences of teenage pregnancy. (United Nations, 1995; Paxman J et al., 1993).

The idea of adolescent sexuality is not easily accepted by the family, the school or society at large. For this reason, adolescents in many countries are denied education on sex or family life, or else the education they are given is inadequate and fails to take account of their real needs. Furthermore, adolescents seldom have proper access to reproductive health care and contraceptive services.

Adolescent sexuality is typically characterised by difficulties in negotiating behaviour with partners, by unstable relationships, conflicting emotions, secretiveness, sometimes rebellion, and often by unprotected intercourse — especially in the early days of sexual activity. Adolescent women who get pregnant may sometimes perceive motherhood as the route to recognition as adults or even as a pathway to the desired status of marriage.

Emergency contraception is useful in preventing unwanted pregnancies in adolescents, and there is no evidence that knowledge of this method of contraception has the effect of encouraging sexual activity among young people. On the other hand, the need for emergency contraception may be the stimulus that brings adolescents into contact with health care personnel, thus providing opportunities for counselling on responsible sexual behaviour, contraception, and the prevention of sexually transmitted diseases (STDs), including HIV/AIDS.

Emergency contraception in a reproductive health context

The International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995 emphasized the importance of responding to women's needs for reproductive health and family planning.

If their reproductive rights are to be honoured, individuals and couples must have access to the information and services they require for healthy, responsible and satisfying sex lives, free from coercion; this includes the freedom to decide for themselves how many children they want to have and when to have them. The concept of reproductive rights should be promoted and the means to fulfil them should be available and accessible.

However, much remains to be done if reproductive health is to become a reality for millions of women and men around the world, especially in developing countries. At present, unwanted pregnancy is an extremely

common event. Lack of knowledge about fertility and the means to regulate it, lack of power to make decisions about one's sexual and reproductive life, lack of access to contraception, and the poor quality of available family planning services are just some of the many reasons behind the statistics. Tackling these problems requires important changes in the education and empowerment of women and in the reproductive health care provided by society (ICPD, 1994). Reproductive health and family planning services that give access to all potential clients regardless of age and marital status can play a major role in this regard.

Emergency contraception also has an important part to play in helping women achieve their reproductive intentions by avoiding unwanted pregnancies. The provision of these methods through official family planning programmes and/or through alternative services, where this is not already the case, should be considered as part of the long-term strategy to improve reproductive health care.

By offering emergency contraception information and care, various service outlets can serve as a first contact point where sexually active women, men and youngsters can receive other reproductive health services and counselling and/or referral information.

Emergency contraception can thus play an important role in linking individuals and couples to ongoing reproductive health/family planning care.



Photo: UNFPA photo by Marie Dorigny

Photo: UNEFA photo by Marie Dorigny



GENERAL ASPECTS

History

For centuries, women have used a variety of devices and preparations to prevent pregnancy after intercourse has taken place. The first human clinical trials of hormonal emergency contraceptives were conducted in the 1960s, using high doses of estrogen. The use of increased doses of combined oral contraceptives (COCs) containing ethinylestradiol and levonorgestrel (known as the Yuzpe method) was initiated in the 1970s. The first trials of an emergency contraceptive using levonorgestrel were conducted around the same time; and the postcoital insertion of an IUD for emergency contraception was first reported in 1976. Other approaches, based on mifepristone and danazol for example, are currently under study.

To date, most of the women who have used emergency contraception are from developed countries, especially in Europe where specially packaged products have been available for several years. However, the practice is now spreading to developing countries as a result of large WHO studies and the interest of many family planning programmes in finding ways to prevent unwanted pregnancy.

Interest in emergency contraception has grown considerably in the past few years. In April 1995, experts from around the world met in Bellagio, Italy, and produced a Consensus Statement on Emergency Contraception, calling on providers to learn about the methods and to make them available to all women who may need them. Later in 1995, seven organizations² involved in women's reproductive health joined to form the Consortium for Emergency Contraception with the aim of promoting access to the method worldwide. The Consortium has prepared a resource pack containing information about emergency contraceptive pills and guidelines for their correct use, as well as material to assist programme managers wishing to

² Concept Foundation, International Planned Parenthood Federation, Pacific Institute for Women's Health, the Program for Appropriate Technology in Health (PATH), Pathfinder International, The Population Council, and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

introduce emergency contraception into the range of services on offer to clients. In December 1995, emergency contraceptive pills (Yuzpe method) were added to the WHO model list of essential drugs, making them much more readily available in countries.

Who may need emergency contraception?

Any woman of reproductive age may need emergency contraception at some point to avoid an unwanted pregnancy, following situations such as:

- after voluntary sexual intercourse that took place with no contraceptive protection;
- after incorrect or inconsistent use of regular contraceptive methods or when there has been an accidental failure of other contraceptive methods such as:
 - condom breakage or slippage;
 - miscalculation of the infertile period when using periodic abstinence or failure to abstain from sexual intercourse during the fertile days;
 - expulsion of an IUD;
 - failed coitus interruptus, when ejaculation has occurred in the vagina or on the external genitalia;
 - failure to take oral contraceptives for more than 3 days in a row;
 - being late for a contraceptive injection;
- when a woman has been a victim of sexual assault and has had no contraceptive protection.

The most common reasons for requesting emergency contraception in selected studies are shown in Table 1 (Van Look P, et al.; in press). Although women requesting emergency contraception come from all age groups and life circumstances, a number of studies have shown that young women (under 25 years old), who are single and nulliparous, are in the majority. It is these women who tend to be at highest risk of unprotected intercourse and unwanted pregnancy.

Table 1
REASONS FOR REQUESTING EMERGENCY CONTRACEPTION:
SELECTED STUDIES

REFERENCE	REASON		
	No Contraception	Barrier Method Failure	Other*
Tully, 1983	52%	34%	14%
Hoffman, 1983	46%	43%	11%
Bagshaw <i>et al.</i> , 1988	57%	32%	11%
Kane <i>et al.</i> , 1989	67%	25%	8%
Roberts <i>et al.</i> , 1995	45%	48%	7%

* Failed coitus interruptus, rape, forgotten pill(s), vomiting of pills, etc.

Methods of emergency contraception

The most common methods of emergency contraception are:

- Increased doses of combined oral contraceptives (COCs) containing ethinylestradiol and levonorgestrel (Yuzpe method).
- High doses of progestogen-only pills containing levonorgestrel.
- Copper-releasing IUDs.

Pills have to be started within 72 hours of unprotected intercourse while IUDs can be inserted up to 5 days following such an event. Potential clients need to be aware of the existence of these methods and the time frame within which they can be used. Dissemination of information is therefore a key element of emergency contraception services.

Although there are pills specially packed for emergency use, most brands of oral contraceptive pills for regular use can also be used for emergency purposes. This means that the methods of emergency contraception are already available at low cost in family planning programmes all over the world, and can also be obtained over the counter in some countries. The use of an IUD requires clinic facilities and skilled personnel to screen clients and insert the device. These are limiting factors in the use of IUDs for emergency contraception, but many family planning clinics already have suitably trained providers. Despite the fact that the methods are on hand, however, oral contraceptives and IUDs are seldom used for emergency purposes, and these methods are still not offered as specific options in the large majority of family planning programmes.

