TRAINING MANUAL
ON
EMERGENCY
CONTRACEPTIVE PILLS
(ECPs)

PARTICIPANTS’ HANDBOOK
2018
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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>CBO</td>
<td>Community Based Organizations</td>
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<tr>
<td>CCW</td>
<td>Central Contraceptive Warehouse</td>
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<tr>
<td>CHC</td>
<td>Combined hormonal contraception/contraceptive</td>
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<td>CHEWS</td>
<td>Community Health Extension Workers</td>
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<tr>
<td>CHO</td>
<td>Community Health Officer</td>
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<td>CI</td>
<td>Confidence Interval</td>
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<td>CiSFP</td>
<td>Civil Society for Family Planning in Nigeria</td>
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<td>CLMS</td>
<td>Contraceptive Logistics management Information System</td>
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<td>COC</td>
<td>Combined Oral Contraceptives</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>Cu-IUD</td>
<td>Copper Intrauterine Device</td>
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<td>CYP450</td>
<td>Cytochrome P450 Hepatic Enzymes</td>
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<tr>
<td>DMPA</td>
<td>Depot Medroxyprogesterone acetate</td>
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<td>EC</td>
<td>Emergency Contraception</td>
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<td>Emergency Contraceptive Pill</td>
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<td>Emergency Contraception Promotion Project</td>
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<td>Intrauterine Contraceptive Device</td>
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<td>Lactational Amenorrhoea Method</td>
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<td>Long-acting Reversible Contraception/contraceptive</td>
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<td>Luteinising Hormone</td>
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<td>Last Menstrual Period</td>
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<td>LNG</td>
<td>Levonorgestrel</td>
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<td>LNG-EC</td>
<td>Levonorgestrel (for emergency contraception)</td>
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<td>LNG-IUS</td>
<td>Levonorgestrel-releasing intrauterine system</td>
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<td>MEC</td>
<td>Medical Eligibility Criteria</td>
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<td>NDHS</td>
<td>Nigeria Demographic Health Survey</td>
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<td>NEML</td>
<td>National Essential Medicine List</td>
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<td>NGO</td>
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<td>National Population Commission</td>
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<td>Post-Exposure HIV Prophylaxis after Sexual Exposure</td>
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<td>Progestin-only Pill</td>
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<td>RCT</td>
<td>Randomized Control Trial</td>
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<td>Reproductive Health Commodity Security</td>
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<td>ACRONYMS CONTD...</td>
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<td>SBCC</td>
<td>Sexual and Behaviour Change Communication</td>
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<td>School Family Life Education</td>
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<td>Sexual and Reproductive Health</td>
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<td>Sexually Transmitted Infection</td>
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<td>United Nations Population Fund</td>
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<td>UPA</td>
<td>Ulipristal acetate</td>
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<tr>
<td>UPA-EC</td>
<td>Ulipristal acetate (for emergency contraception)</td>
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<tr>
<td>UPSI</td>
<td>Unprotected Sexual Intercourse (no contraception used or contraception used incorrectly)</td>
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<td>USAID</td>
<td>United State Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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COURSE REVIEW

TRAINING GOAL

The overall goal of the training programme is to provide participants (physicians, nurse/midwives, Community Health Extension Workers, pharmacists, etc.) with the knowledge, skills and attitude necessary to provide quality Emergency Contraceptive Pills (ECPs) services.

Overall Objective:

To prepare providers to safely provide ECPs in appropriate situations, accompanied clear and correct information and explanations.

Specific Objectives:

Specifically, by the end of the workshop, participants will be expected to be able to:

- Describe the types, mechanism of action, effectiveness and side effects of ECPs
- List the appropriate precautions and considerations concerning the use of LNG-ECPs
- Explain how ECPs are used
- Describe the essentials of client counselling and answer common questions related to ECPs
- Demonstrate actions to be taken in the management of side-effects of ECPs
- Discuss how to address the Needs of Specific Populations
- Discuss the priority areas and Roles in Emergency Contraception programming in Nigeria.

COURSE DESIGN

The course consists of classroom and clinic sessions that focus on key aspects of service delivery. Successful completion of the course will be based on development of right attitude and mastery of skills.

DURATION

Two days.

TEACHING/LEARNING METHODS

- Discussion
- Illustrated lectures
- Individual and group exercises
- Role play
- Brainstorming sessions
- Case studies
- Simulated practice
- Demonstration/Return demonstration

TEACHING MATERIALS

- Flip chart/stand
- Coloured markers
- Screen
- PowerPoint projector
- Reference manuals
- Handouts

EVALUATION:

- Pre and post–course questionnaires
- Daily Participants Evaluation
- Counselling and clinical skills learning guide/checklist
- End-of-Course Evaluation
MODULE ONE

RATIONALE FOR THE USE OF EMERGENCY CONTRACEPTION IN NIGERIA

Learning Objectives:

By the end of the session, participants will be able to:

- Describe Population and Fertility in Nigeria
- Discuss contraceptive use in Nigeria
- Describe the extent and causes of maternal mortality in Nigeria
- Explain the trends and levels of abortion in Nigeria
- Discuss the role of Emergency Contraception (EC) in reproductive health programmes

Session Overview

- Population and Fertility in Nigeria
- Contraceptive use in Nigeria
- The Extent and Causes of Maternal Mortality
- Trends and levels of abortion in Nigeria
- Role of EC in Reproductive Health programmes
  - Importance of ECPs
  - The Bridging role of ECPs

Methods

- Brainstorming
- Illustrated Lecture
- Group work
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
Emergency contraception (EC) is the term given to contraceptive methods that can be used by women in the first few days following unprotected intercourse to prevent an unplanned pregnancy. Emergency contraception is an important component of reproductive health programmes, providing women with the only method that can be used to prevent pregnancy after an unprotected sex or method failure, and possibly a bridge to the practice of regular contraception. There are currently two methods of EC in widespread use worldwide - Oral Emergency Contraceptive Pills (Oral EC or ECPs), and Copper Intrauterine Device (Cu-IUD). While IUDs can be placed as emergency contraception, this practice is uncommon and this training module will address emergency contraceptive pills. In the past, Emergency Contraceptive Pills (ECPs) were considered to be effective only within 72 hours after sex, however studies have indicated that they may have some effectiveness for up to 120 hours. It is more effective the sooner it is taken. Although well-documented and safe, ECPs have not received significant attention in Nigeria and women’s access to this type of contraception continues to be limited.

