Emergency contraception (EC) can safely prevent pregnancy after unprotected sex and fills a unique niche in the family planning method mix. Twenty years of global partnerships have resulted in a dramatic increase in the availability of emergency contraceptive products, yet closer examination reveals that access remains limited, especially in developing countries. In these pages, we describe current access to EC, identify access gaps and barriers, and investigate root causes of these gaps. We offer the following recommendations for advocates, policymakers, and other partners to improve women’s reproductive health by expanding access to EC.

1. Disseminate accurate information about EC to dispel myths and misperceptions among policymakers, health care providers, and women and communities.
2. Create supportive national policy environments for EC by allowing over-the-counter access, incorporating EC into family planning guidelines, and integrating EC into public sector health systems.
3. Integrate EC into the family planning components of provider training, including pre-service training and ongoing professional development for pharmacists, doctors, nurses, midwives, and other providers.
4. Increase EC awareness and demand among women and communities through behavior change communication activities and other community-based interventions.
5. Provide EC in all instances of post-rape care by implementing and enforcing policies requiring EC counseling and provision to sexual assault survivors.
6. Make EC routinely available in all crisis settings.
7. Incorporate EC more fully into existing social marketing programs.
8. Define and fill knowledge and research gaps on EC access.

ABOUT EMERGENCY CONTRACEPTION

What is EC?
“Emergency contraception” refers to contraceptive methods that can be used to prevent pregnancy after sex. These methods include several kinds of emergency contraceptive pills (ECPs) as well as insertion of a copper-bearing intrauterine device (IUD). EC offers women an important second chance to prevent pregnancy when a regular contraceptive method fails, was used incorrectly, or was not used at all, or when sex was forced.

Currently, the most commonly used EC method is a special dose of a hormone called levonorgestrel (LNG) in pill form. Other methods can be used and may be more effective, but at this point, the LNG form of ECPs is the most widely available in developing countries.

How do ECPs work?
ECPs work by interfering with the process of ovulation – in other words, by preventing the release of an egg. They may also interfere with the meeting of the egg and sperm. ECPs will not stop a fertilized egg from implanting in the uterus and cannot interrupt or harm an established pregnancy.

ECPs are sometimes confused with medical abortion (also called the “abortion pill”), but the two treatments are very different. ECPs work after unprotected sex but before pregnancy, while medical abortion works after pregnancy starts (once the fertilized egg is implanted in the uterus).

How safe is EC?
Extensive research and many years of monitoring show that ECPs are extremely safe. They may cause minor short-term side effects, such as irregular menstruation, but they have no long-term effects. They do not affect future fertility or increase the risk of cancer or ectopic pregnancy.

ECPs are appropriate for over-the-counter use without screening by a health care professional, regardless of a woman’s age or history. According to the World Health Organization (WHO), repeated use of ECPs is safe, so women can take ECPs as often as needed. However, like other hormonal contraception, ECPs offer no protection from sexually transmitted infections, including HIV.

Is EC effective?
ECPs are effective up to 5 days after unprotected intercourse and are more effective the sooner they are used. This has implications for service delivery: to use ECPs effectively, women require rapid access, including on nights and weekends. For every 1,000 women who use ECPs after unprotected sex, about 20 will face an unintended pregnancy; without ECPs, this number would be about 80. The IUD can also be used for EC and is almost entirely effective. It also has the added advantage of providing ongoing contraceptive protection.

Who should use EC?
Emergency contraception is appropriate for all women, regardless of their age or marital status, who need to prevent pregnancy after unprotected or inadequately protected sex. This includes:
• Women whose barrier method failed – a condom broke, diaphragm slipped, or cap dislodged.
• Women who were not using their regular contraceptive method – they were late for an injection, needed to refill a pack of birth control pills, or just forgot.
• Women using natural family planning who did not abstain from sex at the correct time.
• Women who were unable to negotiate contraceptive use with their partner or did not expect to have sex so did not have any contraceptive methods available.
• Women who were raped or were coerced into having sex.
• Any woman who had unprotected sex and does not want to get pregnant.
CURRENT ACCESS TO EC

EC pill products are registered in most countries

EC is registered in the vast majority of countries around the world (purple on the map). Several countries (many of which have faltering regulatory systems) do not have a registered EC product but do allow EC to be imported into the country (blue). A small number of countries do not have a registered product and do not import EC (yellow). These include a few countries with active, religiously-based opposition to EC (Costa Rica, Honduras, Malta, and the Philippines), those affected by conflict, some Middle Eastern countries, and some very small countries.