Emergency contraception differs in many respects from regular contraception. Providers need to have clear guidelines on how and when to offer emergency contraceptives and they must give clear instructions to clients in order to avoid incorrect use or confusion. Confusion is a real possibility since both pills and IUDs are used for regular as well as emergency contraception, albeit in very different ways. For example, when regular pills are used for emergency contraception the doses are higher. And in the case of IUDs, many providers are used to inserting the device only while the client is menstruating, but when the method is used for emergency contraception it will need to be inserted at other times in the cycle. When emergency contraception is being introduced into a family planning programme these issues need to be taken into account, as well as the sociocultural context in which the service will be delivered.

Efficacy

Efficacy of a regular contraceptive method is usually expressed as a rate per hundred women exposed over a given period of time, generally 12 months of regular use. This way of presenting efficacy is not useful for emergency contraceptives since they are methods meant for single use during one menstrual cycle. If emergency contraceptive pills were to be used frequently, the failure rate during a full year of use would be higher than that of regular hormonal contraceptives. Therefore ECPs are inappropriate for regular use.

One way of expressing the efficacy of emergency contraception is to calculate the treatment failure rate, i.e. the number of women out of a hundred who get pregnant in spite of using an emergency contraceptive method. The failure rate of emergency contraceptive pills ranges from 1 to 3 per hundred, and the failure rate of copper IUDs is below 1 per hundred.

However, only a minority of women would be expected to become pregnant after a single act of unprotected intercourse. For this reason, it has been suggested that the efficacy of emergency contraception be expressed as the proportion of pregnancies that would be avoided if the method is used. It has been calculated that emergency contraceptive pills prevent around 75% (Trussell J et al., 1996) and copper IUDs more than 98% (Trussell J et al., 1995) of the pregnancies that would occur if no emergency contraception were used.

Photo: UNFPA - photo by Marie Dorigny



Photo: UNFPA photo by Viviane Moos



EMERGENCY CONTRACEPTIVE PILLS

Definition

Emergency Contraceptive Pills (ECPs) are hormonal methods that can be used to prevent pregnancy following unprotected sexual intercourse.

They are sometimes referred to as “morning-after” or “postcoital” pills. These terms do not convey the correct timing of use since emergency contraceptive pills can be used up to three days after unprotected intercourse. In addition, the terms do not convey the important message that emergency contraceptive pills should not be used regularly because they are intended for “emergency” use only. The term Emergency Contraceptive Pills is the correct way of referring to this contraceptive method.

Emergency contraceptive pill regimens

Two emergency contraceptive pill regimens can be used:

1. The standard regimen consists of the “combined” oral pills containing ethinylestradiol and levonorgestrel (or dl-norgestrel³). This regimen is known as the “Yuzpe method” and has been studied and widely used since the mid 1970s.

When pills specially packed for emergency contraception are available or when high-dose pills containing 50 µg of ethinylestradiol and 250 µg levonorgestrel (or 500 µg dl-norgestrel) are available:

- two pills should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse. These should be followed by two other pills 12 hours later.

When only low-dose pills containing 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg dl-norgestrel) are available:

- four pills should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse. These should be followed by another four pills 12 hours later.

³ Because dl-norgestrel contains half the amount of active ingredient as levonorgestrel, a comparable formulation contains twice as much dl-norgestrel than levonorgestrel.

2. Emerging data indicate that an alternative hormonal regimen consisting of levonorgestrel-only pills is equally effective as the Yuzpe regimen but has a significantly lower incidence of side-effects. When pills containing 750 µg(0.75mg) levonorgestrel are available:

- one pill should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse. This should be followed by another pill 12 hours later.

When only mini-pills containing 30 µg levonorgestrel are available:

- twenty five pills should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse. These should be followed by a second dose of twenty five other pills 12 hours later.

When only mini-pills containing 75 µg dl- norgestrel are available:

- twenty pills should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse. These should be followed by a second dose of twenty pills 12 hours later.

For all regimens treatment should not be delayed unnecessarily as the method may become less effective over time.

Mode of action

The mechanism of action of emergency contraceptive pills has not been clearly established. Several studies have shown that emergency contraceptive pills can inhibit or delay ovulation. It has also been suggested that emergency contraceptive pills may prevent implantation by altering the endometrium. However, the evidence for endometrial effects is mixed and whether the endometrial changes that were observed in some studies would be sufficient to prevent implantation is not known. Emergency contraceptive pills also may prevent fertilization or transport of sperm or ova, but no data exist regarding these possible mechanisms. Emergency contraceptive pills do not interrupt pregnancy and thus are no form of abortion.

Efficacy

After a single act of unprotected sexual intercourse, the Yuzpe regimen fails in about 2 percent of women who use it correctly (the chances of

pregnancy are approximately four times greater when the regimen is not used) (Trussell J et al., 1996). The progestogen-only regimen is equally effective (WHO, 1998).

Overall, emergency contraceptive pills are less effective than regular contraceptive methods. Because the ECP pregnancy rate is based on a one-time use, it cannot be directly compared to failure rates of regular contraceptives, which represent the risk of failure during prolonged periods of use in women having regular intercourse. If emergency contraceptive pills were to be used frequently, the failure rate during a full year of use would be higher than that of regular hormonal contraceptives. This is just one reason why emergency contraceptive pills are inappropriate for regular use.

Side-effects and their management

- Nausea: Occurs in about 50 per cent of clients using the combined emergency contraceptive pill regimen but it does not usually last more than 24 hours. Nausea occurs in approximately 20 per cent of women using progestogen-only emergency contraceptive pills.

Management: Taking the pills with food or at bedtime may help reduce nausea. Prophylactic administration of an anti-emetic has been shown to reduce nausea in some women. However, because it is impossible to predict which women will benefit from prophylactic anti-emetic use and because it is costly to administer, routine prophylactic use is not recommended in settings where resources are limited. It may, however, be appropriate to give prophylactic anti-emetics to women who have previously experienced nausea while using hormonal methods of contraception including emergency contraceptive pills. Anti-emetics administered after the onset of nausea are not likely to have any effect.

- Vomiting: Occurs in about 20 per cent of women using the combined emergency contraceptive pill regimen, and in about 5 per cent of those using progestogen-only emergency contraceptive pills.

Management: If vomiting occurs within two hours of taking emergency contraceptive pills, the dose should be repeated. In cases of severe vomiting, the repeat dose of the pills may be administered vaginally.

- Irregular uterine bleeding: Some women may experience spotting after taking emergency contraceptive pills. The majority of women will have their menstrual period on time or slightly early.

Management: If there is a delay in menstruation of more than one week, a pregnancy test should be performed.