Population and Fertility in Nigeria

With more than 177 million people, Nigeria has the largest population in Sub-Saharan Africa. The country also has one of the highest maternal mortality ratios in the world. The current Total Fertility Rate (TFR) of 5.5 children per women has changed little over the past twenty years. TFR in West African countries ranges from 4.0 in Ghana to 7.6 in Niger. Fertility varies by residence and region.

![Figure 1: Total Fertility Rate by Zone in Nigeria](image)
Women in urban areas have 4.7 children on the average, compared with 6.2 children per woman in rural areas. Fertility is highest in the North West Zone, where women have an average of 6.7 children. Fertility is lowest in South-South Zone, where women have an average of 4.3 children.\textsuperscript{3}

\textbf{Figure 2: Trends in Contraceptive Use}\n\textit{(Percent of currently married women age 15 – 49 who are currently using contraception)}

Nearly one quarter (23%) of adolescent women age 15-19 are already mothers or pregnant with their first child. Young motherhood is highest in North West Zone (36%) and lowest in South East and South West (8% each). The median age at first birth for women age 25 – 49 is 20.2 years. Women and men in Nigeria tend to initiate sexual activity before marriage. Nearly one-quarter of women age have had sexual intercourse by age 125 and more than half by age 18. The median age at first sexual intercourse is 17.6 years for women and 21.1 years for men age 25 – 49.\textsuperscript{3}

\textbf{Figure 3: Total Fertility Rates of Western African Countries}\n\textit{(Births per woman for the three years prior to the survey)}

\textsuperscript{*Results are from the preliminary report
Contraceptive Use in Nigeria

Knowledge of family planning methods is high in Nigeria: 85% of women and 95% of men age 15 – 49 know at least one method of family planning. However, fifteen percent of currently married women use any method of contraception. One in ten married women use a modern method of family planning. Another 5% are using a traditional method. Use of family planning method varies by residence and zone. More than one-quarter of married women in urban areas use any method, compared to 9% of women in rural areas. Contraceptive use ranges from a low of 3% among married women in North East Zone to a high of 38% in South West Zone. The use of any family planning has increased from 13% to 15%.

Figure 4: Use of Family Planning Methods
(Percent of married women age 15 – 49 using family planning)

Figure 5: Trends in Contraceptive Use
(Percent of currently married women age 15 – 49 who are currently using contraception)
While Nigeria has had an emergency contraception product in the private pharmacy sector for over 20 years, national data show that the method is still not known by the majority of Nigerian women. Different data sources are remarkably consistent: DHS data shows knowledge of EC in Nigeria is 30%, and PMA2020 data show about the same result, with the number of women who are aware of EC at 29%. The Nigerian Urban Reproductive Health Initiative found almost the same result: 31% of Nigerian respondents were aware of EC. Knowledge in Nigeria seems to be lower than comparable countries. For instance, PMA2020 surveys found knowledge of EC was 38% in Uganda, 52% in Ghana, and 67% in Kenya (https://www.pma2020.org/sites/default/files).

Usage of EC is not currently captured in NDHS; however, the rate of current EC use found by PMA2020 is 10.6% for unmarried women and 3.7% for married women. PMA2020 data showed that 13.5% of Nigerian women report having used EC as their first contraceptive method. In contrast, the rate reported in Kenya was 8.3% and in Ghana was 4.4%.

For brands of EC available in Nigeria, facility audits conducted by FPWatch/PSI found that there were (16 different brands available in Nigeria) methods available in private facilities, pharmacies and patent medicine vendors. Prices ranged from $1.50 to $0.20, with an average price of $1.00 in the private sector. When the data were collected in 2016, no EC was available in any public sector facilities surveyed; however, since then, EC has been procured for the public sector.

![Figure 6: Contraceptive use by Zone](image)

*Figure 6: Contraceptive use by Zone*

*(Percent of currently married women age 15 – 49 who are currently using any method of contraception)*
Unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely, but are not using contraception highlighting a missed opportunity for the public health sector programme to make family planning methods and services available. The 2013 NDHS reveals that 16% of married women have an unmet need for family planning – 12% of women have a need for spacing births and 4% for limiting births. Despite the availability of highly effective methods of contraception, many pregnancies are unplanned and unwanted, even among married women. It is clear that the women are not getting the methods and services they require. Without a full method mix (in which EC plays an important role – preventing pregnancy after sex), Nigeria may find it difficult to reduce the current unmet need and the resulting high fertility rate. The current modern contraceptive use of all women is 11.1% and an unmet need for contraception of 16.1% highlighting a missed opportunity for the public health sector programme to make family planning methods and services available. It is clear that the women are not getting the methods and services they require. Without a full method mix in which EC plays an important role – preventing pregnancy after sex, Nigeria may find it difficult to reduce the current unmet need and the resulting high fertility rate. The Extent and Causes of Maternal Mortality

In Nigeria, maternal mortality is still a relatively common event in spite of a steady increase in the provision of maternal services in the country. Those that do not die suffer untold hardship. In the 2013 NDHS, the maternal mortality for Nigeria was 576 deaths per 100,000 live births. The 95% confidence interval for the 2008 maternal mortality ratio ranged from 500 to 652 deaths per 100,000 live births. The 2013 NDHS ratio was not significantly different from the 2008 NDHS of 545 deaths per 100,000 live births.

