IPPF

From choice, a world of possibilities

February 2018

IMAP Statement on emergency contraception

Emergency contraception refers to any contraceptive method that can be used after having unprotected or inadequately protected sexual intercourse but before pregnancy occurs, providing women with the opportunity to prevent an unwanted pregnancy.

Introduction

This statement has been prepared by the International Medical Advisory Panel (IMAP) and was approved in November 2017.

Emergency contraception (EC) refers to any contraceptive method that can be used after having unprotected or inadequately protected sexual intercourse (UPSI) but before pregnancy occurs, providing women with the opportunity to prevent an unwanted pregnancy. EC is a safe and effective method for preventing unwanted pregnancy and can reduce the risk of pregnancy by up to 99%.

In spite of its effectiveness, EC is not frequently used after UPSI.[1] In many countries, women face barriers to accessing EC. The majority of women in low-income countries are unaware of EC. Moreover, some providers have negative attitudes toward providing EC to women and girls.[2]

One of the common reasons for denying women access to EC is that it is equated to medical abortion. Consequently, it is important to emphasise that EC prevents pregnancy – it does not end a pregnancy. Education of the public, providers and policy makers must therefore stress that EC cannot cause an abortion, that it is safe to use for women of all ages and that there are few side effects.

Dedicated EC products are available in most countries of the world and are listed in many countries' essential medicine lists.[3] EC is included in the list of 13 essential commodities in the Framework for Action of the UN Commission on Life-Saving Commodities for Women and Children.[4] EC is also a component of the Minimum Initial Service Package (MISP) for reproductive health in emergencies and part of the Inter-Agency Reproductive Health Kits for clinical management of rape and short-acting methods of family planning (FP) (Kits 3 and 4).[5]

The purpose of this Statement

This statement aims to provide guidance for health care providers to improve the provision of emergency contraceptive services according to the latest research, experiences and international recommendations, and as an essential method of comprehensive contraceptive services. It is also meant to inform advocacy for the removal of legal and policy barriers to the use of EC.

Intended audience

The statement is primarily intended to inform IPPF Member Associations on this important issue and provide clarity on IPPF's position with regard to EC as an essential part of comprehensive contraceptive services. It is also aimed at other sexual and reproductive health (SRH) organizations, activists, researchers, and policy and decision makers.

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EC methods, effectiveness, and mechanisms of action

There are several methods for EC, including copper IUDs and various pills (emergency contraceptive pills (ECPs)). The most commonly used methods are described below.

INTRAUTERINE DEVICES

The most effective method for EC is placement of a copper intrauterine device (IUD) within five days of an episode of UPSI. When the time of ovulation can be estimated, a Cu-IUD can be inserted beyond five days after intercourse, as long as insertion does not occur more than five days after ovulation.[6] Any copper IUD is safe and effective. No evidence exists on the effectiveness and safety of hormonal intrauterine contraception as EC.

After post-coital insertion of an IUD, the pregnancy rate is less than 0.1%.[7] Furthermore, the IUD can provide up to 12 years of ongoing contraceptive protection after placement.

The main mechanism of action of the IUD is to prevent fertilisation by inhibiting sperm viability and function. If ovulation has already occurred and fertilisation has taken place, copper ions influence the female reproductive tract and impair endometrial receptivity. If a woman is already pregnant, use of an IUD is contraindicated.[8]

LEVONORGESTREL PILLS

Levonorgestrel (LNG) is a progestin that has been used for contraception for more than 50 years. Each ECP contains 1.5 mg of LNG. It is also available in the form of two pills of 750 mcg, which can be taken together.[9] According to the World Health Organization (WHO), LNG ECPs can be used until 120 hours (five days) after UPSI, but they should be used as soon as possible.[10] Based on recent analyses, the Faculty of Sexual and Reproductive Healthcare (FSRH) in the UK has concluded that LNG is ineffective after 96 hours.[11,12]

The effectiveness of LNG ECPs was studied in a multicentre WHO trial in 1998.[13] Overall, 1.1% of the women became pregnant after using LNG ECPs within 72 hours after UPSI. In a meta-analysis of two more recent studies, comparing LNG ECPs with ECPs containing ulipristal, the effectiveness appeared to be lower. In this meta-analysis, 2.2% of the women became pregnant despite using LNG ECPs.[14]

