

EMERGENCY CONTRACEPTIVE PILLS

Medical and Service Delivery Guidelines



International Consortium *for*
Emergency Contraception

VDA Net srl



International Federation of
Gynecology & Obstetrics (FIGO)

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These guidelines were created by a group of experts working with the International Consortium for Emergency Contraception. They have been endorsed by the International Federation of Gynecology and Obstetrics (FIGO), whose representatives participated in reviewing the guidelines.



The International Consortium for Emergency Contraception (ICEC) unites organizations and individuals committed to a common mission: to expand access to emergency contraception, with an emphasis on developing countries. For more information about ICEC, visit our website at: www.emergencycontraception.org.

These guidelines may be freely reviewed, abstracted, and translated in part or whole, provided that publication credit is given to ICEC.

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Foreword

The mission of the International Consortium for Emergency Contraception is to expand access to emergency contraception, with an emphasis on developing countries. Founded in 1996 by seven international organizations (the Concept Foundation, International Planned Parenthood Federation, the Pacific Institute for Women's Health, PATH, Pathfinder International, the Population Council, and WHO's Special Programme of Research, Development and Research Training in Human Reproduction), the Consortium now brings together several dozen agencies and hundreds of individuals in support of its mission. The Consortium first produced guidelines in 2000, based on guidelines initially created by Pathfinder, PATH and IPPF. The guidelines were revised in 2004 and again now, in 2012. Despite more than 15 years of efforts to expand access to EC, this contraceptive method still remains out of reach for many women.

The Consortium has produced these medical and service delivery guidelines about oral emergency contraceptive pills to assist family planning programs and providers in assuring that the women they serve can use these regimens effectively and safely. This document reflects the latest available evidence and has been reviewed by internationally recognized reproductive health experts. Local programs are welcome to adapt these guidelines as needed to comply with national or other requirements.

These guidelines do not discuss the use of the copper-bearing intrauterine device for emergency contraception. This device is the most effective emergency contraceptive option and should be offered to women when appropriate. Further information about this option is available on the ICEC website (www.emergencycontraception.org) and the Emergency Contraception website managed by Princeton University and the Association of Reproductive Health Professionals (www.not-2-late.com).

We hope these updated guidelines will help you in your work, whether you are a pharmacist or pharmacy worker, health provider, program manager, policy maker or advocate. We welcome your participation in our community of practice, which is open to all committed to ICEC's mission of expanding access to EC; please feel free to contact us via our website at www.emergencycontraception.org.

EMERGENCY CONTRACEPTIVE PILLS: MEDICAL AND SERVICE DELIVERY GUIDELINES

Summary Service Protocol

Indication: Emergency Contraceptive Pills (ECPs) are indicated to prevent pregnancy after unprotected or inadequately protected sex.

ECP Regimens: Three regimens are packaged and labeled specifically for emergency contraception.

- Levonorgestrel 1.5 mg, or levonorgestrel 0.75 mg taken twice 12 hours apart
- Ulipristal acetate 30 mg
- Mifepristone 10-50 mg

Take the pills within 5 days after sex, as soon as possible after the sex act.

How ECPs Work: The primary mechanism is disruption of ovulation. Other mechanisms have been postulated but are not well supported by data. No evidence supports the theory that ECPs interfere with the implantation of a fertilized egg. ECPs do not cause abortion of an existing pregnancy.

ECP Efficacy: The levonorgestrel regimen reduces pregnancy risk by at least half and possibly by as much as 80-90% for one act of unprotected intercourse. The ulipristal and mifepristone regimens are more effective than the levonorgestrel regimen.

Safety: ECPs have no known medically serious complications. Side effects may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. ECPs do not appear to be harmful if inadvertently taken in pregnancy.

Precautions and Contraindications: ECPs have no medical contraindications. Do not take ECPs if you are pregnant because they will not work.

Clinical Screening: You do not need any examinations or laboratory tests before taking ECPs.

ECP Use After More Than One Sex Act: Take ECPs after each unprotected sex act; do not wait until a series of acts has occurred. Use only one ECP treatment at a time (e.g., within a 12 hour period).