The ultimate causes of maternal morbidity and mortality have been well defined: direct obstetric causes are responsible for majority of maternal death. Obstetric haemorrhage,
either antepartum or postpartum is often the leading cause of maternal deaths in most health care centres in Nigeria. Other leading causes of death are pre-eclampsia/eclampsia, septic abortions, puerperal sepsis, obstructed labour, uterine rupture and anaesthetic deaths. Indirect obstetric causes of maternal death include fulminating hepatitis, acute hepatic failure, severe anaemia in pregnancy, malaria, post-partum pneumonia and recently HIV/AIDS. However, the immediate determinants of maternal deaths may be more important in terms of prevention of morbidity and mortality. One of important and vulnerable subgroup of pregnant women is married and unmarried adolescents. A pregnant adolescent (10-19 years old) is two to five times more likely to die of pregnancy-related complications than a woman of 20 to 25 years of age. Poor physical development, lack of access to essential reproductive health care and pregnancy termination are important reasons contributing to maternal deaths of adolescent girls.

Trends and levels of abortion in Nigeria

In Nigeria, abortion is legal only when performed to save a woman’s life. Still, abortions are common, and most are unsafe because they are done clandestinely, by unskilled providers or both. Unsafe abortion is major contributor to the country’s high levels of maternal mortality death, ill health and disability. Nigeria has one of the highest maternal mortality ratio in the world, and little improvement has occurred in recent years. In 2012, about one-fourth of Nigeria’s 9.2 million pregnancies were unintended - a rate of 59 unintended pregnancies per 1,000 women aged 15 – 49. More than half (56%) of these unintended pregnancies ended in an induced abortion; 32% ended in an unplanned birth and 12% in miscarriage. In spite of Nigeria’s
highly restrictive abortion law, an estimated 1.25 million induced abortions occurred in 2012. The number doubled from an estimated 610,000 in 1996 because of both population growth and increase in the rate of abortion. The estimated abortion rate was 33 abortions per 1,000 women aged 15 – 49. Nationally, one in seven pregnancies (14%) ended in induced abortion in 2012.7

The slow uptake of family planning methods, including emergency contraception, in Nigeria has contributed to the high levels of unintended pregnancy and abortion. As the number of children that women and couples want declines, their need for modern contraceptive methods to achieve their desired family planning increases. Complications of unsafe abortion range from pain and bleeding to more serious conditions, including sepsis (systemic infection), pelvic infections and injuries from instruments – and even death. About 40% of women undergoing abortion experience complications serious enough to require treatment.

Unsafe abortion places a serious burden on the nation’s health system as well on the health and well-being of women and their families. The economic burden is substantial: A Guttmacher study found that in 2005, post-abortion care in Nigerian hospitals cost US$132 per patient, of which US$95 was paid by the families.9Most abortions result from unintended pregnancies. Given the extent to which unsafe abortions are still occurring in Nigeria, there is a strong need for the government and local and international stakeholders to make more concerted efforts to ensure that women do not continue to suffer or die needlessly from unsafe abortion. Since unintended pregnancy is the reason for most abortions, the most important - and the least expensive step - is to promote access to contraceptive services to prevent such pregnancies.8 Many abortion-related deaths and morbidities can be averted by promoting the use of family planning methods. Emergency Contraceptive Pills (ECPs) may contribute to increased overall family planning use, as a method after unprotected sexual intercourse or as a back-up support in case other family planning methods fail or are incorrectly used.

**Role of EC in Reproductive Health programmes**

EC can provide a unique opportunity for preventing pregnancy after unprotected sex:

- Despite availability of regular and modern methods of contraception, many pregnancies continue to be unplanned. These pregnancies carry a higher risk of maternal morbidity and mortality as women may often attempt to abort these pregnancies through unsafe methods and/or in unhygienic conditions. ECP gives women a second chance to prevent any unplanned or unintended pregnancy.

- ECPs are needed because as of now, there is no method of contraception that are 100% effective. Moreover, not everyone uses a contraceptive method perfectly each time during each act of sexual intercourse which may cause method failure. ECPs offer women the chance to avoid unwanted pregnancy in cases where regular contraceptive methods have failed or were incorrectly used. By preventing unwanted
pregnancies, EC can ensure that fewer women will need to seek an abortion which may result in fewer pregnancy-related maternal deaths and morbidity.

- Millions of women globally have used EC methods safely and effectively. A study from China revealed that ECPs can halve the number of induced abortions.\(^9\)

- By offering ECPs, family planning and reproductive health programmes can improve the quality of reproductive health services and meet the needs of clients more effectively.

- ECPs are important elements in post-rape care as well as essential component of reproductive health care.

Contraceptive methods, even the most effective in preventing pregnancy, may fail for a variety of reasons related to the technologies themselves and/or due to the way they are used. It is estimated that between 8 to 30 million pregnancies each year result from contraceptive failure either due to inconsistent or incorrect use or failure of the method itself.\(^10\) Such failure rate over a period of 12 months was much lower for methods like implants and injectables (2–4%) compared to condom (15%), periodic abstinence (22%) and withdrawal (26%).\(^11\)

**SUMMARY**

- Nigeria is one of the countries with the highest maternal mortality in the world and a significant proportion of it has been attributed to unsafe abortion.

- ECPs can help reduce the incidence of unintended pregnancy which may otherwise result in an unsafe abortion or maternal morbidity and mortality.
MODULE TWO

EMERGENCY CONTRACEPTION (EC) AND EMERGENCY CONTRACEPTIVE PILLS (ECPs)

This module aims to provide service providers with the knowledge and skills desirable for the provision of levonorgestrel-based emergency contraceptive pills (LNG-ECP) using up-to-date information and state-of-the-art methods for service delivery.