- Other side-effects of emergency contraceptive pills include: breast tenderness, headache, dizziness, and fatigue. These side-effects do not generally last more than 24 hours. Aspirin or another non-prescription pain reliever can be used to reduce the discomfort of headaches or breast tenderness.

Apart from these side-effects, there are no known adverse medical effects associated with the use of emergency contraceptive pills.

Eligibility criteria

WHO has drawn up medical eligibility criteria for the use of emergency contraceptive pills based on the relative health risks and benefits of the method for women with given conditions (see Appendix 1 for a description of the methodology used).

The sole contraindication for the use of emergency contraceptive pills is pregnancy. Emergency contraceptive pills should not be given to a woman who has a confirmed pregnancy primarily because they will not be effective.

However, if a woman in whom pregnancy cannot be ruled out with absolute certainty wishes to use emergency contraceptive pills, this is permissible provided it is made clear to her during counselling that the treatment will not work if she is already pregnant.

Taking the results of the studies with high-dose oral contraceptives (which are similar to emergency contraceptive pills) into account, experts believe there is no harm to a pregnant woman or fetus if emergency contraceptive pills are inadvertently used during early pregnancy.

There are no other known medical contraindications to the use of emergency contraceptive pills. The dose of hormones used in emergency contraception is relatively small and the pills are used for a short period of time, so that the contraindications associated with regular use of combined oral contraceptives and progestogen-only pills do not apply to emergency contraceptive pills.

Screening

A. Exclude the possibility that the client may be pregnant by:

- establishing the date of the last menstrual period and whether it was normal;
- establishing the time of the first and last episodes of unprotected intercourse since the last menstrual period to ensure that the client is within the 72-hour treatment time-frame.

B. Other health assessments such as laboratory tests, pelvic exam, etc., are not required unless there is the possibility of pregnancy, but these procedures can be offered as part of routine reproductive health care, if medically indicated or desired by the client. Providers should take the opportunity to ask if the client is using a regular method of contraception and to counsel her on family planning options.

Counselling

As with any contraceptive method, emergency contraceptive pills should be provided in a manner that is respectful of the client and responsive to her needs for information and care. During counselling, providers should reassure all clients, regardless of age and marital status, that all information will be kept confidential. Providers should also be as supportive as possible of the client's choices and refrain from making judgemental comments or indicating disapproval through body language or facial expressions while discussing emergency contraceptive pills. Supportive attitudes will encourage compliance and set the stage for follow-up counselling about regular contraceptive use and prevention of STDs.

Whenever possible, ensure that counselling is conducted in a private and supportive environment. In situations where it is difficult to maintain privacy (for instance, in pharmacies), provide emergency contraceptive pills

with appropriate verbal and printed instructions for using them and advise the client to contact a health care or family planning service for counselling about regular contraceptive methods.

Special issues related to counselling clients for the use of emergency contraceptive pills include:

Stress: Clients may be particularly anxious after unprotected intercourse because of the fear of pregnancy - worry about missing the 72-hour "window of opportunity" for hormonal emergency contraception - embarrassment about having failed to take effective precautions - about being sexually active - because of rape-related trauma - concern about STDs and HIV, or a combination of these factors. Maintaining a supportive atmosphere during counselling is therefore especially important.

Frequent use: Emphasize that emergency contraceptive pills are for emergency use only. They are not recommended for routine use because of the higher possibility of failure compared to regular contraceptives and the increased risk of side-effects. Although frequent use of emergency contraceptive pills is not recommended, repeated use poses no health risks and should never be cited as a reason for denying women access to treatment.

HIV and STDs: Clients may be very concerned about possible infection, especially after intercourse with a new partner or in cases of rape. Counselling on this topic should be provided along with STD diagnostic services (or referrals), and information about how STDs and HIV can be prevented. Clients must be made aware that emergency contraceptive pills offer no protection against STDs, including HIV.

Counselling about other contraceptive methods: Whenever possible, clients requesting emergency contraceptive pills should also be offered information and services for regular contraceptives. However, not all clients want contraceptive counselling at the time of emergency contraception treatment. Thus, while counselling related to the use of regular contraceptives is recommended for all emergency contraception clients, it should not be a prerequisite for providing emergency contraceptives. Clients who are interested in learning about other

methods should receive information and counselling at the time of the emergency contraception visit or at a follow-up appointment scheduled at a more convenient time. If the reason for requesting emergency contraception is that a regular contraceptive method failed, the reason for failure and how it can be prevented in future should be discussed.

Information for the client

- Make certain that the client does not want to become pregnant, and that she understands that there is still a chance of pregnancy even after treatment with emergency contraceptive pills. Explain that there is no reason to think that the emergency contraceptive pills will harm the fetus should the treatment fail to prevent pregnancy.
- Explain how to take emergency contraceptive pills correctly. Advise clients not to take more pills than the regimen requires, as these will likely increase the level of side-effects but will not increase effectiveness of the treatment.
- Describe common side-effects. Counselling in advance helps women to know what to expect and may lead to greater tolerance of side-effects.
- Tell the client that drinking milk or eating a snack with the pills may help reduce nausea. Help the client decide on the appropriate time to take the first dose so that taking the second dose 12 hours later will not be inconvenient. However, the first dose should not be delayed unnecessarily as efficacy may decline over time.
- Explain that the dose needs to be repeated if the client vomits within two hours of taking emergency contraceptive pills. In case of severe vomiting, the repeat dose may be administered vaginally.
- Make sure that the client understands that emergency contraceptive pills will not protect her from pregnancy if she engages in unprotected intercourse in the days or weeks following treatment. This is a common misconception. Advise the client to use a barrier method such as the condom for the remainder of her cycle. A different contraceptive method can be initiated at the beginning of her next cycle.
- Explain that emergency contraceptive pills typically do not cause the client's menses to come immediately. This is another common

misconception, and the client should be made aware that her period may start a few days earlier or later than normal.

- Advise the client to come back or visit a referral clinic (as appropriate) if menstruation is delayed for more than one week, and if she has any reason for concern; or as soon as possible after the onset of her menstrual period for regular contraceptive services, if she wishes.
- Use simple written or pictorial instructions to help reinforce important messages about correct use of emergency contraceptive pills.

Follow-up

If the client has already adopted a method of contraception for regular use and wishes to continue using this method, no follow-up is needed unless there is a delay in menstruation, or the client suspects she may be pregnant, or has other reasons for concern.

During the follow-up appointment:

- record the client's menstrual data to confirm that she is not pregnant (if in doubt, perform a pregnancy test);
- discuss contraceptive options, as appropriate;
- if desired, provide a contraceptive method according to the woman's choice.

If emergency contraceptive pills have failed and the client is pregnant:

- advise her about other options and let her decide which is most appropriate for her situation. Her decision should be respected and supported. Refer the client to other service providers as appropriate;
- if the client decides to continue the pregnancy, she should be reassured that there is no evidence of any teratogenic effect following emergency contraceptive pill use;
- Emergency contraceptive pills are unlikely in themselves to increase a woman's risk of ectopic pregnancy. However, for

various reasons, there may be a higher percentage of ectopic pregnancies among emergency contraceptive pill failure cases than among a normal pregnant population. Providers should be trained appropriately to rule out the possibility of ectopic pregnancy in all cases of emergency contraceptive pill failure.