Repeated ECP Use: Use ECPs as often as needed. However, deliberate use of ECPs as a regular, routine contraceptive method is not recommended because more effective methods exist for this purpose.

Drug Interactions: Concurrent use of some drugs may reduce ECP efficacy. However, the ECP regimen is the same whether or not you are using these drugs.

Follow-up after ECP Use: No scheduled follow-up is required after ECP use. But if you have not had a menstrual period by 3 weeks after taking ECPs, consider that you may be pregnant.

Starting or Resuming Regular Contraceptives after ECP Use: ECPs are not designed to provide contraceptive protection at sex acts that occur in the future. Using a regular contraceptive after taking ECPs is CRITICAL to minimizing your pregnancy risk. Start hormonal methods (oral contraceptives, patch, vaginal ring, injectables, implants, levonorgestrel intrauterine system) either immediately or after your next menstrual period; if you wait, use a barrier method such as condoms in the interim. Copper-bearing IUDs provide highly effective emergency contraception, so you do not need oral ECPs if you get this type of IUD within 5 days after sex. Do not rely on fertility awareness methods until you have had at least one normal menstrual period.

Resources

- International Consortium for Emergency Contraception website: www.emergencycontraception.org
- The Emergency Contraception website, managed by Princeton University and the Association of Reproductive Health Professionals: www.not-2-late.com

1. INTRODUCTION

Despite the availability of highly effective methods of contraception, many pregnancies are mistimed or unwanted. These pregnancies may carry a high risk of morbidity and mortality, particularly in settings where safe abortion is not accessible or where quality obstetric services are not available for those women continuing a pregnancy to term. Many of these unintended pregnancies can be avoided using emergency contraceptive pills (ECPs).

2. INDICATIONS

ECPs are drugs taken orally that can be used to prevent pregnancy after an unprotected or inadequately protected sex act. ECPs are sometimes referred to as “morning after pills” or “postcoital oral contraceptives.”

ECPs are indicated when:

- no contraceptive was used;
- a contraceptive was used incorrectly;
- a contraceptive was used correctly but was immediately observed to have failed.

Examples of common situations in which ECPs may be needed by a woman who is using a routine contraceptive method are listed below.

Method	A woman should consider using ECPs after sex if...
Oral contraceptives, contraceptive patch, vaginal ring	<ul style="list-style-type: none"> • she started the method later in the menstrual cycle than instructed. • she did not use the method consistently as instructed during the cycle. • she used drugs that might have reduced the effectiveness of the method.
Progestin-only injections	<ul style="list-style-type: none"> • she started the method later in the menstrual cycle than instructed. • the period of contraceptive protection from the last injection ended before the sex act.
Implant	<ul style="list-style-type: none"> • the period of contraceptive protection from the implant ended before the sex act.
Intrauterine device or system	<ul style="list-style-type: none"> • the device had been expelled. • she cannot feel the string. • the period of contraceptive protection from the device ended before the sex act.
Condoms	<ul style="list-style-type: none"> • the condom broke, slipped, or was used incorrectly.
Diaphragm or cap	<ul style="list-style-type: none"> • the device dislodged or was removed before or during sex. • the device dislodged or was removed earlier after sex than instructed.
Spermicide	<ul style="list-style-type: none"> • she did not insert the spermicide before sex as instructed. • the spermicide tablet or film failed to melt before sex.
Fertility awareness methods	<ul style="list-style-type: none"> • she was in the fertile period when she had sex. • she is uncertain about whether or not she was in the fertile period when she had sex.
Coitus interruptus	<ul style="list-style-type: none"> • ejaculation occurred in the vagina or on the external genitalia.

Because of the difficulties in determining the risk of pregnancy in any particular situation and the serious consequences of a mistimed or unwanted pregnancy, a woman who does not want to be

pregnant should consider taking ECPs after any sex act during which contraceptive protection was not reasonably assured.

ECPs are particularly indicated in cases of non-consensual sex (rape) when the woman was not protected by an effective contraceptive method.

