



**International  
Planned  
Parenthood  
Federation**

## **Statement on Emergency Contraception**

### **Introduction**

Despite the availability of highly effective methods of contraception, many pregnancies are unplanned and unwanted. Such pregnancies can result in abortion and carry an excess risk of morbidity and mortality. The risk of pregnancy with one unprotected act of sexual intercourse can be as high as one in three, depending on the cycle day of exposure in relation to ovulation. For the woman exposed to unprotected sexual intercourse, e.g., through lack of contraceptive use, condom breakage, missed pills, or sexual assault, emergency contraception can be used to prevent an unwanted pregnancy.

Since the mid-1960s, the post-coital use of certain orally administered steroid hormones has been shown to be effective in preventing pregnancy. In addition, intrauterine devices (IUD) and the anti-progestin mifepristone are also highly effective for emergency contraception.

### **Hormonal Methods**

Two commonly available oral regimens have proved to be safe and effective for emergency contraception.

#### **Levonorgestrel-only regimen**

The most convenient regimen is a single dose consisting of 1.5 mg levonorgestrel taken as soon as possible after unprotected intercourse; alternatively, one dose of 0.75 mg levonorgestrel can be taken as soon as possible after unprotected intercourse followed by the same dose taken 12 hours later.

Levonorgestrel pills are more effective the sooner they are taken after unprotected intercourse. They are most effective if taken within 3 days (72 hours). However, there is still some effect up to 5 days after unprotected intercourse.

Where pills containing 0.75 mg levonorgestrel are not available, 0.03 mg levonorgestrel pills which are used for regular contraception offer a possible alternative. Twenty-five of these mini pills should be taken initially, and a further twenty-five 12 hours later. There is anecdotal evidence to support this regimen, but no clinical studies have evaluated its efficacy.

### **Combined oestrogen-progestin regimen**

This regimen consists of two 50 µg ethinyl estradiol/0.25 mg levonorgestrel pills, or four 30 µg ethinyl estradiol/0.15 mg levonorgestrel pills, taken as soon as possible within 72 hours after unprotected intercourse, followed by a second similar dose 12 hours later. This method shows little efficacy after 72 hours from unprotected intercourse.

### **Choice of method**

The levonorgestrel-only regimen should be the first choice where available because it is more effective and is less likely to cause nausea and vomiting than the combined regimen. However, the combined regimen should remain an option where the levonorgestrel-only regime is less accessible and more costly, as in many countries.

### **Mechanism of action**

Hormonal emergency contraception achieves its contraceptive effect by several mechanisms depending on the time in a woman's cycle it is taken. It can inhibit or delay ovulation and may also interfere with ovum and sperm transport and fertilization. Studies differ on whether hormonal emergency contraception can cause changes in the endometrium that would be sufficient to interfere with implantation. There is no evidence that hormonal emergency contraception dislodges the embryo after implantation has occurred. Hormonal emergency contraception does not cause an abortion.

### **Efficacy**

Various studies have shown that the levonorgestrel-only regimen reduces the risk of pregnancy by 60%-93% or more after a single act of intercourse, and the combined regimen reduces it by 56%-89%. In direct comparisons, the levonorgestrel regimen has been shown to be more effective than the combined regimen. Emergency contraceptive pills (ECPs) are not as effective as consistent and correct use of most modern contraceptive methods.

### **Eligibility Criteria**

No known contraindications exist to the use of hormonal emergency contraception. Although this method is not indicated for a woman with a known or suspected pregnancy, it will not affect the course of her pregnancy, or harm the foetus. There is no need for a physical examination or pregnancy test before it is provided.

### **Side-effects**

Nausea and vomiting are common among women using the combined regimen and considerably less common among women using the levonorgestrel-only regimen. When the combined regimen is used, anti-emetic pretreatment may be considered; with the levonorgestrel-only regimen this is unnecessary.

If vomiting occurs within one hour after taking a dose, it is common practice to repeat the dose. However, there is no evidence that this improves efficacy; indeed, vomiting can be an indication that the hormone has been absorbed. In case of vomiting, further pills may be administered vaginally. Although there are no clinical data supporting the efficacy of this practice, contraceptive steroid hormones are known to be readily absorbed from the vagina.

Other side-effects with hormonal emergency contraception include abdominal pain, fatigue, headache, dizziness, and breast tenderness. After the use of hormonal emergency contraception, menses usually occur at the regular time, but may be either earlier or later. Some women may experience irregular bleeding or spotting after taking ECPs.

## **Drug Interactions**

Women should be advised that the effectiveness of ECPs may be reduced if they are taking drugs which reduce the efficacy of regular oral contraceptives (including but not limited to rifampicin, griseofulvin, barbiturates). At the current time there is insufficient information on drug interactions to make any specific recommendations on increased ECP dosing schedules.

## **Frequency of Use**

Hormonal emergency contraception should not be used for routine pregnancy prevention since the cumulative pregnancy rate for frequent use of ECPs is higher than that with regular contraception. However, if unprotected intercourse occurs in a cycle where emergency contraception has already been used it can be repeated. Women should understand that emergency contraception pills may not protect them from the possibility of pregnancy from episodes of unprotected intercourse more than 5 days before the ECPs are taken or from intercourse after the pills are taken.