Session 1: Levonorgestrel Emergency Contraceptives Pills (LNG-ECPs) as a Method.

Session 2: Service Delivery Guidelines for LNG Emergency Contraceptive Pills (LNG-ECPs)
MODULE TWO: SESSION 1

LEVONORGESTREL EMERGENCY CONTRACEPTIVE PILLS (LNG-ECPs) AS A METHOD

Learning Objectives:

By the end of the session, participants will be able to:

- Describe the Types of Emergency Contraception
- Describe the Types of Emergency Contraceptive Pills (ECPs)
- Discuss the Suggested Regimens for ECP
- Explain the Mechanism of action of ECPs
- Describe the effectiveness of ECPs

Session Overview

- Introduction
- Types of Emergency Contraception
- Types of Emergency Contraceptive Pills (ECPs)
- Suggested Regimens for ECP
- Mechanism of action of ECPs
- Effectiveness of ECPs

Methods

- Brainstorming
- Illustrated Lecture
- Group work
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
- Samples of ECPs
Introduction

Nigeria was one of the first countries in the world to make emergency contraception available to women. The Fertility Research Unit (FRU) of the Department of Obstetrics and Gynaecology, University College Hospital, Ibadan evaluated the effectiveness of the Yuzpe regimen (combined oral contraceptives) in Nigerian women as far back as 1998 through a grant from the South-to-South Cooperation in Reproductive Health, Salvador, Brazil. In 1998, Pathfinder International (Boston, USA) provided a grant to FRU to promote and introduce Emergency Contraceptive Pills (ECPs) as clinic-based family planning method in South West Nigeria. In 1999, Society for Family Health (SFH) provided funds to FRU to explore the legal and regulatory aspects of prescribing and marketing emergency contraception in Nigeria. SFH introduced the Postinor EC product around 20 years ago.

Previous studies on the knowledge and use of emergency contraception among Nigerians have reported a widespread lack of knowledge on how to use them, or where to obtain services. The authors concluded that this could be traced to a myriad of factors such as cultural influences that discourage its provision and use, legal and regulatory obstacles, service delivery obstacles and lack of knowledge. Policies towards ECPs are favorable: the Nigerian Task Shifting Guidance states that a number of cadres of staff can provide ECPs, and the Essential Medicines List, revised in 2016, now includes ECPs for the first time.

Types of Emergency Contraception

EC is intended for occasional use to reduce the risk of pregnancy after unprotected sexual intercourse (UPSI). It does not replace effective regular contraception. EC should be considered if a woman does not wish to conceive and has had UPSI:

- On any day of a natural menstrual cycle. Pregnancy is theoretically possible after UPSI on most days of the cycle. However, the risk of pregnancy is highest after UPSI that takes place during the 6 days leading up to and including the day of ovulation.
- From Day 21 after childbirth unless all criteria for Lactational amenorrhoea are met.
- From Day 5 after miscarriage, abortion, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease (GTD).
- After regular hormonal contraception has been compromised or used incorrectly.

There are currently two methods of EC in widespread use worldwide:

(a) Oral Emergency Contraceptive Pills (Oral EC or ECPs), and
(b) Copper Intrauterine Device (Cu-IUD)

Copper IUD inserted following the usual procedures within 5 days after unprotected or inadequately protected sexual intercourse. May be used up to 8 days after intercourse, if ovulation is known to have occurred 3 days or more after the UPSI.

This training manual does 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 at http://www.cecinfo.org/icecinfo.org/icec-publications/intrauterine-device-iud-emergency-contraception/, and www.not-2-late.com.

Types of ECPs

The Oral EC can also be subdivided into 3 types:

(i) The progestin-only Pills (POPs)

Two kinds of LNG-ECP packages are available: one contains a single pill with a dosage of 1.5 mg, and the other contains two pills of 0.75 mg each. The labels on both kinds of ECP packages say that the treatment should be started within 72 hours (3 days) after unprotected intercourse. The labels on two-pill ECP packages specify that the second pill should be taken 12 hours after the first. However, these labels do not reflect current scientific information.

**Dosage:** A WHO-led study in 10 countries established that a single dose of 1.5 mg LNG is as effective as two doses of 0.75 mg. Two Nigerian studies found similar results. Taking only one dose is simpler for women than taking two doses 12 hours apart.

**Timing:** Data suggest that LNG ECPs have some efficacy 4 days or even 5 days after sex. Some but not all studies have found that LNG ECPs may be more effective the sooner they are taken after sex.

(ii) The Yuzpe Method using levonorgestrel-containing COCs

Two large doses of COCs with at least 100 ug of ethinyl estradiol and either 100 mg of norgestrel or 50 mg of levonorgestrel. Take first dose ASAP within 72 hours after UPSI; take second dose 12 hours later (second dose may be more than 72 hours after unprotected sex).

(iii) Ulipristal Acetate (UPA-EC - Ella-One in the European Union or Ella in the USA)

Ulipristal Acetate is a selective progesterone receptor modulator with antagonistic and partial agonistic effects (a progesterone agonist/antagonist)
at The progesterone receptor. It binds the human progesterone receptor and prevents progesterone from occupying the receptor.

For emergency contraception, a 30 mg tablet is used within 120 hours (5 days) after UPSI or contraceptive failure.