LNG ECPs work by inhibiting or delaying ovulation. LNG ECPs have no effect on sperm function, embryo viability, or endometrial receptivity. Because ovulation is delayed, no fertilisation takes place. LNG ECPs do not cause an abortion. They are no longer effective if ovulation or fertilisation have occurred. They also do not harm a pregnancy if the woman is already pregnant.[15]

ULIPRISTAL ACETATE PILLS

Ulipristal acetate (UPA) is a selective progesterone receptor modulator. It was recently introduced as an alternative to LNG ECPs. It is dosed at 30 mg. UPA ECPs have been approved for use until 120 hours (five days) after UPSI.

The previously mentioned meta-analysis of studies in which LNG and UPA were compared showed a higher effectiveness of UPA. Of the women who had used UPA ECPs within 72 hours after UPSI, 1.4% became pregnant, compared to 2.2% pregnancies within the LNG group. If EC was taken within 24 hours after UPSI, there was an even larger difference (0.9% versus 2.3% in the UPA and LNG groups respectively).[16,17]

Like LNG ECPs, the main mechanism of action of UPA is prevention of follicular rupture and ovulation. However, in contrast with LNG, UPA is still effective after the onset of the luteinising hormone (LH) surge which precedes ovulation but not post LH peak. This means that there is a wider 'window of effect' for UPA, which explains its higher effectiveness.[18]

OTHER EC METHODS

A few methods are less common. Low-dose mifepristone pills (10, 25 or 50 mg) are available in a few countries, such as Russia, China and Vietnam.[19,20]

A high dose of combined hormonal pills (the Yuzpe method) was commonly used until LNG-only pills were introduced, and they still are in contexts where no other options are available. This consists of a dose of 0.1 mg ethinylestradiol and 0.5 mg LNG and a repeat dose 12 hours later. It is less effective and leads to more side effects than LNG-only ECPs.[21,22]

When can EC be used?

EC is recommended after any episode of UPSI for any girl or woman who wants to avoid becoming pregnant. UPSI generally means that either no contraceptive method was used during intercourse, or that the effectiveness of the contraceptive method was compromised during its use. The effectiveness of contraception may be lower due to, for example, irregular use of pills or incorrect use of a condom. If a woman is aware of these risks, she may reduce the chance of getting pregnant by taking EC.

TIME FRAME FOR USING EC

It is important to let women know that EC may still be used later than 'the morning after'. However, ECPs should be taken as soon as possible after UPSI. The effectiveness of ECPs is highest when they are taken within 24 hours of UPSI.[23] EC can be used to prevent pregnancy up to 120 hours (five days) after UPSI.

REPEAT USE OF EC

There are no known adverse health effects if ECPs are used more than once during the same menstrual cycle, although the bleeding pattern will be affected. However, if a woman has many episodes of UPSI, it may be advisable to recommend that she considers using a more effective contraceptive method or that she changes her current method. Repeated use of ECPs would entail the same contraindications as those of regular hormonal contraceptive methods.[24] An IUD as EC may be useful in this case, and should be suggested as a first choice.[25] Although no long-term adverse health effects are to be expected from repeat use, women do suffer more from side effects if they use ECPs repeatedly, particularly bleeding irregularities.[26]

Concerns have been raised about whether easy access to ECPs could lead to lower uptake of regular contraception. However, there is no evidence of such a relationship.

Effectiveness of ECPs is not affected by repeat use and remains the same for each UPSI. However, overall effectiveness over one-year use is lower than most modern contraceptives, so ECPs should not be recommended as an ongoing method of contraception.[27]

Concerns have been raised about whether easy access to ECPs could lead to lower uptake of regular contraception. However, there is no evidence of such a relationship. For example, women who receive an advance supply of ECPs have been found to be more likely to use them when they have had UPSI, but are not more likely to abandon regular contraception.[28]

Safety of EC

All common EC methods are extremely safe and have limited side effects.