Global policies support EC

The most commonly used type of emergency contraception, called levonorgestrel, is included in the WHO’s Essential Medicines List as well as its guidelines for family planning and for care after sexual assault. The International Federation of Gynecology and Obstetrics (FIGO) recommends that “emergency contraception be easily available and accessible at all times to all women.”

ECPs can be purchased by donors or governments. Many donors, including UN agencies and donor country governments, have procured EC for many years.

EC provision varies by sector

The private commercial sector is providing EC in virtually all countries where it is available. Private pharmacies, drug stores, and other outlets are often favored by women seeking EC. In most countries, the private commercial sector is a much more significant source of EC than the public sector.

In the public sector, just over half of developing countries surveyed (20 out of 37) offered EC in their public sector programs. Public sector support is critical to ensuring integration of EC education and counseling along with other contraceptive methods and making EC a routine part of post-rape care.

The social marketing sector is a natural fit for EC: women like to buy EC from pharmacies and often are willing to pay for it. However, a survey in early 2012 found that only a third of social marketing family planning programs offered an EC product.

Over 90 manufacturers produce emergency contraception. Manufacturers are located in Europe, the United States, Latin America, and Asia.
Providers’ knowledge and opinions of EC are often low

Front-line health care providers (such as medicine vendors, pharmacists, nurses, midwives, doctors, and others) are both gatekeepers to and facilitators of women’s access to health services. Surveys of health care providers in a number of countries, however, indicate that significant gaps still exist in knowledge about EC and that biases persist regarding the provision of EC.

Surveys conducted by the Population Council in Nigeria, Senegal, and India found substantial variation in providers’ attitudes toward EC and access to information and training on ECPs. In all three countries, the majority of providers surveyed said that they believe that EC is safe and effective; however, views on acceptable reasons for use and frequency of use, accessibility, and appropriate users were often less favorable. In Ethiopia, DKT International interviewed pharmacists and found many of them held incorrect beliefs about the safety of EC, especially when used repeatedly.

In some settings, reports have emerged of “provider refusals” in which pharmacists, doctors, or other health care providers withhold access to EC or information about EC. Laws and policies ensuring clients’ rights to receive the full range of contraceptive information and methods can help alleviate this issue, as can additional training and sensitization for service providers.

EC inclusion in family planning and post-rape care guidelines varies

Including EC in national family planning norms and guidelines is essential to standardizing EC counseling and provision as part of routine medical care. However, inclusion of EC in these policies varies widely. Country-level guidance on EC as a part of post-rape care is also uneven and evidence suggests that access to EC is poor in many post-rape care settings.

Only half of countries include EC in their Essential Medicines Lists

Most countries maintain a national Essential Medicines List (EML), which lists medicines determined necessary to meet the basic health needs of the country. Of 111 countries’ EMLs available via the WHO, 54 list dedicated EC products and 57 do not. Inclusion in EMLs is an important step toward full integration into public sector services, as governments generally do not supply drugs that are not listed in their EMLs.

Women too often need a prescription to access EC

Access to ECPs falls broadly into three categories: over-the-counter (OTC), behind-the-counter (BTC), and prescription-only. OTC products are available directly on the shelves of retail outlets. BTC products do not require a prescription, but they are held at the pharmacy counter. Prescription-only products can only be purchased after a woman obtains a prescription. This often requires women to make two trips, one to the doctor and one to the pharmacy, delaying access and presenting a significant barrier for women who lack transportation or live in rural areas. It also makes access to ECPs on weekends and at night (when many contraceptive mishaps occur) more difficult.

Only 7 countries allow direct access to ECPs over-the-counter. ECPs are available behind-the-counter in 67 countries, while they are available by prescription only in more than 100 countries. (However, anecdotal evidence suggests that in some contexts in which a prescription is officially required, women have reported being able to access EC over-the-counter.)

Most women in developing countries do not know about EC

Demographic and Health Surveys (DHS) provide standardized, comparable data about women’s knowledge and use of EC in developing countries around the world. These surveys show that despite more than 10 years of EC programming and marketing, most women do not know about EC and even fewer women have ever used it. Within the developing world, use seems to be highest in Latin America.

Providers’ knowledge and opinions of EC are often low

Front-line health care providers (such as medicine vendors, pharmacists, nurses, midwives, doctors, and others) are both gatekeepers to and facilitators of women’s access to health services. Surveys of health care providers in a number of countries, however, indicate that significant gaps still exist in knowledge about EC and that biases persist regarding the provision of EC.