3. ECP REGIMENS

These guidelines focus primarily on two oral ECP regimens, one containing the progestin hormone levonorgestrel, and the other containing the progesterone receptor modulator ulipristal acetate:

- Levonorgestrel regimen: 1.5 mg levonorgestrel in a single dose or in two doses of 0.75 mg taken 12 hours apart;
- Ulipristal acetate regimen: 30 mg ulipristal acetate in a single dose.

The levonorgestrel regimen appears to be effective for at least 4 days after sex¹ and potentially up to 5 days. The ulipristal regimen appears to be effective for 5 days after sex.^{2,3} Taking either regimen as promptly as possible within these time frames is prudent and is strongly recommended.

Both regimens are marketed as dedicated products specifically packaged and labeled for emergency contraception. Products based on the levonorgestrel regimen are currently available in most countries in the world. Ulipristal-based ECP products are all produced by a single manufacturer. These products were first sold in Europe in 2009, in the USA in 2010, and are now also available elsewhere.

Two other ECP regimens have been well studied, one containing mifepristone, a progesterone receptor modulator, and the other containing a combination of estrogen and progestin hormones:

- Mifepristone regimen: 10-50 mg mifepristone as a single dose;
- Combined hormonal (Yuzpe) regimen: one dose of 100 mcg ethinyl estradiol plus 0.5 mg levonorgestrel followed by a second identical dose 12 hours later.

Mifepristone ECPs are available as dedicated ECP products in only a few countries, including China, Vietnam, and Russia. The combined hormonal regimen is not currently marketed anywhere, but it can be made up from many brands of widely available oral contraceptive pills. This regimen may be useful in settings where none of the dedicated products are available. Some data suggest that both the mifepristone and combined hormonal regimens are effective up to 3 days after sex and possibly up to 5 days.^{4,5}

Listings of ECP products and regimens by country are available at www.emergencycontraception.org and www.not-2-late.com.

4. MODE OF ACTION

The primary documented mechanism of action for both the levonorgestrel and ulipristal regimens is interference with the process of ovulation.⁶⁻⁹ If taken before the pre-ovulatory luteinizing hormone surge has started, levonorgestrel can inhibit the surge, impeding follicular development and maturation and/or the release of the egg itself. Ulipristal has been shown to prevent ovulation both before and after the surge has started, delaying follicular rupture for at least 5 days.⁸

These regimens have been shown not to prevent implantation of a fertilized egg into the uterus in several studies.^{6,9-11} Additional postulated mechanisms include interference with corpus luteum function; thickening of the cervical mucus resulting in trapping of sperm; and alterations in the tubal transport of sperm or egg.

If taken after implantation has occurred, the levonorgestrel regimen has no effect on an existing pregnancy and does not increase rates of miscarriage.^{12,13} Early data on ulipristal do not show any effect on existing pregnancies.

5. EFFICACY

Twelve studies of the levonorgestrel regimen that included a total of more than 13,500 women concluded that this regimen reduced a woman's chance of pregnancy after a single sex act by between 52% and 100%.^{2,4,14-23} A rigorous analysis of data from two randomized trials demonstrated that the levonorgestrel regimen reduces the absolute risk of pregnancy after an unprotected sex act by at least 49% (95% confidence interval 17-69%).²⁴

Some data suggest that the efficacy of the levonorgestrel regimen decreases with time since coitus.^{18,25} In contrast, a combined analysis of data from four large trials did not find a significant decline in efficacy of this regimen over the first 4 days after sex. In this analysis, the regimen appeared to have minimal or no efficacy if taken on day 5.¹

Several studies have found that both the efficacy and the side effects of the levonorgestrel regimen are equivalent whether the hormone is taken as a single 1.5 mg dose or as 2 doses of 0.75 mg either 12 or 24 hours apart.^{4,14,15}

Two randomized trials have found that the ulipristal regimen is at least as effective as the levonorgestrel regimen when used within 72 hours after sex.^{2,18} An analysis that combined data from these trials suggested that the ulipristal regimen is more effective through five days after sex.² No decline in efficacy of the ulipristal regimen was apparent within 5 days after sex.