Selecting a product

1. Products such as Tetragynon/PC4, Neo-Primovlar4/E-Gen-C, or Fertilan (Yuzpe regimen) and Postinor-2 (levonorgestrel) are specially packaged for emergency contraception, but at present they are registered in only a limited number of countries. They have advantages for service delivery since, being specifically for emergency contraception purposes, they contain instructions for correct use as well as the required number of pills. They simplify the task of delivering emergency contraception through pharmacies and social marketing programmes.

2. If specially packaged pills are not available, however, emergency contraception can be provided using the available combined oral contraceptives (COCs) in one of several ways. (Table 2 shows the formulations and doses required for this purpose).

- 4 pills of high-dose or 8 pills of low-dose COCs can be packed in suitable containers and specially labelled for emergency contraception use.
- A pill packet can be cut into strips of 4 pills of high-dose or 8 pills of low-dose COCs and dispensed in envelopes with instructions for use as emergency contraception.
- Clients can be supplied with an entire packet of COCs with instructions on how to use them for emergency contraception.

Because COCs are readily available in most countries, these are practical, low-cost ways to ensure access to emergency contraception. To avoid confusion, instructions should always be clear and special care must be taken to avoid errors in repacking COC pills.

Initiating regular contraception after the use of emergency contraceptive pills

Condoms can be used immediately.

Diaphragms can be used immediately.

Spermicidal foam or films can be used immediately.

Oral contraceptives should be started within 5 days of the beginning of the next menstrual cycle (or according to the instructions for the type of pill being used).

Injectable contraceptives should be given within 7 days of the beginning of the next menstrual cycle.

IUDs should be inserted during the next menstrual cycle. (If the client intends to use an IUD as a long-term method and meets IUD screening criteria, emergency insertion of a copper-releasing IUD may be an alternative to emergency contraceptive pill use.)

Natural family planning should be started after onset of menstruation if there are no bleeding irregularities. If this method is new to the client, she should be given counselling to ensure she knows how to practise it correctly.

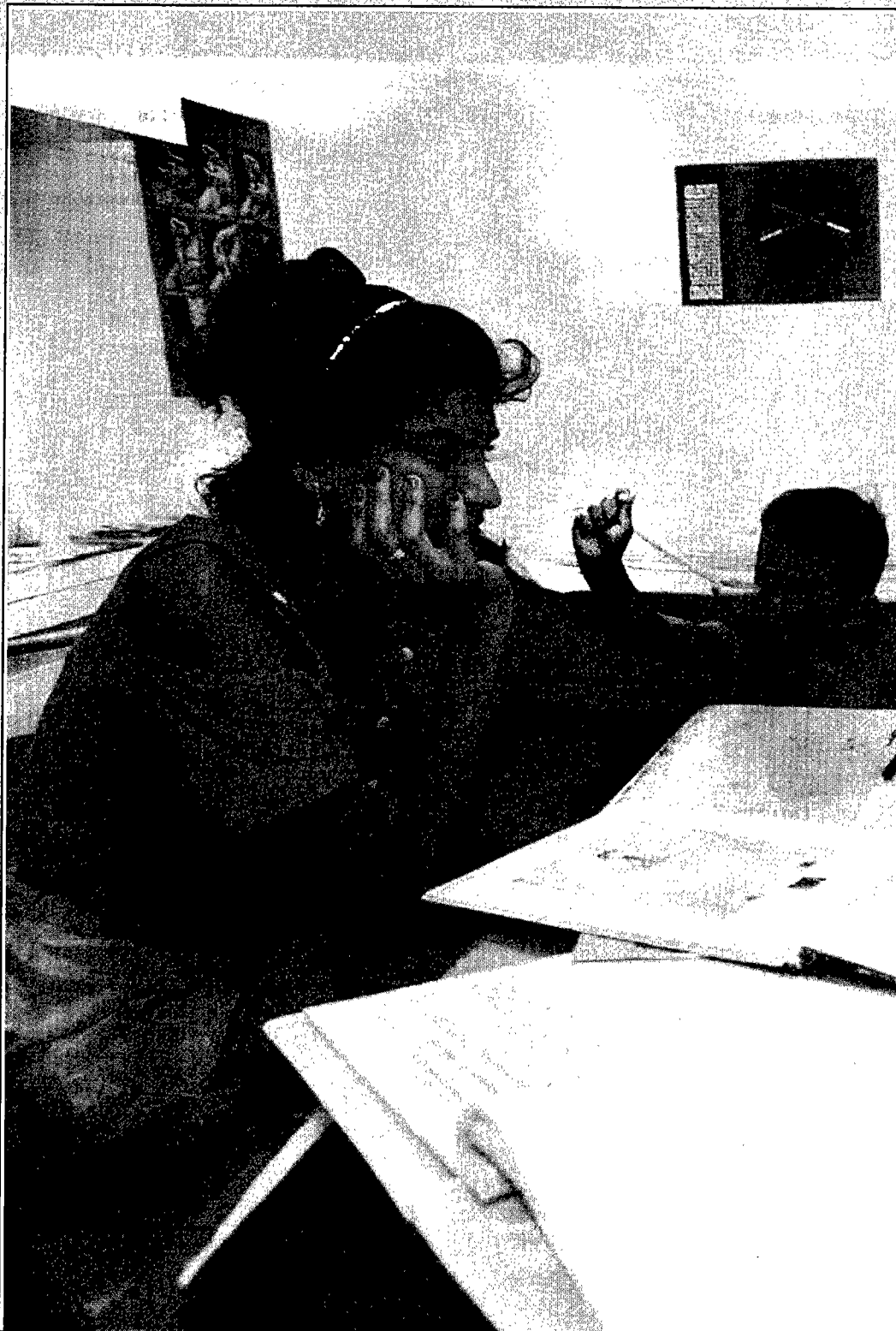
Implants should be given within 7 days of the beginning of the next menstrual cycle.

Sterilization should only be performed once it is clear that this method has been freely chosen and the client is fully aware of the issues involved. However, it is recommended that clients should be discouraged from making this decision under the stressful conditions that typically surround emergency contraceptive pill use.