**As of yet, UPA is not widely available in Nigeria. This manual will focus on Oral ECPs using the progestin-only, levonogestrel regimen ONL**

The levonorgestrel ECP is the regimen marketed as a dedicated product specifically packaged and labeled for emergency contraception in Nigeria. Today, there are 15 ECP products on the market according to FPWatch data. Of these, just a few are quality assured. The others are of unknown quality. This does not mean that they are of poor quality; however, some counterfeit Postinor has been identified in Nigeria. EC was only available in the public sector as of December 2016\(^\text{16}\). All the EC products currently available in Nigeria have levonorgestrel as their active ingredient.

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 the dedicated levonorgestrel ECP regimen is not available. Some data suggest that the combined hormonal regimen is effective up to 3 days after sex and possibly up to 5 days.\(^\text{17,18}\)

**Mechanism of Action**

The primary documented mechanism of action for levonorgestrel ECP is interference with the process of ovulation.\(^\text{17-21}\) LNG-EC inhibits ovulation, delaying or preventing follicular rupture and causing luteal dysfunction.

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. This regimen has been shown not to prevent implantation of a fertilized egg into the uterus in several studies.\(^\text{9,10}\) 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.\(^\text{17,22}\)

If taken after implantation has occurred, LNG-ECPs have no effect on an existing pregnancy and do not increase rates of miscarriage.\(^\text{23,24}\) In vitro, LNG-EC did not impair endometrial receptivity or the attachment of human embryos.\(^\text{25}\) After taking LNG-EC, women who ovulate later in the cycle are at risk of pregnancy from further UPSI. It is essential that women are made aware of this risk and advised regarding ongoing contraception.
Effectiveness of LNG-ECP

Twelve studies of the levonorgestrel ECP 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%. A rigorous analysis of data from two randomized trials demonstrated that the levonorgestrel ECP regimen reduces the absolute risk of pregnancy after an unprotected sex act by at least 49% (95% confidence interval 17-69%).

Some data suggest that the efficacy of levonorgestrel ECPs decreases with time since coitus. 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.

Several studies have found that both the efficacy and the side effects of levonorgestrel ECPs 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. 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 ECP regimen may be less effective in obese women than in thinner women. Increasing the dose of this regimen in obese women has never been studied and is not recommended. The combined hormonal regimen is less effective than the levonorgestrel ECP regimen.

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. 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. Tackling the public health problem of unintended pregnancy requires a multidimensional approach of which provision of ECPs is only one aspect.

After LNG-ECP, a woman is at risk of pregnancy if she ovulates later in the cycle and has subsequent UPSI. Women should be advised to quick start a suitable, reliable contraceptive method immediately after LNG-ECP.

Effect of Weight/BMI on Effectiveness of ECP

Women should be informed that it is possible that higher weight or BMI could reduce the effectiveness of oral EC, particularly LNG-ECP. Some studies have suggested that LNG-ECP in women who are overweight, obese or have higher body weight than those with normal or underweight BMI or lower body weight. The European Medicines Agency (EMA) concluded in 2014 that the available evidence was limited and not robust enough to support with certainty a conclusion that ECP is less effective in women with higher body weight or BMI.

One analysis of pooled data from three RCTs conducted by the WHO concluded that there is no apparent effect of BMI or body weight on the effectiveness of LNG-EC. A
A recent study\textsuperscript{38} of the pharmacokinetics of LNG-EC in five obese and five non-obese women demonstrated that obesity adversely impacts maximum serum concentrations of LNG. The authors postulate that this may explain a reduction in effectiveness of LNG-EC in obese women. The Guideline Development Group (GDG) considers that these findings suggest that the LNG-EC could be less effective in women weighing >70 kg or with a BMI >26 kg/m\textsuperscript{2}.

It is important to note that double dosing has been suggested but there is no clear global guidance yet.

### Drug Interactions relevant to Use of ECPs

#### a). Inducers of hepatic CYP450 enzymes

EC Providers should advise women using enzyme-inducing drugs that the effectiveness of LNG-EC could be reduced.

The metabolism of LNG-EC is increased during and for 28 days after use of drugs that induce liver enzymes.\textsuperscript{39,40} The clinical relevance of this interaction in terms of potential reduction in effectiveness is unknown. A Cu-IUD should be recommended for women using enzyme-inducing drugs if the criteria for use are met as the Cu-IUD is unaffected by liver enzyme induction.

#### b). HIV post-exposure prophylaxis

EC may be indicated at the same time as post-exposure prophylaxis for sexual exposure to HIV (PEPSE). The current recommendation from the British Association for Sexual Health and HIV (BASHH) is that Truvada\textsuperscript{R} (tenofovir and emtricitabine) and raltegravir are given for PEPSE.\textsuperscript{41} This regimen contains no enzyme-inducing drugs that would reduce the effectiveness of ECP.

No other specific data are available about interactions of LNG-ECPs with other drugs. However, it seems reasonable to assume that drug interactions with the LNG-ECP regimen might be similar to those with regular daily oral contraceptive pills. Thus, efficacy of levonorgestrel ECPs 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). 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).

**Side-Effects of LNG-ECP**

LNG-ECPs are extraordinarily safe. No deaths or serious complications have been causally linked to any ECP regimen. Some side-effects that women could experience are:

- Menstrual problems
- Nausea
- Headache
- Dizziness
- Fatigue
- Breast tenderness

Side effects are fairly rare, occurring in a minority of women. Some side effects that are medically minor but may be troublesome to some users are described below:

a). **Altered vaginal bleeding patterns**

Most women who have used LNG-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 levonorgestrel ECPs. Some women experience irregular bleeding or spotting after taking ECPs. The proportion with this side effect varies between different studies. Bleeding alterations due to ECPs are not dangerous and will resolve without treatment.

b). **Nausea**

Nausea is the most commonly experienced side effect. The symptom is generally limited to three days and generally resolves within 24 hours after treatment. Nausea, rarely accompanied by vomiting, occurs in less than 20% of women using levonorgestrel ECPs. These symptoms are uncommon enough that prophylactic administration of an antiemetic drug is not routinely warranted before use of levonorgestrel ECPs.

c.) **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.