Surveys conducted by the Population Council in Nigeria, Senegal, and India found substantial variation in providers’ attitudes toward EC and access to information and training on ECPs. In all three countries, the majority of providers surveyed said that they believe that EC is safe and effective; however, views on acceptable reasons for use and frequency of use, accessibility, and appropriate users were often less favorable. In Ethiopia, DKT International interviewed pharmacists and found many of them held incorrect beliefs about the safety of EC, especially when used repeatedly.

In some settings, reports have emerged of “provider refusals” in which pharmacists, doctors, or other health care providers withhold access to EC or information about EC. Laws and policies ensuring clients’ rights to receive the full range of contraceptive information and methods can help alleviate this issue, as can additional training and sensitization for service providers.

EC inclusion in family planning and post-rape care guidelines varies

Including EC in national family planning norms and guidelines is essential to standardizing EC counseling and provision as part of routine medical care. However, inclusion of EC in these policies varies widely. Country-level guidance on EC as a part of post-rape care is also uneven and evidence suggests that access to EC is poor in many post-rape care settings.

Only half of countries include EC in their Essential Medicines Lists

Most countries maintain a national Essential Medicines List (EML), which lists medicines determined necessary to meet the basic health needs of the country. Of 111 countries’ EMLs available via the WHO, 54 list dedicated EC products and 57 do not. Inclusion in EMLs is an important step toward full integration into public sector services, as governments generally do not supply drugs that are not listed in their EMLs.

Women too often need a prescription to access EC

Access to ECPs falls broadly into three categories: over-the-counter (OTC), behind-the-counter (BTC), and prescription-only. OTC products are available directly on the shelves of retail outlets. BTC products do not require a prescription, but they are held at the pharmacy counter. Prescription-only products can only be purchased after a woman obtains a prescription. This often requires women to make two trips, one to the doctor and one to the pharmacy, delaying access and presenting a significant barrier for women who lack transportation or live in rural areas. It also makes access to ECPs on weekends and at night (when many contraceptive mishaps occur) more difficult.

Only 7 countries allow direct access to ECPs over-the-counter. ECPs are available behind-the-counter in 67 countries, while they are available by prescription only in more than 100 countries. (However, anecdotal evidence suggests that in some contexts in which a prescription is officially required, women have reported being able to access EC over-the-counter.)

Most women in developing countries do not know about EC

Demographic and Health Surveys (DHS) provide standardized, comparable data about women’s knowledge and use of EC in developing countries around the world. These surveys show that despite more than 10 years of EC programming and marketing, most women do not know about EC and even fewer women have ever used it. Within the developing world, use seems to be highest in Latin America.
WHAT CAN WE DO TO EXPAND ACCESS TO EC?

Access to emergency contraception depends on factors ranging from policy environment and supply chain dynamics to providers’ and women’s knowledge and attitudes. To ensure that women have access to the full range of contraceptive choices, EC should be included in the broader framework of reproductive health care services. Advocacy efforts should emphasize EC’s unique niche within the family planning spectrum. The right to choose a contraceptive method includes the choice to access and use EC when a woman needs it.

This section provides recommendations to help governments, donors, NGOs, advocates, service providers, and other partners looking to improve women’s reproductive health by expanding access to emergency contraception. The most effective strategies will likely combine a number of the following recommended steps into an integrated approach to improving knowledge of and access to EC.

Dispel misperceptions and myths: Promote accurate information on EC

In order to combat confusion about how EC works and ambivalence about who should use it, it is critical to disseminate accurate, unbiased information about EC. This information should be adapted to local contexts for a wide range of audiences, including policymakers, health care providers, and women and communities. Some of the more controversial aspects of EC may need specific attention: how it differs from abortion, whether it is acceptable for youth to use, and whether it is appropriate for repeated use.

Key Messages:
• Women of any age, including youth, can use EC.
• EC is not abortion.
• EC is safe and can be used more than once.
• Women have a right to access EC as a contraceptive option when they need it.

Young women and EC:
Young women as a group have a special need for ECPs, as they are especially vulnerable to sexual coercion and forced sex, are less likely to be using an ongoing method, have less knowledge about contraception generally, and in some settings face increased discrimination from pharmacists and health care providers.