Table2
Formulations and Dose Required for Emergency Contraception

	Formulation per dose	Common Brand Names	Tablets Required Per Dose	Doses	Timing of Administration
Combined-pill Regimen	EE ⁻ 50 µg + LNG ^{††} 250 µg	Neogynon, Noral, Nordiol, Ovidon, Ovran, Tetragynon, PC4 Neo-Primovlar 4 E-Gen-C Fertilan	2	2	First dose within 72 hours of unprotected sex. Second dose 12 hours later.
	or EE ⁻ 50 µg + NG [*] 500 µg	Eugynon 50, Ovral	2	2	
	EE 30 µg + LNG 150 µg	Microgynon 30, Nordette, Rigevidon	4	2	First dose within 72 hours of unprotected sex. Second dose 12 hours later.
	or EE 30 µg + NG 300 µg	Lo-Femeral, Ovral L	4	2	
Progestogen-only Regimen	LNG 750 µg	Postinor, Postinor 2	1	2	First dose within 72 hours of unprotected sex. Second dose 12 hours later.
	LNG 30 µg	Microlut, Microval, Norgeston	25	2	First dose within 72 hours of unprotected sex. Second dose 12 hours later.
	or NG 75 µg	Ovrette	20	2	
⁻ EE = ethinylestradiol ^{††} LNG = levonorgestrel [*] NG = dl-norgestrel					
Adapted from Consortium for Emergency Contraception. Emergency Contraceptive Pills. A Resource Package for Health Care Providers and Programme Managers. 1996.					

Photo: UNFPA photo by Viviane Moos



COPPER-RELEASING IUDS AS EMERGENCY CONTRACEPTION

A copper-releasing IUD can be used within 5 days of unprotected intercourse as an emergency contraceptive. However, when the time of ovulation can be estimated, the IUD can be inserted beyond 5 days after intercourse, if necessary, as long as insertion does not occur more than 5 days after ovulation.

Efficacy

This method is highly effective. After unprotected sexual intercourse, less than 1% of women are reported to become pregnant if they use a copper-releasing IUD as an emergency contraceptive.

Mode of action

Scientific evidence from a number of studies has indicated that copper-bearing IUDs act primarily by preventing fertilization, and by both decreasing the number of sperm reaching the fallopian tube and interfering with their motility. Thus, although it is unlikely that a single mechanism of action accounts for their antifertility effect, the primary mode of action of IUDs is clearly interference with fertilization rather than implantation.

Indications

In addition to the general indications for emergency contraception, the IUD is especially indicated when:

- more than 72 hours have elapsed after unprotected intercourse, in which case emergency contraceptive pills are not considered an effective option;
- the client is considering using an IUD for continuous, long-term contraception.

It should be kept in mind that the insertion of an IUD in nulliparous women may be more difficult and painful than in parous women and that, for this reason, emergency contraceptive pills may be a better choice for them.

Eligibility criteria

The same eligibility criteria that apply to the insertion of a copper IUD in routine circumstances should be applied for insertion as an emergency contraceptive. WHO has drawn up medical eligibility criteria for IUDs based on the relative health risks and benefits of using the method for women with given conditions (see Appendix 1 for a description of the methodology used).

Category 4: The following conditions represent an unacceptable health risk and IUDs must not be inserted in women who have:

- an established pregnancy;
- puerperal or post-abortion sepsis (current or within last 3 months);
- Pelvic inflammatory disease (PID) (current or within last 3 months);
- STD (current or within last 3 months);
- purulent cervicitis;
- confirmed or suspected malignancy of the genital tract;
- congenital uterine abnormalities or fibroids distorting the cavity in a manner incompatible with proper IUD placement;
- malignant gestational trophoblastic disease;
- known pelvic tuberculosis;
- unexplained vaginal bleeding (which may indicate a serious condition).

Category 3: For women with these conditions, the theoretical or proven risks of using the method outweigh the advantages.

These conditions require careful consideration before an IUD is inserted. This is the method of last choice and should not be used unless other methods are unavailable or unacceptable. Clinical judgement is required and careful follow-up is needed if the method is chosen. Rape and risk of STDs come under this category.

Risk of STDs: For a woman who presents no clinically obvious gynaecological infection, but who is at high risk of STDs (e.g. she has multiple sex partners), emergency contraceptive pills are a better option than an IUD. However, if more than 72 hours have elapsed since the first episode of unprotected intercourse, she can have an IUD inserted for emergency contraception but she must be advised to switch to another contraceptive method at the next menstrual period. If possible, STD screening should be provided before insertion of the IUD and/or prophylactic antibiotics should be given at the time of insertion.

Rape: Insertion of an IUD may be emotionally traumatic for a woman who has been a victim of sexual abuse. There is also an increased possibility that she has contracted an STD. Therefore, the use of an IUD for emergency contraception should be reserved for those cases in which more than 72 hours have elapsed since unprotected intercourse and emergency contraceptive pills can no longer be used.

Counselling and information

The general aspects of counselling for the use of emergency contraceptive pills also apply to counselling for emergency use of IUDs.

When discussing regular contraception, suggest to the client that she may like to keep the IUD in place. If she decides on this option, further counselling should be given as for any client selecting an IUD for regular contraception. If she does not wish to continue using the IUD, however, she should be advised to return during or soon after her next menstrual period for its removal.

Screening

- Exclude the possibility that the client may be pregnant by:
 - assessing the date of the last menstrual period and whether it was normal;
 - assessing the dates and times of the first and last episodes of unprotected intercourse;
 - performing a sensitive urine pregnancy test if there is any doubt.

- Record the medical and gynaecological history.
- Record present illnesses, including history of STDs and risk factors for STDs such as multiple sexual partners.
- Perform a physical examination, including speculum visualization of cervix and bimanual pelvic examination.
- Perform any other examination as indicated by the medical history.

Insertion of the IUD

Insertion procedures for emergency use of IUDs are the same as for regular IUD use.

Instructions to the client

- Advise the client that cramping or pain may occur for the first 24 to 48 hours after insertion of the device. If she experiences this, she should take pain-relief tablets such as aspirin, ibuprofen or paracetamol.
- If the client does not plan to keep the IUD for regular contraception, instruct her to come back during or soon after her next menstruation for removal of the IUD.
- If the client plans to keep the IUD for regular contraception, inform her that:
 - vaginal discharge may occur during the first few weeks. This should not be a cause for concern, but if the discharge is heavy, or accompanied by pelvic pain and/or fever, she should contact the clinic immediately;
 - she should return to the clinic if she is experiencing any of the following signs and symptoms which might indicate a possible complication: fever and/or chills; pelvic pain or tenderness; purulent vaginal discharge; excessive abnormal bleeding; or if the IUD threads cannot be felt.

Follow-up

Advise the client to return during or soon after the next menstrual period.

- If the client does not wish to keep the IUD, remove it and provide counselling on alternative contraceptive options and relevant services, as necessary.
- If the client wishes to keep the IUD for continuous contraception, check that the device is properly placed and provide information related to continuous use and follow-up.

If the menstrual period is delayed after insertion of the IUD for emergency contraception, consider the possibility of pregnancy. If the client is pregnant, proceed to remove the IUD, exclude the possible existence of extra-uterine pregnancy and provide care in the same way as when pregnancy is diagnosed during continuous use of an IUD.

Photo: UNFPA photo by Chieko Ishikawa



SERVICE ASPECTS

The services required for emergency contraception differ according to whether pills or IUDs are used. With IUDs, clinic facilities and trained providers are needed for screening clients and for safe insertion procedures. Emergency contraceptive pills, on the other hand, can be provided by a large variety of people including doctors, nurses, midwives, pharmacists, and trained traditional birth attendants, auxiliary nurses, and community health workers. They can be supplied over the counter by retailers, or through other innovative distribution systems by providers who have received some training in counselling and the correct use of emergency contraceptive pills.

