



Consensus Statement on Emergency Contraception

"PROGRAMA UNIVERSITARIO DE
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Twenty-four experts from around the world, representing the fields of research, policy, communications, women's advocacy and medicine, gathered at the Rockefeller Foundation Conference Center in Bellagio, Italy, in April 1995 to discuss emergency contraception. The conference was hosted by South-to-South Cooperation in Reproductive Health and co-sponsored by the International Planned Parenthood Federation, Family Health International, the Population Council and the World Health Organization. The conference was supported by the Rockefeller Foundation. CONTRACEPTION 1995;52:211-213

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Background

Emergency contraceptives are methods that women can use after intercourse to prevent pregnancy.^{1,2} Emergency contraceptives are sometimes called post-coital or morning-after contraceptives. Several methods of emergency contraception are safe and effective. These include two tablets of ethinyl-estradiol/levonorgestrel oral contraceptive given twice, 12 hours apart, and the insertion of a copper intrauterine device (IUD). These regimens avert approximately 75 to 99% of the pregnancies expected among women seeking treatment.³ Levonorgestrel alone may also be used.⁴ A promising antiprogesterone, mifepristone, is currently under study to establish the optimal dose.^{5,6}

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Any woman at risk of unwanted pregnancy may need these methods occasionally. Millions of unwanted pregnancies could be averted if emergency contraceptives were widely accessible.

Existing regimens are usually inexpensive, often consist simply of altered doses of widely available medications and have been used for decades in some countries. So why are emergency contraceptives not used more widely? We believe that there are three main hurdles to making the option of emergency contraception available to all women who require it.

First, women and providers are uninformed about the methods. Particularly because of the short time frame within which women must use emergency contraception following unprotected intercourse, women must know about the methods *before they need them*. We call upon family planning providers to educate themselves about the methods and to educate women at routine visits. We encourage the prophylactic provision of emergency contraceptives so that women can have them on hand as needed.

Second, there are few products marketed for emergency contraceptive use. Most methods involve use of medications marketed for routine contraception. We call upon regulatory agencies throughout the world to require manufacturers of appropriate combined oral contraceptives and copper IUDs to inform the public about the emergency uses of these products. The pharmaceutical industry should cooperate to produce and publicize complete, accurate information and to educate health care providers about the emergency use of suitable products.

Third, service providers are too often reluctant to provide this method. In case there is any misunderstanding, emergency contraceptives are *not* abortifacient. Emergency contraceptives prevent unwanted pregnancy.

Women everywhere should have access to these safe and effective ways to prevent unwanted pregnancy. We must make access to emergency contraception a reality.

Proposed Recommendations

Methods

1. Methods of emergency contraception should be effective, safe, convenient to use and easily accessible. Among the methods now available, ethinyl-estradiol/dl-norgestrel combination oral contraceptives and the copper intrauterine device (IUD) best meet these requirements and should be provided. We recommend additional research, however, to improve these methods and to develop new ones responsive to women's needs. When developing contraceptive products, researchers should explore and develop any potential these products may have for emergency contraceptive use.

2. The class of compounds known as anti-progestogens appears very promising for emergency use. Anti-progestogens deserve top medical research priority.

Policy and Regulatory

3. Inter-governmental agencies, governments and non-governmental organizations (NGOs) should ensure that emergency contraceptives are included in all family planning programs and on all national essential drug lists.

4. Drug regulatory authorities should require explicit description of emergency use in the labelling of ethinyl-estradiol/dl-norgestrel oral contraceptives and for the copper IUD.

IEC/Advocacy

5. Advocacy and information/education/communication (IEC) activities should be developed collaboratively and should foster community and policy support among women's groups, professional associations, health advocates, policymakers, non-governmental organizations, donors and community leaders. Potential users of emergency contraception require information on the methods *before* they need them. Therefore, IEC efforts should be broad-based, culturally sensitive and locally relevant.

6. IEC strategies should consider groups with special needs, such as adolescents.

Service Delivery, Monitoring, Service Evaluation

7. Emergency contraception should be made available to all women who seek it, provided no contraindications are present. Women should be able to select from among available emergency contraceptive methods. Providers should think broadly about women for whom emergency contraception is appropriate,

including women who are not currently using a family planning method, women who are currently using a family planning method but are concerned that the method may have failed or who have not used that method one or more times, and women who may currently not be part of the family planning client base, such as adolescents and single women. Each group should be considered in formulating IEC strategies.

8. In order to prevent pregnancy following acts of sexual violence and coercion, emergency contraception should also be available from other sources of support, such as sexually transmitted disease clinics, rape crisis centers, police stations and hospitals.

9. Training in emergency contraception should be included in the curricula of all medical and non-medical personnel who will be involved in health care delivery. Training should include counselling as well as method-specific service requirements, including treatment regimens, management of side effects and proper follow-up.

10. Women seeking emergency contraception should also be counselled and offered a choice of effective and reliable methods of contraception for regular use in addition to receiving an appropriate emergency contraceptive. When the environment is not conducive to proper counselling and/or service provision, clients should be referred to an appropriate service provider for ongoing contraception when appropriate.

11. In all family planning consultations, women choosing a method of contraception for which emergency contraception is an appropriate backup (e.g., barrier methods, periodic abstinence) should be informed about and, when appropriate, provided with emergency contraceptives for future use.

12. Hormonal emergency contraception is appropriate for distribution through many channels, including clinics, over-the-counter in pharmacies, and community-based programs. Any provider trained in IUD insertion can provide IUDs for emergency use.

13. Research should be conducted on innovative service delivery options.

14. Data should be collected on emergency contraceptive use. Questions about emergency contraception should appear in national surveys such as contraception prevalence and demographic/health surveys, as well as in country- or program-based situation analyses.

The views expressed are those of the participants and do not necessarily reflect the views of the cosponsoring organizations of the conference.

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