**Safety of ECP**

Studies of women who became pregnant despite using levonorgestrel ECPs 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.

ECPs are considered very safe:

- In the more than 20 years in which ECPs have been used, no deaths or serious medical complications have been reported.
- The dose of hormones in ECPs is relatively small.
- Available data suggest that ECPs do not increase the possibility that a pregnancy following use of ECPs will be ectopic.

Summary of the Characteristics of ECPs

- Documented safety.
- Readily available (both COCs and LNG-only pills).
- Acts to prevent ovulation, fertilization and possibly interfere with sperm function.
- Reduces the need for abortions.
- Reduces the risk of unwanted pregnancy.
- Appropriate for use after unprotected intercourse (including rape or contraceptive failure).
- Can be used by adolescents and young people who may be less likely to prepare for a first sexual encounter.
- Drug exposure and side effects (if any) are of short duration.
- Does not protect against the transmission of sexually transmitted infections (STIs) and HIV/AIDS.
- Does not provide ongoing protection against pregnancy.
- Should be used as soon as possible within three-five days of unprotected intercourse.
- May cause nausea and sometimes vomiting, especially with COC regimens.
- May change the time the woman’s next menstrual period begins.
- Not appropriate for regular use, however, repeat use is safe and more effective than using no method.
Summary/Evaluation

Emergency contraception (EC) includes any method that acts after unprotected sexual intercourse (UPSI) to prevent pregnancy. It does not replace effective regular contraception. The levonorgestrel ECP is the regimen marketed as a dedicated product specifically packaged and labeled for emergency contraception in Nigeria.

- Levonorgestrel regimen: 1.5 mg levonorgestrel in a single dose (preferably). When using a two-pill product, they can be taken in two doses of 0.75 mg taken 12 hours apart. Alternatively, it is safe and effective to take the two pills in one single dose.

Taking the regimen as promptly as possible within a maximum of 120h is strongly recommended. The levonorgestrel ECP regimen appears to be effective for at least 4 days after sex and potentially up to 5 days. Efficacy diminishes with interval between unprotected intercourse and use.
MODULE TWO: SESSION 2

SERVICE DELIVERY GUIDELINES FOR LNG EMERGENCY CONTRACEPTIVE PILLS (LNG-ECPs)

Learning Objectives:

By the end of the session, participants will be able to:

- Explain who can provide services for LNG-ECPs
- Explain who is eligible for services related to LNG-ECPs
- Describe the services providers should offer
- Describe how services should be provided to clients who have requested for LNG-ECPs

Session Overview

- Who can provide services for LNG-ECPs
- Who is eligible for services related to LNG-ECPs
- What services providers should offer
- How services should be provided to clients who have requested for LNG-ECPs

Methods

- Brainstorming
- Illustrated Lecture
- Group work
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
- Samples of ECPs
Who can provide LNG-ECPs?

LNG-ECPs can be provided and/or distributed safely and effectively by a variety of trained personnel and through clinical and non-clinical service delivery systems.

- For instance doctors, nurses, midwives, pharmacists, and other clinically-trained personnel; as well as community health workers and trained sexual assault counsellors may be able to provide ECPs, depending on local regulations and practice. All ECP providers should follow clear service delivery guidelines and be trained on:
  - Information on indications for ECPs
  - Regimen and mode of action of ECPs
  - Safety and Efficacy
  - Side effects and their management
  - Screening of women who have requested for ECPs; (note that there are no contraindications to taking LNG-ECPs and women are able to decide for themselves to take them).
  - Counselling and follow-up procedures

In addition, since ECPs are a back-up support within the full range of the contraceptive method mix, training should also include information on other contraceptive methods, if possible. Refresher training on other method would help participants understand in which context emergency contraceptive pills are appropriate and how to counsel clients on methods suitable to their needs.

- Appropriate distribution mechanisms can include:
  - Family planning and reproductive health care clinics
  - Hospitals and health care clinics (including emergency rooms)
  - Community-based services,
  - Pharmacies and patent medicine stores
  - Social marketing programmes and
  - Youth friendly centres
  - Post-rape care services

Mass media informational campaigns and advertising can improve access to all sources of ECPs.

- When ECPs are provided through non-clinic outlets, the providers must have access to referral service for those cases where it may be required (for instance, if more than 120 hours have passed since the act of UPSI occurred and ECPs may not be appropriate.)
Who is eligible for ECPs?

ECPs are used to prevent pregnancy after unprotected sexual intercourse (UPSI), including:

- When no contraception has been used.
- When there is a contraceptive accident or misuse, including:
  - Condom rupture, slippage, or misuse
  - Two oral contraceptive pills missed consecutively
  - More than two weeks late for a progestin-only contraceptive injection (depomedroxy-progesterone acetate [DMPA] or norethisterone enanthate [NET-EN]).
  - More than three days late for a combined estrogen-plus-progestin injection (medroxy progesterone acetate and estradiol cypionate).
  - Failure of a spermicide tablet or film to melt before intercourse
  - Diaphragm or cap dislodgement, breakage, tearing, or early removal.
  - Failed coitus interruptus (e.g. ejaculation in vagina or on external genitalia)
  - Miscalculation of the periodic abstinence method or failure to abstain on a fertile day of the cycle.
  - Intrauterine (IUD) expulsion
- By adolescents and young people who may be less prepared for first sexual encounters.
- In cases of sexual assault when the woman was not protected by a reliable contraceptive method.

What Services Should Providers Offer?

Service providers should:

- Routinely inform women and girls, men and boys about ECPs and their availability during regular family planning consultations.
- Distribute materials on ECPs to create awareness among potential clients.
- Try and provide women with a supply of ECPs in advance.