Service delivery settings

Emergency contraceptive methods can be delivered in a variety of service settings:

Clinical outlets: Emergency contraceptive pills can be provided at family planning clinics, other health care facilities such as hospitals, emergency services, outpatient clinics, work place or school clinics and the offices of general practitioners or gynaecologists. IUDs can only be provided in settings where the insertion and removal can be performed in aseptic conditions.

Community-based services: Community-based services that currently deliver oral contraceptives would be very appropriate for providing emergency contraceptive pills to individuals living beyond the usual catchment areas of clinics. Pills can also be provided by women's health groups or other community health groups trained to provide appropriate information and counselling.

No checklists are necessary to provide emergency contraceptive pills. However, a referral system is needed for clients who contact the community worker after more than 72 hours have elapsed since unprotected intercourse, as they may require insertion of a copper IUD or services for the diagnosis of pregnancy. Clinical facilities providing oral contraceptives should be prepared to provide services for clients who are referred from non-clinical outlets.

Social marketing / commercial distribution: Where a specially packed emergency contraceptive pill product is available, social marketing may be a useful distribution mechanism. Contraceptive social marketing involves selling contraceptive products at reduced prices through a variety of retail outlets in order to increase their availability to clients. Incorporating emergency contraceptive pills into an existing social marketing programme would involve defining the target audience(s), conducting market research, developing marketing strategies (including the packaging, pricing, and promotion and distribution mechanisms), promoting and distributing the product, and evaluating the results. Social marketing of a dedicated emergency contraceptive pill product may be a particularly effective way of reaching clients who do not generally make use of contraceptive or reproductive health services.

Even when a dedicated emergency contraceptive pill product is not available, commercial outlets can be used to supply emergency contraceptive pills. For instance, where regulations permit, pharmacists who are authorized to sell COCs could also be trained to sell them with instructions for use as emergency contraceptives. The pharmacist's training should cover everything related to the method, including appropriate regimens, efficacy, screening protocols, side-effects and their management, and follow-up procedures. Whenever possible, pharmacists should be provided with printed materials about emergency contraceptive pills (both service delivery guidelines and information for clients). As with other non-clinic suppliers, pharmacists should be able to refer clients to a clinical facility if they request emergency contraceptive pills more than 72 hours after unprotected intercourse or are in need of other contraceptive services.

Youth advisory centres: Adolescents are often inexperienced contraceptive users and are at high risk of pregnancy. By providing emergency contraceptive information and services to them, programmes can help young people avoid the major health risks associated with early pregnancy.

However, reaching adolescents (girls and boys) with emergency contraceptive information and services poses special challenges to programmers. For example, young people may:

- be unaware of the availability of emergency contraceptive pills;
- lack confidence or be embarrassed to visit a family planning clinic;

- not know where the clinics are located;
- find the clinic hours inconvenient;
- fear a pelvic examination or other laboratory tests;
- be anxious about judgemental attitudes of providers;
- fear lack of confidentiality.

Youth advisory centres could provide information on emergency contraception in their counselling sessions. Teachers and school counsellors could also provide information and advice on emergency contraception, and centres with specially trained staff could provide emergency contraceptive pills.

Training

Effective contraceptive services require providers with technical training in the correct and timely administration of the methods. It may require a special effort to encourage positive attitudes towards emergency contraception in the providers.

All providers should be given appropriate training⁴ and be required to follow clear service delivery guidelines. Training should include:

- indications for emergency contraception use;
- methods recommended for emergency contraception, their efficacy and mode of action;
- client information and counselling needs;
- contraindications and screening, including screening for pregnancy;
- side-effects and their management;
- correct use of emergency contraceptive pills;
- correct procedures for IUD insertion if appropriate;
- follow-up procedures;
- management of pregnancy in cases of failure of emergency contraception;
- referral procedures in cases where a client's condition requires more specialised management or care.

⁴ The Consortium for Emergency Contraception has prepared a curriculum for the training of providers in the correct use of emergency contraceptive pills.

⁵ The Consortium for Emergency Contraception has developed a prototype brochure on emergency contraceptive pills for client's information.

Information for clients

Emergency contraception will only have an impact on reducing unwanted pregnancies if women know about the methods before they are needed. The health services should therefore make an effort to create widespread awareness about emergency contraception⁵.

Information can be delivered during educational or counselling sessions and/or through printed materials such as brochures and leaflets. Information materials should meet the needs of potential clients as well as those actually requesting emergency contraception. Women should be made aware of the methods available, when and where to get them, their efficacy and their safety. Actual users of emergency contraception should receive additional information on how the methods work, side-effects and their management, and the follow-up procedures.

When emergency contraceptive pills are offered outside a clinical setting, the quality of information materials is of particular importance. They should be easy to read, with simple, clear messages. They should also emphasize the need for clients to consider regular contraception after emergency contraceptive pill use.

Monitoring the services

Monitoring and supervision are important for maintaining high-quality services. As experience in the provision of emergency contraception increases in a country or at a service delivery point, it may be necessary to modify IEC materials, managerial procedures and training. Monitoring and evaluation should take account of clients' and providers' perceptions and experiences. There should be a continuous process of training through which providers are brought up to date on new information about emergency contraception methods and receive feedback on the work they are doing.

Photo: UNFPA photo by Marie Dorigny



Photo: UNFPA photo by Chieko Ishikawa



INTRODUCING EMERGENCY CONTRACEPTION INTO REPRODUCTIVE HEALTH PROGRAMMES

Before a new contraceptive method is introduced into a community, the need for such a method and its acceptability should be assessed. The organization and management of services should also be looked at to ensure they are capable of the safe distribution and successful use of the method (Cleland et al, 1990; Simmons et al 1997). Policy-makers and programme managers need to plan the introduction of emergency contraception in a way that is sensitive to the values and culture of the population groups concerned. And they also need to consider the policy context in which emergency contraception is being introduced, and seek support for their plans at the appropriate and necessary levels. This is particularly important for emergency contraception because of the misconceptions that exist about the safety of the methods and their mode of action, and the common fear that making emergency contraception available will lead to irresponsible sexual or contraceptive behaviour.

When introducing emergency contraception it is particularly important to:

- identify factors that influence contraceptive choice and potential use of emergency contraception;
- understand users' attitudes towards emergency contraception and other contraceptives;
- understand users' views on the service delivery system;
- identify the service delivery, training and management requirements for providing good-quality emergency contraception services;
- use the results of these enquiries to develop a strategy for introducing emergency contraception and eventually making it widely available.

Ideally, emergency contraception should be introduced as part of the range of contraceptive methods offered by the national reproductive health

programme. Emergency contraception methods should be included in the basic and ongoing training curricula of providers, in the IEC materials and in the logistic and distribution systems.