The WHO eligibility criteria have no absolute contraindications for using ECPs. The main contraindication against all EC methods is a pre-existing pregnancy. A pregnancy test is however not necessary before taking ECPs, since they have no adverse effect on an existing pregnancy. In such cases, ECPs are no longer effective.[29] The only examination that is essential before using copper IUDs is a pelvic/genital examination/STI clinical risk assessment.[30] It is recommended that a routine pregnancy check is done before insertion of an IUD, because this may lead to a spontaneous abortion if a woman is already pregnant.[31]

When a woman is breastfeeding, IUDs can be used for EC. If ECPs are preferred, LNG ECPs may be used. Although a small amount of LNG appears in breast milk, no adverse effects on the quality or quantity of the milk, or on the infant have been identified.[32,33] When UPA ECPs are used, it is recommended to pump and discard the milk during one week, after which breastfeeding can be resumed.[34] Nevertheless, studies on mifepristone (a compound very similar to UPA) at higher doses show very low levels in breast milk that are not considered to be harmful.[35]

In case of a history of severe cardiovascular disease, migraine or severe liver disease, there may be theoretical risks in using ECPs, but the advantages generally outweigh the disadvantages.[36] IUDs may be inserted regardless of history or risk of STIs, previous ectopic pregnancy, young age, and nulliparity. However, if a woman is diagnosed with STIs, particularly gonorrhoea or chlamydia, broad-spectrum antibiotics should be used.[37,38]

EC should also be made available to all women and girls in humanitarian contexts or emergency response programmes.

SIDE EFFECTS

The side effects after insertion of an IUD for EC are the same as when an IUD is inserted for ongoing contraception. These include abdominal discomfort and changes in vaginal bleeding or spotting.[39] Some of the side effects of copper IUDs, such as expulsion or heavy menstrual bleeding, are only relevant when a woman decides to keep the IUD for ongoing protection.[40]

The side effects that are reported by users of LNG and UPA ECPs are similar. Most common are headaches, which are mentioned by less than 20%. Dysmenorrhoea and nausea are each reported by less than 15% of users. Abdominal pain, dizziness, fatigue, upper abdominal pain and back pain are mentioned by around 5% or less of users.[41] Additionally, women may experience irregular vaginal bleeding after using ECPs.[42,43]

LONG-TERM HEALTH EFFECTS

No serious adverse health effects have been reported for ECPs; specifically, no causal relationship has been found with thromboembolism after ECPs use.[44] Because ECPs are used occasionally, the hormonal intake is much lower than among women who use LNG for a longer period of time, therefore adverse events are unlikely.[45] Experience with UPA is less extensive, but so far no serious adverse health outcomes have been identified.[46,47]

When women present for EC, counselling may include several elements to help women make responsible and informed decisions. However, when women are not required to get a doctor's prescription for ECPs they may not receive any counselling. Nevertheless, lack of counselling should not constitute a barrier to obtaining and using EC.

Counselling

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REDUCE BARRIERS

It is important for counsellors to be respectful and non-judgmental of the woman or girl and to be responsive to her needs.[48] Women may feel anxious or ashamed when they require EC and supportive attitudes may improve adherence as well as enable constructive counselling, for example about using effective contraception regularly. There may be several misconceptions among women in need of EC, which may make them reluctant to use EC, especially repeatedly. These should be addressed in counselling.[49]

EC should also be made available to all women and girls in humanitarian contexts or emergency response programmes.

WHICH METHOD

Many people are unaware that the copper IUD can be used as EC.[50] Because of its high effectiveness and its ability to function as an ongoing method, the IUD should be made available and offered to every woman who needs EC. Women who decide to use an IUD must be medically eligible for the insertion.[51]

If oral ECPs are preferred, UPA is the method of choice because it is more effective than LNG, particularly if more than 72 hours have lapsed. Women with high body weight who do not want to use an IUD may be advised to take UPA. There is some evidence that the effectiveness of LNG ECPs decreases with increasing body weight, more so than with UPA ECPs.[52,53]

However, if LNG is more readily available and the window of 120 hours has not been exceeded, it is generally advisable to use LNG, as the effectiveness of ECPs decreases over time. If a progestogen-containing contraceptive (which is true for all hormonal contraceptive methods) has been taken within a week prior to the ECP use or if the start of such a method is planned within five days after EC use (or since UPSI), then LNG should be recommended.[54,55]

Where no dedicated ECP products are available, the Yuzpe method is an option, because 8-10 ordinary combined oral contraceptive pills (OCPs) can be used, depending on their dosage (adding up to 0.1 mg of ethinyl estradiol and 0.5 mg of LNG, with the same dose repeated after 12 hours).