In cycles where unprotected intercourse has occurred more than once, hormonal emergency contraception can be used. However, efficacy will be influenced by the time interval since the first act of unprotected intercourse. If the woman is already pregnant because of earlier intercourse, emergency contraception will not be effective.

## **Mifepristone**

A single dose of mifepristone 10 mg taken within 5 days after unprotected intercourse is highly effective for emergency contraception. It has a low incidence of side-effects. However, 9-18% of women experience a delay of menses of more than 5 days. Women should be counselled appropriately. A major constraint for the use of mifepristone is its limited availability.

## Copper-releasing IUDs

The copper-releasing IUD is also highly effective for emergency contraception. It can reduce the chance of pregnancy by more than 99% when inserted within 5 days after unprotected intercourse. This method may be particularly useful when the client is considering its use for long-term contraception and/or when the hormonal regimens are less effective because more than 72 hours have elapsed. When using an IUD for emergency contraception, the eligibility criteria are the same as those for regular use of these devices.

## Essential information for users

Information on emergency contraception should be available to all women who may need the method. Whether contained in product pamphlets or offered by a service provider, it should include guidance on the following:

- Correct use
- Possible side-effects and their management
- Risk of pregnancy (detection and management of possible failure of the ECPs to prevent pregnancy)
- Changes in the menstrual pattern
- Preferences for regular contraception
- Risk of sexual transmitted infection

### Risk of pregnancy

If menstruation is delayed by more than one week from the expected time or if it is much lighter than normal, emergency contraception may have failed and the woman should consider the possibility that she may be pregnant. In the event of a pregnancy, she should be counselled on the available options and her decision should be respected and supported. If she chooses to continue with the pregnancy, she should be reassured that there is no evidence that hormonal emergency contraception affects the foetus. The use of hormonal emergency contraception has no impact on future fertility.

### Regular contraception

After use of emergency contraception, the woman should employ another method of contraception (e.g. condoms) if she continues to have sexual intercourse. If oral contraception is chosen, it can be started the day after the ECP regimen is completed. Women who begin regular use of hormonal contraception immediately after emergency contraception should be advised to expect withdrawal bleeding three weeks after starting the pills. Women choosing a long-acting hormonal contraceptive should start the method after the onset of the first menstrual period or after pregnancy has been excluded. Women opting for the IUD for emergency contraception should be advised that the IUD will provide ongoing protection from pregnancy from the time of insertion: follow-up should be arranged after the expected date of menstruation to ensure that pregnancy has been prevented and for counselling on regular contraception. Women who choose to continue using the IUD for long-term contraception should subsequently

receive the same services as any other IUD user. If a woman chooses to have the IUD removed, she should be advised to come back during menstruation for removal and initiation of another contraceptive method.

### **Sexually transmitted infections (STIs)**

Emergency contraception does not protect against sexually transmitted infections. Women who have had unprotected intercourse should be advised about the possibility of STIs. Those who may have been exposed to STIs should be offered testing or presumptive treatment that cures the commonly occurring STIs and be counselled appropriately. For women who may have been exposed to HIV, post-exposure prophylaxis with ARVs should be offered where available and with appropriate counselling and follow-up.

### **Advocacy and Access**

IPPF member associations have an important role to play in increasing awareness of emergency contraception and advocating for easy access to it in local communities. Member associations should undertake activities in the following areas:

**Increasing the availability** - Member associations providing services should include emergency contraception in their method mix and integrate emergency contraception into their national programmes. Associations can play a lead role in ensuring the existence of a dedicated emergency contraception product in their countries and campaigning for its over-the-counter status.

**Advocacy and dissemination** - Member associations should disseminate information on emergency contraception and how to obtain it, by various means including mass media, training of service providers, and sexual and reproductive health education programmes. Information geared specifically to the needs of young people is particularly important.

**Increasing access to supplies and services** - Emergency contraception should be widely available in clinical and non-clinical settings such as community-based services, social marketing programmes, and the commercial sector. Member associations can work to increase access through the advance provision of emergency contraception to individual women.

**Overcoming obstacles** - Member associations should initiate locally relevant efforts aimed at removing any existing social, cultural, and religious barriers to emergency contraception.

*Statement developed by the International Medical Advisory Panel (IMAP), May 2000 and revised after its October 2003 meeting. IMAP reserves the right to amend this Statement in the light of further developments in this field.*

#### **INTERNATIONAL PLANNED PARENTHOOD FEDERATION**

REGENT'S COLLEGE, INNER CIRCLE, REGENT'S PARK, LONDON, NW1 4NS, UK

TELEPHONE: +44 (0)20 7487 7847

AX +44 (0)20 7487 7981

E-MAIL ADDRESS: [medtech@ippf.org](mailto:medtech@ippf.org)

IPPF WEBSITE: [www.ippf.org](http://www.ippf.org)