Involving providers and managers

Strategies for introducing emergency contraception into reproductive health programmes need to be discussed with providers and managers who are responsible for implementing emergency contraception services, and with all others involved in policy decisions regarding health, family planning and education. Reproductive health providers and managers can contribute to the development of strategies for introducing emergency contraception methods in their services and in alternative delivery systems.

Involving the community

Involving the community in the design of reproductive health programmes and services is a key factor in their success. The needs and concerns of clients and potential users must be taken into consideration.

Steps in the introductory process

The following steps are recommended when introducing emergency contraception although the order in which they are taken may vary between settings, depending on the stage of development of the reproductive health programme and the cultural environment within which emergency contraception is being introduced.

- Assess users' needs and attitudes: clients' perception of the need for emergency contraception and acceptance of the methods as well as their involvement in the design of services are essential components in the introduction of emergency contraception.
- Assess the regulatory requirements: if the products are not available, approval for their registration must be obtained early in the introductory process.
- Assess the service capabilities, including providers' views and knowledge of emergency contraception: providers' acceptance and understanding of emergency contraception as well as their involvement in the design of introductory strategies and services is essential. The mechanisms already available for the delivery of emergency

contraception should be assessed including family planning services, other health services, community-based distribution programmes and commercial outlets. The need for training different types of providers should also be established.

- Enlist support for the introduction of emergency contraception at appropriate levels: gaining support from key government officials, community leaders and women's health advocates early in the process may help to ensure acceptance and facilitate the introductory process.
- Select a single product for emergency contraceptive pills, if necessary, and develop a distribution plan.
- Train the managers and the providers, according to their role in the provision of emergency contraception.
- Meet clients' information needs: reaching the community and potential clients with information about emergency contraception is another essential component of the introductory strategy. Information materials should be prepared and tested locally.
- Introduce the product at the different service levels.
- Monitor and evaluate the services.
- Disseminate the results of the evaluation.

Acceptability of emergency contraception

The acceptability of emergency contraception and the service conditions perceived as important by potential users, providers, programme managers and policy-makers should be explored, and appropriate strategies for the introduction of emergency contraception developed on the basis of the results.

It is particularly important to assess the acceptability of emergency contraceptive methods in providers since their personal attitudes have a strong influence on clients' decision-making processes. Providers' opinions on which contraceptive methods are appropriate for whom and under what circumstances, as well as their attitudes towards such issues as adolescent sexuality, "responsible sexual behaviour", and abortion, all affect their attitudes towards emergency contraception. These attitudes can facilitate or obstruct the effective introduction of emergency contraception in programmes.

The gender and age of providers also need to be taken into account, since these factors have a powerful influence on how they perceive and react to clients and their personal needs. It is particularly important for the creation of client-friendly services that these issues be addressed in training programmes.

Gender issues as seen by the client also need careful consideration as they affect attitudes towards emergency contraception. Gender issues include, among other, women's feelings about expressing their sexuality, about "ownership" of their bodies vis-à-vis their partners, about pregnancy as a means of strengthening relationships, etc. Such feelings affect a woman's reaction to an unwanted pregnancy (Cardich and Carrasco, 1993). These issues may be particularly important to adolescents, and need to be explored with them since they will affect emergency contraceptive practice. For example, lack of autonomy in sexual matters plays against the use of emergency contraception by an adolescent woman, while fear of the social stigma of becoming a single mother may play in favour.

Whatever the age of the woman, a decision regarding emergency contraception may be more difficult to make than a decision about a regular contraceptive method because it has to be made in a relative hurry.

Barriers to the introduction of emergency contraception

In trying to introduce emergency contraception a variety of obstacles may be encountered and it is important to devise strategies to deal with them.

Client-related barriers: Lack of knowledge about emergency contraception among women is one of the major obstacles to its use. Risk-taking behaviour, which is common among young people, is another obstacle to the use of emergency contraception when needed.

Provider-related barriers: Lack of knowledge among providers, programme managers and policy-makers is an obstacle to the introduction of emergency contraception in reproductive health programmes. They may not have a clear understanding of the role emergency contraception can play in improving the reproductive health of women, or they may be reluctant to provide emergency contraception because they have insufficient training in the procedures involved.

Sometimes providers may restrict women's access to emergency contraception because the practice goes against their own beliefs or value systems. Another factor that may contribute to the bias against emergency contraception is the fact that, in many countries to date, it has been provided mainly by hospitals to women in cases of rape, rather than by reproductive health services as a matter of routine. Providers may also be uncertain about damage to a fetus if the emergency contraceptive method should fail, or they may be anxious about the risks associated with IUD insertions when they are unable to screen for STDs, or when the woman is not menstruating.

Cultural barriers: Another potential barrier to the introduction of emergency contraception is the influence of traditional religious groups whose opposition to fertility regulation programmes tends to reinforce conservative attitudes in politicians, policy-makers, health providers, teachers, school counsellors and the media. Emergency contraception may be especially controversial since it is often wrongly perceived as an abortifacient.

Product-related barriers: Pills specially packed for emergency contraception are available only in a few countries and are relatively expensive. Furthermore, many providers are not aware of the fact that several brands of COC pills distributed for regular contraception can be used for emergency contraception. The different pill regimens may be confusing for providers and clients alike, and this is likely to contribute to incorrect use and reduced efficacy.

Economic considerations

Emergency contraception is highly cost-effective. With appropriate training, almost any health provider or community health worker can distribute emergency contraceptive pills. Family planning clinics that provide IUDs for regular contraception can easily provide IUDs for emergency purposes. The cost of pills especially packed for emergency contraceptive use may be slightly higher than COCs used for regular contraception.

The cost of emergency contraceptive supplies and services, including the dissemination of information, will be more than covered by the savings to the health system in preventing unwanted pregnancies and abortions and their complications.

Photo: WHO photo by Eric Schwab



DISSEMINATION OF INFORMATION

Making emergency contraception available is not enough in itself to prevent unwanted pregnancies and abortions that result from unprotected intercourse. People need to know that it exists; thus the communication component of an introduction strategy for emergency contraception is a key determinant of success.

Information about emergency contraception should be delivered through all appropriate channels, for example health centres, family planning clinics, community centres and the mass media. Information should be culture-sensitive and targeted at all potential clients. This means that appropriate materials⁶ need to be developed as well as sustainable networks created that will provide information to the new cohorts of potential users.

The most appropriate communications strategies will vary from place to place, according to how freely people are prepared to discuss sexuality, contraception and other reproductive health topics. It is important to seek advice on this from potential users and providers.

A summary of the different target audiences and examples of how to reach them with information are shown in Table 3.

Informing the community

A variety of groups can help spread information about emergency contraception, for example women's health advocates, community health groups, school teachers and counsellors, and mass media professionals. They need information materials to help them when presenting emergency contraception to their audiences. However, to create expectations without being able to deliver emergency contraception may work against successful introduction, and the services to supply emergency contraception should be in place and providers adequately trained before awareness activities begin.

⁶ The Consortium for Emergency Contraception has developed materials that can assist programme managers and providers in the task of preparing information materials.