REGULAR CONTRACEPTION

It is important to counsel women who need EC about regular methods of contraception. Not only will women who have not used any regular contraception benefit from a discussion about alternative options; women who repeatedly have trouble using their chosen method correctly may be better off with another method as well. Health providers should however be aware that not every woman who needs EC is willing to discuss regular contraception, and that, although strongly recommended, it should not be considered a prerequisite for provision of EC.[56]

Quick starting OCPs is critical, because there are increased odds of becoming pregnant when women have sex soon *after* having used ECPs.[57] After use of ECPs, and (quick) starting hormonal contraception, a backup contraceptive method (such as condoms) needs to be used for the next seven days (or only two days when progestin-only pills are used).[58,59] There may be drug interactions between UPA and regular hormonal contraception.[60,61] While findings are inconclusive, it is advisable to wait until the sixth day after using UPA ECPs before starting hormonal contraception, until more is understood about this relationship.[62,63] However, for women with missed pills or who want to quick start a hormonal method, LNG ECPs may be the best option.

STI RISK

ECPs do not prevent the transmission of sexually transmitted infections (STIs). It is important to emphasise that this applies to all contraceptives other than condoms and should not constitute a selective bias against ECPs. Furthermore, because EC is used *after* the UPSI, any transmission will have already occurred. If a woman is at risk of an unwanted pregnancy, she may be at risk of STIs as well and STI and HIV testing could be offered.[64]

Many women in developing countries have never heard of EC. Lack of awareness is the first barrier that must be overcome in order to make EC accessible to all women who need it. Member Associations have a critical role to play in educating the public and thereby creating demand for EC.

Recommendations for Member Associations and other organizations

Member Associations should work with ministries of health and other stakeholders to ensure that EC is available to every woman who needs it, every time she needs it. Any barriers to the use of EC should be actively removed. Member Associations should ensure availability of contraceptive supplies, including EC, and support the education of women and girls and the public about the possibility of preventing pregnancy after UPSI by using EC.

EDUCATION

Many women in developing countries have never heard of EC.[65] Lack of awareness is the first barrier that must be overcome in order to make EC accessible to all women who need it. Member Associations have a critical role to play in educating the public and thereby creating demand for EC.[66] Various strategies can be used to reach the public, including written information material, such as brochures and posters; mass media, such as television infomercials; and m-health in the form of a text messaging campaign.[67]

Health care providers also need to be educated on EC to address negative attitudes, misperceptions and lack of awareness, which are common barriers to access. Health care providers in several developed and developing countries have been found to object to the provision of EC and many have received inadequate training with regard to EC. Member Associations can contribute to ensure provider education – with attention to attitudes – is addressed in national policies.[68,69]

EC is important for all women, and IPPF Member Associations should make every effort to provide these services. However, there are some women who warrant special attention, particularly young women and survivors of sexual violence.

SERVICE PROVISION MODELS

IPPF Member Associations are mandated to provide a comprehensive and integrated package of essential SRH services (IPES) that comprises a broad method mix of contraception including emergency contraception. EC is a critical component of the Minimum Initial Service Package (MISP)/SRH services in humanitarian contexts. Below are models that Member Associations can adopt to improve EC provision.

EC services can be provided with or without the need to consult a physician. For IUDs, a physician or trained family planning practitioner (nurse/midwife) is required to insert the device. For ECPs, there is no medical need for a doctor's intervention. Increasingly, ECPs have become available over the counter, without prescription.[70] ECPs are now available in vending machines in women's toilets at Stanford University Student Union. This model will no doubt be a game-changer, similar to the male condom vending machines in men's public toilets.[71]

Social marketing, the provision of contraceptives by non-profit and non-governmental organisations, mostly through existing commercial and clinic channels, has been demonstrated to make EC readily available to women. Many EC programmes have become self-supporting because of the high volumes of sales through social marketing. Social marketing programmes can be particularly important in challenging contexts, or in reaching otherwise hard-to-reach populations.[72]

SPECIFIC TARGET GROUPS

EC is important for all women, and IPPF Member Associations should make every effort to provide these services. However, there are some women who warrant special attention, particularly young women and survivors of sexual violence.