ECPs can be provided either at the time treatment is required or given to women as advance supplies (i.e., in advance of the need for treatment). Advance supplies can be provided at the time of a regular visit and may be particularly appropriate for women who select methods that are highly dependent upon correct use at the time of intercourse (for instance, condoms or the diaphragm). ECPs can also be provided to women who intend to use an effective method later but may need to come back for insertion (i.e., women who are waiting for menses to initiate IUD or other method.)
Advance supplies can greatly improve the conveniences of the method and help ensure that women have access to treatment as soon as they need it. Taking ECPs as soon as possible after unprotected sex reduces the risk of pregnancy.

- Service providers should remember that sexual assault is an important indication for EC. In such cases, the victim survivor needs counselling, medical, legal and long-term psychosocial support.

How should Emergency Contraceptive Pills be taken?

Like other tablets, emergency contraceptive pills should be swallowed with water. If a two-pill regimen has been provided, they should be taken together. They should be taken as soon as possible; the provider may wish to provide water for the woman to take the pills immediately.

How should the Three-Days (72 hours) Interval be calculated?

Most studies have only examined the effectiveness of emergency contraceptive pills after a single penetrative sexual act. However, it is possible that couples may have multiple sexual encounters prior to starting a course of emergency contraceptive pills. The calculation of 72 hours or 3 days should start from the first unprotected penetrative vaginal intercourse the woman has had during that particular menstrual cycle. There is no evidence that emergency contraceptive pills can work against unprotected sexual intercourse before or after this (72 hours) period, or during the period when the woman is taking emergency contraceptive pills. However, it is possible that emergency contraceptive pills may work against multiple intercourses that have occurred within the 72-hour time period, but there is no study available to support this important event.

The interval MAY be extended to 120 hours. If UPSI has occurred earlier in the cycle, ECPs cannot disrupt a pregnancy that may have already occurred. However if UPSI has occurred within the past 120 hours, LNG-ECP can be supplied. It will not harm a pregnancy that has started earlier in the cycle.

Client Screening

Screen the client for ECP use by:

- Assessing the date of the last menstrual period and whether it was normal to exclude the possibility that the client may already be pregnant.
  - If the client has not had a recent menstrual period for a discernible reason other than pregnancy (for example, she has been using an injectable contraceptive, she has recently been pregnant, she is breastfeeding, or she often has irregular or prolonged cycles), or if the client cannot remember the date of her last menstrual period accurately then ECPs may be administered, as long as the client understands that pregnancy has not been ruled out.
Establishing how long ago the episode of unprotected sex occurred.

- If unprotected sex occurred within the past 72-120 hours then treatment should be given, but the woman must be warned that effectiveness gradually decreases as the time of beginning treatment approaches the 120-hour mark.
- If more than 120 hours have passed since the episode of unprotected sex, the provider may, with appropriate screening and unless contraindicated, offer to insert a Copper IUD. LNG-ECPs are not effective at this stage.

Other health assessments (e.g. pregnancy test, blood pressure, laboratory tests, pelvic exam, etc.) are not required, but could be offered if medically indicated for other reasons and desired by the client.

Providers also should ask if the client is currently using a regular method of contraception; this question can be a good starting point for a subsequent discussion of regular contraceptive use and how to use methods correctly.

If the woman wishes to continue with COCs as her contraceptive method immediately after ECP use, patient history needs to be considered (i.e., cardiovascular disorders, smoking, breastfeeding, breast cancer, or high blood pressure).

**Sample ECP Screening Checklist**

<table>
<thead>
<tr>
<th>Ask the potential client the following questions:</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the first instance of unprotected sex during this menstrual cycle been <strong>within the last 72 hours</strong>?</td>
<td>YES</td>
</tr>
</tbody>
</table>

If the client answers YES then she may be eligible for ECPs.

**Note:** ECPs may be given after 72 hours, although effectiveness will be lower.

Continue the screening checklist.

| 2. Have you had your last menstrual period within the last month? Write the date of the first day of the last menstrual period. | YES | NO |
|-------------------------------------------------------------------------------------------------------------------|----------|
| (________________)                                                                                                                                 |

| 3. Was this period normal in both its length and timing? | YES | NO |

If the client answers YES to both of these questions, you may give ECPs.

If the client answers NO to either of these questions or you suspect that the sexual history may not be accurate, do a pregnancy test and/or refer the client for a physical examination to diagnose pregnancy.

| 4. Is the client pregnant? | YES | NO |
If the client is not pregnant, you may give ECPs. If the client’s pregnancy status is unclear, you may still give ECPs, with the explanation that the method will not work if she is already pregnant.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. After using ECPs, do you want to use birth control pills? If &quot;no,&quot; which other method? (Provide counseling and give other method, or plan for her to receive the method at the follow-up visit.) If yes continue</td>
<td></td>
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<tr>
<td>6. Are you currently breastfeeding a baby under 6 months of age and plan to continue?</td>
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</tr>
<tr>
<td>7. Do you smoke cigarettes AND are you over 35 years of age?</td>
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</tr>
<tr>
<td>8. Do you have frequent and very severe headaches that cause you problems, such as blurred vision or temporary loss of vision that you get during the headache?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have high blood pressure?</td>
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</tr>
<tr>
<td>10. Have you ever had a stroke, blood clot in your legs or lungs, or a heart attack?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you have diabetes (sugar in your blood)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have or have had breast cancer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you have a serious liver disease or jaundice (yellow skin or eyes)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Do you regularly take any pills for tuberculosis (TB), fungal infections, or seizures (fits)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the client answers YES to any of the above questions, refer her to the clinic/physician, and give her condoms and/or spermicide to use in the meantime.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information for the Client

Women should be provided with basic information about ECPs before receiving emergency contraceptive pills. ECP information for the client should include:

- discussion of how and when to take the pills,
- what to expect once the pills are taken,
- possible side effects and what the woman should do,
- failure rates, and the importance of using ongoing contraception.
Information regarding services for regular contraceptive use also should be provided if desired by the client.