Topics that are important to clarify include:

- the purpose of emergency contraception;
- situations in which it is useful;
- the methods of emergency contraception;
- safety and efficacy of methods;
- service delivery points where emergency contraception can be obtained.

Messages that may be highlighted include the following:

- emergency contraception is a means of preventing unwanted pregnancy after unprotected intercourse has taken place;
- emergency contraception can prevent abortions;
- women must know about this contraceptive option before needing it;
- emergency contraception is safe and effective for the majority of women;
- emergency contraception is meant for use in “emergency situations”, and responsible use of regular contraception by women and couples who are sexually active should be encouraged when disseminating information about emergency contraception.

Dealing with common concerns

The anxieties and misconceptions about emergency contraception vary from one community to the next and acceptability studies among clients and providers can help identify those that are most relevant in a given place. Common misconceptions include:

Misconception 1

- *Emergency contraception is a form of abortion.* This is not so. Emergency contraception methods work in a variety of ways to prevent pregnancy depending on when in the menstrual cycle they are used. They do not displace an implanted embryo, and cannot terminate an established pregnancy;

Misconception 2

- *Emergency contraception promotes irresponsible and/or promiscuous sexual behaviour.* There are no data to suggest that the use of emergency contraception leads to irresponsible and/or promiscuous sexual behaviour. On the contrary, emergency contraception can act as a bridge to contraceptive information and counselling for regular use and as an opportunity to provide information on prevention of STDs and HIV/AIDS. This is particularly valuable in the case of young people who may first contact a health service because of the need for emergency contraception.

Misconception 3

- *Emergency contraception is targeted mainly at unmarried adolescents and may undermine parental authority and community morals.* Women of all ages may need emergency contraception and adolescents are not the only target group. However, young women with little contraceptive knowledge and experience are at specially high risk of an unwanted pregnancy, and preventing pregnancy in adolescents is a high priority in all countries. Parents of adolescents should also be aware of the existence of emergency contraception because they may be willing to advise their youngsters on this option if they confide in them about their sexual relations.

Misconception 4

- *Women or couples may stop using regular contraception if emergency contraception is easily available.* The information given to clients about emergency contraception should clearly state that it is meant only for "emergency" situations. The efficacy of emergency contraceptive pills is lower than that of the regular use of combined pills and is associated with unpleasant side-effects such as nausea and vomiting. Also, repeated use of emergency contraceptive pills in any month can expose women to higher doses of steroids than those recommended during one cycle. In addition, emergency contraceptive pills are more expensive than regular use of oral contraceptives.

Misconception 5

- *Men may be less willing to use condoms if they know that their partners can use emergency contraception.* Couples use condoms to prevent both pregnancy and the transmission of disease. Emergency contraception does not protect against STDs, including HIV. The use of emergency contraceptive pills is associated with side effects that can be avoided if condoms are used instead. However, couples may be more willing to rely on condoms for contraception and protection against STD/HIV infection if they know that emergency contraception is available as a back-up in the case of condom failure during intercourse such as a breakage or slippage.

Table 3
COMMUNICATION ACTIVITIES TO INFORM AND BUILD
CONSENSUS ON EMERGENCY CONTRACEPTION,
BY AUDIENCE

Audience	Strategy or vehicle for dissemination		
	Publications	Meetings	News Media
Potential users	Brochures Information sheets Wall charts Laminated cards	Mothers' clubs, bazaars, town meetings	Coverage in mainstream and alternative media, women's magazines and radio and television programmes
Youth	Posters for youth centres and at concerts Brochures	Participatory meetings on adolescent reproductive health	
International policy-makers	Brief, attractive publications Executive summaries	Donor coordination meetings Task forces Audiovisual presentations Briefing packs	Major media coverage through news releases, experts
National policy-makers	Brief publications by national experts Bellagio consensus statement	In-country policy seminars to outline research needs and build consensus Audiovisual presentations	Coverage of local data, experts
Health providers	Scientific journal articles Fact sheets for conferences Brochures Bellagio consensus statement Up-to-date service delivery guidelines Professional association publications Case studies Training materials	Meetings to update guidelines Consensus-building seminars Contraceptive technology seminars to disseminate scientific information Panels at existing meetings Training workshops	Coverage via health newsletters and in-service medical broadcast programmes
Pharmacists	Product information brochures Fact sheets	Professional meetings	Coverage in membership publications

Audience	Strategy or vehicle for dissemination		
	Publications	Meetings	News Media
Nongovernmental organizations	Collaboratively produced brochures Research summaries Bellagio consensus statement	Consensus-building seminars	Coverage in membership publications Announcements over electronic media
Women's groups	Brochures Journal articles Bellagio consensus statement	Conferences on women's health In-country policy seminars	Women's publications Broadcast programmes NGO newsletters
Media	Media information packs	Panel discussion by scientific experts for editors of women's publications International development communication meetings Science journalism Conferences	Coverage through news releases and expert panels Column by local women's advocate or physician Electronic news bulletin

From Robinson ET, Metcalf-Whittaker M and Rivera R.
International Family Planning Perspectives 22: 71-80, 1996.

Medical Eligibility Criteria

The medical eligibility criteria for the use of contraceptives have been recently revised by WHO on the basis of a thorough review of the latest clinical and epidemiological information. The WHO experts developed a new approach to classifying a woman's eligibility to use a contraceptive method based on the relative health risks and benefits of using such a method for a woman with a given condition.

A condition affecting eligibility for contraceptive use was defined as either a personal characteristic (e.g., age, parity, history of pregnancy) or a known pre-existing medical/pathological condition (e.g., diabetes, hypertension). Those responsible for developing service delivery guidelines must decide on the strategies to be used to determine these conditions. Taking a full client history will often be the most appropriate approach.

It was proposed that these conditions be classified under one of the following four categories:

1. A condition for which no restriction for the use of the contraceptive method is warranted.
2. A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
3. A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
4. A condition which represents an unacceptable health risk if the contraceptive method is used.

Categories 1 and 4 are self-explanatory. A condition or characteristic that classifies the use of a particular contraceptive method in category 3 requires careful clinical evaluation, taking into account the severity of the condition and the availability, practicality and acceptability of an alternative contraceptive method. It should be the method of last choice, and careful follow-up of the user will be required. Classification under category 2 does not imply that a restriction on the use of the method is necessary, but the condition or characteristic should be considered in the counselling process and in the selection of the method.

Other methods may represent a better choice for a woman with such a condition or characteristic, or careful follow-up may be required.

This classification system should be adapted by countries and programmes when required, to reflect local conditions. In particular, the levels of clinical knowledge and experience of the different providers and the resources available to programmes will have to be taken into consideration. Where clinical skills are limited, such as in community-based programmes, it may be advisable to simplify the four-category classification system, reducing it to two categories (see table).

CLASSIFICATION	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstances	Yes*
2	Generally use the method	Yes
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No*
4	Method not to be used	No

Source: Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use. WHO, 1996.

* Yes= method can be used; No= method should not be used.

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