With any EC regimen, the risk of pregnancy is substantially higher if the woman has subsequent unprotected sex acts in the same menstrual cycle than if she does not.

Some data from Europe and North America suggest that the levonorgestrel regimen may be less effective in obese women than in thinner women.² Whether the same is true for the ulipristal regimen is not yet clear. Increasing the dose of either regimen in obese women has never been studied and is not recommended.

The mifepristone regimen is more effective than the levonorgestrel regimen²⁶ but it has never been directly compared to the ulipristal regimen. A recent systematic review indicated that doses of 25-50 mg mifepristone may be significantly more effective for emergency contraception than a dose of 10 mg.²⁶

The combined hormonal regimen is the least effective of the four ECP regimens.²⁶

Although ECPs are effective in reducing pregnancy risk after unprotected sex, increasing the availability of this method to populations has not been shown to reduce rates of unintended pregnancy or abortion.^{27,28} The reason for this apparent discrepancy is likely at least in part because even with ready access to ECPs, women do not use them after every unprotected sex act. In addition, one study suggested that easy access may encourage some women to substitute ECPs for other, more effective contraceptive methods.²⁹ Tackling the public health problem of unintended pregnancy requires a multi-dimensional approach of which provision of ECPs is only one aspect.

6. SIDE EFFECTS

ECPs are extraordinarily safe. No deaths or serious complications have been causally linked to any ECP regimen. Side effects that are medically minor but may be troublesome to some users are described below.

6.1 Altered vaginal bleeding patterns

Most women who have used ECPs have their next menstrual period within 7 days of the expected time. Menstruation has been reported to occur on average 1 day earlier than expected after use of the levonorgestrel regimen and 2 days later than expected after use of ulipristal. About 24% of women in clinical trials of ulipristal reported a delay of more than 7 days.² Some women experience irregular

bleeding or spotting after taking ECPs.^{30,31} The proportion with this side effect varies between different studies. Bleeding alterations due to ECPs are not dangerous and will resolve without treatment.

6.2 Nausea and vomiting

Nausea, rarely accompanied by vomiting, occurs in less than 20% of women using the levonorgestrel regimen^{4,20} and in about 12% of women using the ulipristal regimen.^{2,3} These symptoms are uncommon enough that prophylactic administration of an antiemetic drug is not routinely warranted before use of these regimens. If vomiting occurs within two or three hours after taking an ECP dose, some experts recommend that the dose should be repeated.³²

6.3 Other symptoms

Other symptoms that may occur in users of ECPs include headache, abdominal pain, breast tenderness, dizziness, or fatigue. These side effects usually do not occur more than a few days after treatment, and they generally resolve within 24 hours.

7. EFFECTS ON PREGNANCY

Studies of women who became pregnant despite using the levonorgestrel regimen or who used it inadvertently after becoming pregnant indicate that this regimen does not harm either a pregnant woman or her fetus; in particular, it does not increase rates of miscarriage, low birth weight, congenital malformations, or pregnancy complications.^{12,13} According to the ulipristal ECP product manufacturer, few pregnancies have been reported to date after the ulipristal regimen, but no complications have been noted in those pregnancies.

8. PRECAUTIONS AND CONTRAINDICATIONS

ECPs are not dangerous under any known circumstances or in women with any particular medical conditions. Recognized contraindications to oral contraceptives do not apply to ECPs. In particular, the following conditions are NOT contraindications to ECPs: young age, obesity, personal or family history of venous thromboembolism, prior or current breast cancer, prior ectopic pregnancy, breastfeeding, migraine headaches, cardiovascular disease, liver disease, diabetes, hypertension, and prior ECP use in the same menstrual cycle.

ECPs are not indicated for a woman who has a confirmed pregnancy because they will have no benefit. However, if an evaluation for pregnancy has not been performed or if pregnancy status is unclear, ECPs may be used, as no evidence exists suggesting harm to a developing fetus.