Evidence shows that adolescents and youth are able to use ECPs as safely and effectively as older women, and can understand the instructions necessary to access ECPs over-the-counter. Moreover, studies show that enhancing access to ECPs does not increase sexual or contraceptive risk-taking behavior in youth. ECPs are an important component of comprehensive care for young women, and young women have as much of a right to access EC as older women.

Messaging and advocacy campaigns should seek to ensure that youth have information about and access to EC.

The role of governments: Create supportive national policy environments and ensure public sector engagement in supplying and providing EC

At the country level, policies to support access to EC are critical, but they are uneven. Ideally, all countries should:
• Register at least one EC product;
• Include EC in national Essential Medicines Lists and family planning guidelines;
• Require EC provision as part of post-rape care;
• Ensure that EC is available over the counter without age restrictions;
• Integrate EC into public sector health systems at all levels;
• Include EC in provider training, including both pre-service training (such as pharmacy, nursing, and medical school) and in-service training (on-the-job training, job aids, contraceptive technology updates);
• Where appropriate, incorporate EC into community-based distribution;
• Procure EC;
• Integrate EC into supply systems and health information systems;
• Support activities to share information about EC with women, by including EC in health education materials and public information campaigns.

Public sector engagement legitimizes and standardizes care in many settings. Even though the private commercial sector does an excellent job in meeting demand for EC, it is important that the public sector is also involved, especially as it is often best positioned to supply EC as part of post-rape care. Key opinion leaders should be encouraged to mainstream EC into current family planning programs and other appropriate channels, including hospital emergency rooms, school-based clinics, sexual assault crisis centers, pharmacies, social marketing programs, and private health practices.

The public sector is also responsible for ensuring that locally available EC products are of high quality; this may require additional investments in regulatory and enforcement capacity.
Ensure that providers open the door for women to access EC: Training and integration with other FP services

Front-line health care providers must know about EC and be willing to provide it, as well as incorporate it into their counseling messages for all women (including women using barrier methods or any method that might fail). EC should routinely be included in the family planning components of both pre-service provider training and ongoing professional development for pharmacists, doctors, nurses, midwives, and other front-line providers.

EC training need not take up a lot of additional resources if it is integrated into training systems that already exist. Information on EC can be provided in short formats, such as pharmacy detailing materials and slide decks. Providers should know about the safety of ECPs (including when used more than once), the science of how ECPs work, clinical guidelines for administering ECPs, and use by various populations (including adolescents).

As part of these efforts, it is important to link ECPs with other sexual and reproductive health services, including voluntary HIV and other STI testing, counseling, and treatment, and provision of ongoing contraceptive counseling and services. Engaging with international professional bodies (representing pharmacists, nurses, and other providers) to create and disseminate guidelines and checklists for their members may be an effective approach.

Increase EC awareness and demand among women and communities

Most women in developing countries have never heard of EC. Governments, the commercial sector, and NGOs all have roles to play in increasing overall community-level knowledge and awareness of EC. Mainstreaming EC into current family planning counseling and provision programs is critical. More targeted efforts may also be needed to spread the word sufficiently.

Behavior change communication (BCC) activities can raise awareness about EC use and availability. BCC is intended to motivate individuals to seek out services and to reduce barriers to access by creating informed and voluntary demand, ensuring individuals can use products appropriately, and helping health care providers and clients interact with each other effectively. BCC activities may take the form of interpersonal communication, community sensitization and other community-based activities, mass media campaigns, and new communications technologies and social media efforts. These efforts can fuel positive attitudes, dispel myths, and improve access to information about EC.

Innovative strategies to increase awareness of EC:

- Develop materials (such as leaflets, information cards, and posters) that pharmacists and other health care providers can distribute to women or display in public places.
- Integrate EC into popular health websites and mHealth strategies.
- Place ads or stories in magazines or newspapers read by women of reproductive age.
- Encourage producers of popular media dramas to develop storylines incorporating EC messaging.
- Create public service messages addressing misperceptions about EC.
- Add EC into health worker curricula and materials, including for community-based health workers.

Require access to EC in post-rape care

Post-rape care is a particularly critical setting for EC provision, and policies at all levels should support it. This includes requiring first responders to counsel women about EC, ensuring that a dedicated EC product is dispensed on-site, and mandating that police officers, forensic examiners, and other emergency health providers receive sufficient training on EC provision. Advocates can work to ensure that EC is included in policies and that such policies are enforced.