Young people

Although EC is very important for young people, they may face challenges that make ensuring EC access particularly critical. For example, they may have been inadequately prepared for having sex, because of a lack of comprehensive sexuality education; access to all contraceptives may be restricted, and it may be more difficult for them to use methods correctly; young people may find it more difficult to negotiate contraceptive use with a partner; and age restrictions may be upheld for EC.[73]

There is no medical necessity for an 'age threshold'; girls and women of all ages should be able to obtain EC when they need it. Young people and adolescents may use IUDs for EC as well as ECPs. Insertion of an IUD is possible among young and nulliparous women.[74]

Survivors of sexual violence

For women and girls surviving rape, EC should be offered systematically if the rape has taken place less than five days before. These women and girls should be enabled to do everything they can to avoid becoming pregnant with their assaulter's child. To facilitate access, EC needs to be made available whenever and wherever post-rape care is provided, including police stations.[75,76] Women and girls who have been raped may also be at increased risk of STIs; prophylactic regimens should be offered for different STIs, including HIV.[77]

Conclusion

- Emergency contraception is a safe and effective method of preventing unplanned pregnancy, following unprotected sexual intercourse. Emergency contraception is not medical abortion.
- Emergency contraception should be available to all women who need it, especially young women and girls and survivors of sexual violence.
- IUDs should be considered as one of the options for those needing emergency contraception as they are more effective than ECPs and can bridge to being a long-acting method.
- IPPF Member Associations can play a critical role in advocating for improved laws and policies to reduce barriers to emergency contraception.
- As key providers of comprehensive contraception services, IPPF Member Associations need to ensure that they are providing a wide range of contraceptive methods, including various options for emergency contraception.

References

1 Goulard, H, Moreau, C, Gilbert, F, Job-Spira, N, Bajos, N, the Cocon Group (2006) Contraceptive failures and determinants of emergency contraceptive use. *Contraception.* 74, pp. 208-213.

2 Westley, E, Kapp, N, Palermo, T, Bleck, J (2013) A review of global access to emergency contraception. 123, pp. 4-6.

3 Ibid.

4 United Nations (2012) *UN Commission on Life Saving Commodities for Women and Children Commissioners' Report September 2012*. New York: UN.

5 UNFPA (2011) Inter-Agency Reproductive Health Kits for Crisis Situations. Available at: <https://www.unfpaprocurement.org/c/document_library/get_file?uuid=acbe2252-3dd4-47b2-a390-66f720bb7877&groupId=10157>.

6 World Health Organization (2016) *Selected Practice Recommendations*. 3rd ed. Geneva: WHO.

7 Cleland, K, Zhu, H, Goldstuck, N, Cheng, L, Trussell, J (2012) The effectiveness of intrauterine devices for emergency contraception: A systematic review of 35 years of experience. *Human Reprod.* 27 (7), pp. 1994-2000.

8 Gemzell-Danielsson, K, Berger, C, Lalitkumar, PGL (2013) Emergency contraception – mechanisms of action. *Contraception.* 87, pp. 300-308.

9 Von Hertzen, H, Piaggio, G, Ding, J, WHO Research Group on Postovulatory Methods of Fertility Regulation (2002) Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: A WHO multicentre randomized trial. *Lancet.* 360, pp. 1803-1810.

10 World Health Organization (2016). Op. cit.

11 Cameron, ST, Li, HWR, Gemzell-Danielsson, K (2017) Current controversies with oral emergency contraception. *BJOG.* 124, pp. 1948-1956.

12 Faculty of Sexual and Reproductive Healthcare (2017) *FSRH Guideline Emergency Contraception.* Available at: <https://www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017/>.

13 Task Force on Postovulatory Methods of Fertility Regulation (1998) Randomized controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet.* 352, pp. 428-433.

14 Glasier, AF, Cameron, ST, Fine, PM, Gainer, E (2010) Ulipristal acetate versus levonorgestrel for emergency contraception: A randomised non-inferiority trial and meta-analysis. *Lancet.* 375, pp. 555-562.