9. CLINICAL SCREENING

Because ECPs are safe for all women and women can determine for themselves whether they have had unprotected or inadequately protected sex, no provider screening is needed before use of ECPs. Clinical assessments (e.g., pregnancy tests, blood pressure measurements, laboratory tests, pelvic examination) are not necessary.

10. SPECIAL ISSUES

Several issues commonly raised regarding ECPs are discussed below.

10.1 Use in Adolescents

Adolescents' access to ECPs should not be limited by clinical or programmatic concerns. ECPs are safe for all women regardless of age. Adolescents do not suffer greater rates of side effects³³ and are able to comprehend the label and other instructions about how to use the method.³⁴

10.2 Breastfeeding

A woman who is less than six months postpartum, is exclusively breastfeeding, and has not had a menstrual period since delivery is unlikely to be ovulating and therefore is unlikely to need ECPs. However, a woman who does not meet all three criteria may be at risk for pregnancy. The levonorgestrel

regimen of ECPs is not contraindicated during lactation. The manufacturer of the ulipristal ECP product recommends that nursing mothers should feed the baby immediately before taking the tablet and then express and discard the milk for the next 36 hours, or she should use another ECP regimen.

10.3 Use of ECPs before sex

No data are available about how long the contraceptive effect of ECPs persists after the pills have been taken. Presumably, ECPs taken immediately before sex are as effective as ECPs taken immediately afterwards. However, if a woman has the opportunity to plan to use a contraceptive method before sex, a method other than ECPs, such as condoms or another barrier method, is recommended.

10.4 Use after more than one unprotected act

Women should try to use ECPs as promptly as possible after each unprotected sex act; waiting until a series of acts has occurred is not recommended. However a woman should not refrain from taking ECPs simply because she has had multiple unprotected sex acts, although she should be aware that the efficacy of the ECPs may be limited if the earliest unprotected act was more than 4-5 days earlier. She should use only one ECP treatment at a time regardless of the number of prior unprotected acts.

10.5 Repeated use

ECPs are not intended for deliberate repeated use or use as a regular, routine contraceptive method. After using ECPs, women who do not wish to become pregnant in the future are advised to initiate or resume using an established ongoing contraceptive. No specific data are available about the efficacy or safety of frequent use of current ECP regimens. However, at least 10 studies have confirmed that levonorgestrel 0.75 mg administered multiple times per cycle causes no serious adverse effects; the most common side effect was irregular bleeding.³⁵ These data provide reassurance that women may safely use the levonorgestrel regimen as many times or as often as needed. Some experts recommend that no more than one dose is needed in a 12 hour period.³² The manufacturer of the ulipristal ECP product recommends that it should not be used more than once in a cycle, although no evidence is provided to support this recommendation.

Whether the efficacy of the levonorgestrel regimen is reduced by recent or subsequent use of ulipristal, which is a progesterone receptor modulator, is unknown. Therefore, if a woman who has recently used the levonorgestrel regimen has a subsequent need for emergency contraception, she should probably use the levonorgestrel regimen again. If a woman who has recently used the ulipristal regimen needs emergency contraception a second time, she should consider having a copper-bearing IUD inserted. If that is unacceptable, inappropriate, or unavailable, then no data are available to guide her as to which ECP regimen she should use. Repeated use of ECPs is safer than pregnancy.

10.6 Use of ECPs during the “infertile period”

Studies have shown that fertilization can result from sex only during a 5-7 day interval around the time of ovulation.³⁶ Theoretically, ECPs should not be needed if unprotected sex occurs at other times in the cycle, because the chance of pregnancy even without ECPs would be zero. However, in practice, determining whether a specific act occurred on a fertile or infertile cycle day is often impossible. Therefore, women should not refrain from using ECPs because of the assumption that a particular sex act occurred on a nonfertile day.

10.7 Drug interactions

No specific data are available about interactions of ECPs with other drugs. However, it seems reasonable to assume that drug interactions with the levonorgestrel regimen might be similar to those with regular daily oral contraceptive pills. Thus, efficacy of this regimen may be reduced by concomitant use of drugs that may reduce oral contraceptive efficacy (including but not limited to rifampicin, griseofulvin, certain anticonvulsant drugs, Saint John’s wort, and certain antiretroviral drugs).