Make EC consistently available in all crisis settings

In crisis settings, such as during and after conflicts and natural disasters, women are often in particular need of EC, as contraceptive supplies may be disrupted and sexual assault and transactional sex increase significantly. In fact, EC was identified as a critical need in the Balkan conflict in 1994 and has long been integrated into crisis emergency kits and supply packages.

However, assessments show that women have little access to EC in these situations, despite its having been integrated into systems and policies for almost 20 years. There is an urgent need to step up the focus on EC in crisis settings. EC should be made available from the beginning of a response to a humanitarian crisis and should continue to be available in long-term settings. Health workers may require additional training on EC if they are not familiar with its use.

Further capitalize on the potential for social marketing of EC

Social marketing programs have been extremely successful in making EC available to women, yet only a third of social marketing family planning programs include EC. Donors and social marketing organizations can greatly increase women’s access to EC by integrating it more fully into existing social marketing programs and looking for new EC markets. Technical support and financial “start-up” funds for integrating EC into current programming and orienting country-level staff may help address barriers faced by these agencies.

Define and fill knowledge gaps regarding EC access

Our review of data on EC access reveals that there are many areas for further investigation. Future research should largely focus on country-level and local access to EC:

- What are the most effective strategies to raise women’s awareness of EC?
- How can providers and systems better integrate EC into contraceptive counseling, post-rape care, and HIV-related services? Is community-based distribution a promising strategy?
- How and why do women choose EC, in the context of a range of contraceptive options?
- How can EC programs be tailored to meet the needs of the most vulnerable women?
- Why do some countries have such vibrant EC markets, while in others, EC uptake is slow?
- What can we learn from countries with successful EC programs?
- What strategies are effective to defend legal access to EC in countries with restrictive laws?

Investments in EC access have yielded great dividends: women in almost all countries can purchase EC, global policies and guidelines include EC, and many manufacturers supply EC. But at the country and local levels, access has stalled, especially for the most vulnerable – women who are poor, live in less developed countries, face sexual assault, or are affected by conflict. Advocates, donors, researchers, governments, and service delivery organizations must take the next steps so that all women can access the full range of contraceptive methods, including emergency contraception.
This report reflects three years of collaborative research and consultation, managed by the International Consortium for Emergency Contraception and involving partners from around the world. It was written by Elizabeth Westley, Sarah Rich, and Hilary Lawton. Staff and interns involved in this project also include Kathleen Schaffer, Jamie Bass, Philicia Castillo, Megan Guzman, Kristin Wunder, and Sidra Zaidi. Virginia Taddoni designed the publication, and Sandy Zimmerman designed the map.

ICEC thanks the Bill & Melinda Gates Foundation for their generous financial support that made this brief possible. The findings and conclusions contained within are those of the International Consortium for Emergency Contraception and do not necessarily reflect positions or policies of the Bill & Melinda Gates Foundation. In addition, for their contributions to the content of this brief, ICEC thanks Babatunde Ahonsi, Ian Askew, Isha Bhatnagar, Jennifer Bleck, Martha Brady, Kelly Cieland, Nafissatou Diop, Anvita Dixit, Emily Gold, Salisu Mohammed Ishaku, M.E. Khan, Babacar Mané, Fatou Bintou Mbow, Ayo Oginni, Tia Palermo, Andrew Piller, Saumya RamaRao, Tara Shochet, Ababacar Thiam, John Townsend, and Deepthi S. Varma.

Photo credits: Richard Lord, Women Deliver / After Before Photography

Data Sources

The majority of the information in this publication can be found within the website and publications of the International Consortium for Emergency Contraception (www.emergencycontraception.org). ICEC maintains a global database of EC status and availability by country, gathering data from pharmaceutical companies, key informants, and other sources.

Specific ICEC publications cited include:

- Emergency Contraceptive Pills Registration Status by Country (2013)
- Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (2010)
- How Social Marketing and NGOs are Expanding Access to Emergency Contraception (2012)
- The Intrauterine Device (IUD) for Emergency Contraception (2012)

External data sources include:

- AccessRH, Reproductive Health Interchange (http://www.myaccessrh.org/ri-home)
- MEASURE DHS, Demographic and Health Surveys, 2008-2012 (http://www.measuredhs.com)
- Population Council, research briefs on providers’ and key opinion leaders’ beliefs, attitudes, and practices concerning emergency contraception, 2011-2013 (http://www.popcouncil.org/projects/335_ProviderBeliefsPracticesEC.asp#/QueryUItabs1-3)