15 Gemzell-Danielsson, K, Berger, C, Lalitkumar, PGL (2013). Op. cit.

16 Glasier, AF, Cameron, ST, Fine, PM, Gainer, E (2010). Op. cit.

17 Shen, J, Che, Y, Showell, E, Chen, K, Cheng, L (2017) Interventions for emergency contraception. *Cochrane Database of Systematic Reviews.* 7, CD001324. doi 10.1002/14651858.CD001324.pub5.

18 Gemzell-Danielsson, K, Berger, C, Lalitkumar, PGL (2013). Op. cit.

19 Von Hertzen, H, Piaggio, G, Ding, J, WHO Research Group on Postovulatory Methods of Fertility Regulation (2002). Op. cit.

20 Shen, J, Che, Y, Showell, E, Chen, K, Cheng, L (2017). Op. cit.

21 Task Force on Postovulatory Methods of Fertility Regulation (1998). Op. cit.

22 Shen, J, Che, Y, Showell, E, Chen, K, Cheng, L (2017). Op. cit.

23 Cleland, K, Zhu, H, Goldstuck, N, Cheng, L, Trussell, J (2012). Op. cit.

24 World Health Organization (2015) *Medical Eligibility Criteria for Contraceptive Use.* 5th ed. Geneva: WHO.

25 Faculty of Sexual and Reproductive Healthcare (2017). Op. cit.

26 International Consortium for Emergency Contraception (2015) *Repeated Use of Contraception: The Facts.* New York, NY: ICEC.

27 Raymond, EG, Halpern, V, Lopez, L (2011) Pericoital oral contraception with levonorgestrel: A systematic review. *Obstetrics & Gynecology.* 117, pp. 673-681.

28 International Consortium for Emergency Contraception (2015). Op. cit.

29 Gemzell-Danielsson, K, Berger, C, Lalitkumar, PGL (2013). Op. cit.

30 World Health Organization (2016). Op. cit.

31 World Health Organization (2015). Op. cit.

32 Shen, J, Che, Y, Showell, E, Chen, K, Cheng, L (2017). Op. cit.

33 Stewart, F, Trussell, J, and Van Look, PFA (2007) Emergency contraception. In Hatcher, RA, Trussell, J, Nelson, AL, Cates Jr, W, Stewart, F, Kowal, D (eds) *Contraceptive Technology.* 19th revised edition. New York, NY: Ardent Media Inc.

34 World Health Organization (2015). Op. cit.

35 Sääv, I, Fiala, C, Hämäläinen, JM, Heikinheimo, O, Gemzell-Danielsson, K (2011) Medical abortion in lactating women: Low levels of mifepristone in breast milk. *Acta Obstetrica et Gynecologica Scandinavica.* 89, pp. 618-622.

36 World Health Organization (2015). Op. cit.

37 Faculty of Sexual and Reproductive Healthcare (2017). Op. cit.

38 Glasier, A (2013) Emergency contraception: Clinical outcomes. *Contraception.* 87, pp. 309-313.

39 International Consortium for Emergency Contraception (2015). Op. cit.

40 Glasier, A (2013). Op. cit.

41 Glasier, AF, Cameron, ST, Fine, PM, Gainer, E (2010). Op. cit.

42 Stewart, F, Trussell, J, and Van Look, PFA (2007). Op. cit.

43 Richardson, AR, Maltz, FN (2012) Ulipristal acetate: Review of the efficacy and safety of a newly approved agent of emergency contraception. *Clinical Ther.* 34 (1), pp. 24-36.

44 Vasilakis, C, Jick, SS, Jick, H (1999) The risk of venous thromboembolism in users of postcoital contraceptive pills. *Contraception.* 59, pp. 79-83.

45 International Consortium for Emergency Contraception (2015). Op. cit.

46 Richardson, AR, Maltz, FN (2012). Op. cit.

47 Levy, DP, Jager, M, Kapp, N, Abitbol, JL (2014) Ulipristal acetate for emergency contraception: postmarketing experience after use by more than 1 million women. *Contraception.* 89, pp. 431-433.

48 Stewart, F, Trussell, J, and Van Look, PFA (2007). Op. cit.

49 Nappi, RE, Lobo Abascal, P, Mansour, D, Rabe, T, Shojai, R, and the Emergency Contraception Study Group (2014) Use of and attitudes towards emergency contraception: A survey of women in five European countries. *European Journal of Contraception and Reproductive Health Care.* 19, pp. 93-101.