The packaging of the ulipristal regimen lists potential interactions with these same drugs and also with bosentan and medicines used to treat acidity of the stomach or ulcers (for example, omeprazole).

Women who are using these drugs or have taken them in the past month and need emergency contraception should consider using a copper-bearing IUD. If the levonorgestrel ECP regimen is selected, some experts recommend taking double the dose (3 mg levonorgestrel).³² The manufacturer of the ulipristal ECP product does not recommend changing the dose if this regimen is chosen.

Because ulipristal is a progesterone receptor modulator, it may in theory reduce the efficacy of other hormonal contraceptives containing progestin hormones. However, no data are available on this matter.

10.8 Ectopic pregnancy

All contraceptive methods reduce the absolute risk of ectopic pregnancy by preventing pregnancy in general. A systematic review of world literature found that 1% of pregnancies occurring after use of the levonorgestrel regimen and 0.6% of pregnancies occurring after use of the mifepristone regimen were ectopic. These figures are similar to the risk that pregnancies not exposed to ECPs will be ectopic. Thus, the review concluded that neither regimen increases the chance that a pregnancy will be ectopic.³⁷

11. SERVICE DELIVERY SYSTEMS

Because of the short timeframe during which ECPs are effective, unique service delivery issues arise in ensuring that women can benefit maximally from ECPs.

11.1 Advance education

Every effort should be made to ensure that all women and men are informed about ECPs before the need arises. Key messages include:

- A woman who does not want to be pregnant should consider using ECPs any time she has sex that was not adequately protected by effective contraception;
- She should try to obtain and use the emergency contraceptive as promptly as possible;
- ECPs are not intended for ongoing, routine contraception; an established method is recommended for that purpose.

In addition, every woman should know where and how she can obtain ECPs in her community. To ensure that she will have ECPs available whenever she needs them, she may consider obtaining a package in advance.

Providers and programs may disseminate these messages by numerous approaches. These include:

- Routinely informing women about ECPs at all visits to clinics, pharmacies, or other facilities where health care is provided;
- Informing abortion clients about ECPs;
- Including information about ECPs on clinic or pharmacy websites and telephone answering machines;
- Distributing information about ECPs with other contraceptive supplies or medications;
- Including information about ECPs in health education programs in schools, youth centers, or other venues;
- Instituting mass media informational and advertising campaigns for ECP products and services.

11.2 ECP provision settings

To facilitate access, ECPs should be readily available. Because no clinician screening or assessment is needed and women can decide on their own whether the treatment is needed, ECPs may appropriately be sold over-the-counter, as they are in most countries. However, if women may have difficulty obtaining ECPs because a prescription is required or for some other reason, providers and programs may use the following approaches to ensure that women can obtain and use this treatment quickly:

- Provide an advance prescription or supply;
- Prescribe by telephone without seeing the woman;

- Allow non-physician personnel, such as pharmacy staff, nurses, and community health workers, to provide ECPs;
- Ensure that all personnel who provide care or counseling to women presenting after sexual assault routinely offer ECPs to these women;
- Distribute ECPs in non-clinical settings, like schools, non-pharmacy commercial outlets, and social service offices.

12. PROVIDING ECPs

Because many women who use ECPs will obtain them over-the-counter, input from a health professional may not be available. However, if a provider is present, the following guidelines may be useful.

12.1 Selecting and providing the method

- A copper IUD is the most effective emergency contraceptive, and it offers the added benefit of ongoing contraception for at least 10 years. Therefore, consider offering this alternative to oral ECPs if it is readily available and the woman is medically eligible to receive it.
- If the woman chooses to use oral ECPs and if both ulipristal and levonorgestrel ECP products are readily available, inform her that the ulipristal regimen may be more effective, particularly if 4-5 days have elapsed since the first unprotected sex act. However, if only one of these products is available, the client should consider using that product immediately rather than delaying treatment in order to obtain an alternate product.
- If the levonorgestrel regimen is selected and the particular product provided contains two tablets of 0.75 mg levonorgestrel, advise the woman to take both tablets at once rather than 12 hours apart as on the package label. Taking the two pills together will not compromise efficacy or increase side effects, but it is more convenient and will avoid the possibility that a second dose will be lost or forgotten.
- If possible, provide the desired ECPs and recommend that the woman swallow them immediately. Alternatively, provide a prescription and instructions about where in the community the woman can obtain the product.
- Tell the client that if she does not have a menstrual period within 3 weeks after taking the pills, she should consider the possibility that she may be pregnant and seek appropriate evaluation and care.

12.2 Optional additional services

Additional services are not necessary but should be provided if the client desires. These services may include:

- Provision of a regular contraceptive method (see Section 13);
- Pregnancy testing;
- Testing, prophylaxis, or treatment for sexually transmitted infections. (Inform the woman that tests will not necessarily diagnose very recent infections, in particular infections that she may have acquired at the most recent unprotected sex act. If that is a concern, recommend retesting after an appropriate time interval.)

ECPs should not be withheld from clients who decline these additional services.

12.3 Follow-up

No scheduled follow-up is required after ECP use unless the client identifies a problem or question. However, she should be encouraged to seek follow-up care if she:

- Needs ongoing contraception or wishes to switch methods;
- Has not had a menstrual period by 3 weeks after taking the ECPs, as this could be a sign of pregnancy;

- Has irregular bleeding with lower abdominal pain more than a few days after taking ECPs, as these could be symptoms of an ectopic pregnancy;
- Desires evaluation for sexually transmitted infections;
- Needs management of issues related to rape;
- Has any other health concerns.

13. STARTING OR RESUMING REGULAR CONTRACEPTIVES AFTER ECP USE

ECPs do not provide contraception for later sex acts. Therefore, after using ECPs, a woman should select another method to use before she resumes sexual activity. The following table indicates when a woman may start a regular method after ECPs.

Desired method	When to initiate
Condoms or other barrier methods	<ul style="list-style-type: none"> • Start using immediately at the next sex act.
Hormonal methods: Oral contraceptives Contraceptive patch Vaginal ring Injectables Implants Levonorgestrel intrauterine system	<ul style="list-style-type: none"> • Start using immediately – that is, the same day as the ECPs, or the following day. Use a barrier method for 7 days after the levonorgestrel ECP regimen or for 14 days after the ulipristal ECP regimen. • Alternatively, start after the next menstrual period, but use a barrier method in the interim. • Before insertion of implants or the hormonal intrauterine system, a pregnancy test to rule out preexisting pregnancy may be advisable for practical or cost reasons (not for safety reasons).
Copper-bearing intrauterine device	<ul style="list-style-type: none"> • A copper-bearing IUD inserted within 5 days after sex will provide highly effective emergency contraception. Therefore, oral ECPs are not needed if this type of IUD is inserted in this time interval. • If a woman wants a copper-bearing IUD more than 5 days after using ECPs, it may be inserted after the start of the next menstrual period.
Fertility awareness methods	<ul style="list-style-type: none"> • Initiate after the first normal menstrual period following ECP use. Note that the first bleeding episode after taking ECPs may not be a “normal” menstrual period. • Use a barrier method until the first normal period.
Sterilization	<ul style="list-style-type: none"> • Perform the procedure after the start of the menstrual period following ECP use. • Use a barrier method until the sterilization is completed.

14. IF THE USER BECOMES PREGNANT

A woman who has used ECPs may later find herself to be pregnant because the ECPs have failed, because she was already pregnant before taking the ECPs, or because sex acts after taking the ECPs led to pregnancy. In any of these cases, she should be aware that ECPs have no known adverse effects on a pregnancy. Whether she chooses to continue the pregnancy or to seek abortion, she should know that she does not need any special management because of exposure to ECPs.

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Further information about specific issues of interest,
including listings of specific ECP products by country,
may be found through the following websites:

- International Consortium for Emergency Contraception website:
www.emergencycontraception.org
- The Emergency Contraception website, managed by Princeton University
and the Association of Reproductive Health Professionals:
www.not-2-late.com