50 Wright, RL, Frost, CJ, Turok, DK (2012) A qualitative exploration of emergency contraception users' willingness to select the copper IUD. *Contraception.* 85, pp. 32-35.

51 World Health Organization (2015). Op. cit.

52 Glasier, A, Cameron, ST, Blithe D, Ulmann, A (2011) Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception.* 84, pp. 363-367.

53 Festin, MPR, Peregoudov, A, Seuc, A, Kiarie, J, Temmerman, M (2017) Effect of BMI and body weight on pregnancy rates with LNG as emergency contraception: analysis of four WHO HRP studies. *Contraception.* 95, pp. 50-54.

54 Faculty of Sexual and Reproductive Healthcare (2017). Op. cit.

55 Dawson, A, Tran, N-T, Westley, E, Mangiaterra, V, Festin, M (2014) Improving access to emergency contraception pills through strengthening service delivery and demand generation: A systematic review of current evidence in low and middle-income countries. *PLOS ONE.* 9, e109315.

56 Stewart, F, Trussell, J, and Van Look, PFA (2007). Op. cit.

57 Glasier, A (2015). Starting hormonal contraception after using emergency contraception: What should we recommend? *Human Reproduction.* 30, pp. 2708-2710.

58 World Health Organization (2016). Op. cit.

59 Faculty of Sexual and Reproductive Healthcare (2017). Op. cit.

60 Brache, V, Cochon, L, Duijkers, IJM, Levy, DP, Kapp, N, Abitbol, JL, Klipping, C (2015). A prospective, randomized, pharmacodynamic study of quick-starting a desogestrel progestin-only pill following ulipristal acetate for emergency contraception. *Human Reproduction.* 30, pp. 2785-2793.

61 Cameron, ST, Berger, C, Michie, L, Klipping, C, Gemzell–Danielsson, K (2015) The effects on ovarian activity of 'quick-starting' a combined oral contraceptive pill after ulipristal acetate: prospective, randomised, double-blind parallel-arm, placebo-controlled study. *Human Reproduction.* 30, pp. 1566-1572.

62 World Health Organization (2016). Op. cit.

63 Glasier, A (2015). Op. cit.

64 Stewart, F, Trussell, J, and Van Look, PFA (2007). Op. cit.

65 Westley, E, Kapp, N, Palermo, T, Bleck, J (2013). Op. cit.

66 Garcia, M, and Puig Borrás, C (2015) Available at: <http://www.cecinfo.org/icec-publications/top-tips-advocates-working-emergency-contraception/>.

67 Dawson, A, Tran, N-T, Westley, E, Mangiaterra, V, Festin, M (2014). Op. cit.

68 Westley, E, Kapp, N, Palermo, T, Bleck, J (2013). Op. cit.

69 Garcia, M, and Puig Borrás, C (2015). Op. cit.

70 European Consortium for Emergency Contraception (2016) *An update on access to emergency contraception in European Union countries.* Available at: <http://www.ec-ec.org/custom-content/uploads/2016/04/UPDATE-Access-to-EC-in-EU-countries-ECEC-April2016.pdf>.

71 Caron, C (2017) Students look to vending machines for better access to emergency contraception. *The New York Times*, 28/9/2017. Available at: <https://nyti.ms/2fAAFPg>.

72 Westley, E, and Shochet, T (2013) Social marketing of emergency contraception: Are we missing a valuable opportunity. *Contraception.* 87, pp. 703-705.

73 Garcia, M, and Puig Borrás, C (2015). Op. cit.

74 World Health Organization (2015). Op. cit.

75 Dawson, A, Tran, N-T, Westley, E, Mangiaterra, V, Festin, M (2014). Op. cit.

76 International Consortium for Emergency Contraception (2013) *Emergency Contraception for Rape Survivors: A human rights and public health imperative.* New York, NY: ICEC.

77 Krause, KH, Lewis-O'Connor, A, Berger, A, Votto, T, Yawetz, S, Pallin, DJ, Baden, LR (2014) Current Practice of HIV postexposure prophylaxis treatment for sexual assault patients in an emergency department. *Women's Health Issues.* 4, e407-e412.

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WHO WE ARE

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

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