Key Points
The following list covers key points to include when giving information to ECP clients:

- The woman should take the LNG-ECPs as soon as possible after unprotected sex. A single dose of 1.5 mg LNG is as effective as two doses of 0.75 mg taken at the same time. Taking only one dose is simpler for women than taking two doses 12 hours apart.

- Make certain that the client does not want to become pregnant, but that she understands that there is still a chance of pregnancy even after treatment with ECPs. Explain that ECPs will not harm the fetus should they fail to prevent pregnancy.

- Explain how to take ECPs correctly.

- Describe common side effects. Advance counseling about possible side effects helps women know what to expect and may lead to greater tolerance.

- Explain that the dosage needs to be repeated if the client vomits within one hour of taking ECPs.

- Make sure that the client understands that ECPs will not protect her from pregnancy if she engages in unprotected intercourse in the days or weeks following treatment. This is a common misperception among some clients.
  - Advise the client to use a barrier method, such as the condom, for the remainder of her cycle. A different contraceptive method can be initiated at the beginning of her next cycle. For some women, initiating or continuing COCs, injectables, IUDs or other methods on the same day as using ECPs may be an option.

- Explain that ECPs typically do not cause the client’s menses to come immediately. This is another common misperception.
  - The client should understand that her period might come a few days earlier or later than normal. Explain that if her period is more than a week late, she might be pregnant. She should seek evaluation and care for possible pregnancy.

- Advise the client to come back or visit a referral clinic (as appropriate) if there is a delay in her menstruation of more than one week past the expected date, if she has any reason for concern, or as soon as possible after the onset of the menstrual period for contraceptive counseling, if desired.

- Use simple written or pictorial instructions to help reinforce important messages about correct use of ECPs.

Follow-up
If the client has already adopted a method of contraception for regular use and wishes
to continue using this method, no follow-up is needed unless the client has a delay in her menstruation, suspects she may be pregnant, or has other reasons for concern.

During the follow-up appointment:

- Use simple written or pictorial instructions to help reinforce important messages about correct use of ECPs.
- Record the client's menstrual data to verify that she is not pregnant (if in doubt, perform a pregnancy test).
- Discuss contraceptive options, as appropriate.
- If desired, provide a contraceptive method according to the woman's choice.

If ECPs have failed and the client is pregnant:

- Advise the client on available options and let her decide which is most appropriate for her situation. Her decision should be respected and supported. Refer the client to other service providers as appropriate.
- If the client decides to continue the pregnancy, she should be reassured that there is no evidence of any teratogenic effect (birth defects) following ECP use.
- Available information suggests no increased likelihood that a pregnancy will be ectopic as a result of ECP failure.

Precautions and Considerations to the use of ECPs

- ECPs should not be given to a woman who has a confirmed pregnancy, primarily because ECPs will not be effective if a pregnancy is already established.
- ECPs may be given when pregnancy status is unclear and pregnancy testing is not available as there is no evidence suggesting harm to the woman or to an existing pregnancy.
- No other medical conditions are known in which ECPs should not be used since the pills are used for such a short time. Experts believe that the precautions associated with continuous use of oral contraceptive pills do not apply to ECPs. Women with a history of previous ectopic pregnancy may use ECPs.

Initiating or Resuming Regular Contraception

Whenever possible, clients receiving ECPs should be given contraceptive counseling and provided with an ongoing contraceptive method, such as condoms, for at least immediate future use. However, such counseling may not be appropriate in all situations or may not be desired by clients at the time of ECP provision, and it should not be a prerequisite for providing ECP services. Clients who need or desire counseling, but who do not receive it at the ECP visit, should be referred for a follow-up appointment at the
earliest convenient time.

Clients may wish to restart their previous contraceptive method after taking ECPs, or they may prefer to initiate a new method. If the reason for requesting ECPs is because the regular contraceptive method failed (for example, the condom broke, or the client missed taking oral contraceptive pills), discuss with the client the reasons for failure and how it can be prevented in the future.

Most women, and especially those with risk factors for STIs (rape victims, youth, adolescent with an older partner, or having had multiple partners within the past year), should receive special counseling on how to prevent STIs as well as pregnancy. Use of condoms in addition to or as the primary contraceptive method should be emphasized.

- Condoms and spermicidal foam or film can all be used immediately.
- Oral contraceptives may be initiated either immediately or within five days of the beginning of the next menstrual cycle (or according to the instructions for the type of pill being used). See sample screening checklist for COCs.
- Progestin-only injectables (including SAYANA Press) should be initiated within seven days of the beginning of the next menstrual cycle.

### Initiating Regular Contraception after ECP Use

<table>
<thead>
<tr>
<th>Method</th>
<th>Appropriate Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>Can be used immediately</td>
</tr>
<tr>
<td>Spermicides</td>
<td>Can be used immediately</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td>Two Options:</td>
</tr>
<tr>
<td></td>
<td>1. Initiate within five days of the beginning of the next menstrual cycle (or according to the instructions for the type of pill being used). Use a barrier method or abstain from sex for the remainder of the cycle.</td>
</tr>
<tr>
<td></td>
<td>2. Initiate or continue a low-dose COC for the remainder of the menstrual cycle immediately following ECP use. She should start COCs the day after she takes ECPs. She may begin a new pack of pills, or if she was using COCs before taking ECPs (The ECPs were needed because of missed pills), she may continue taking pills from the pack she was using. She should also use a barrier method during the first seven days when COCs are started mid-cycle.</td>
</tr>
<tr>
<td>Injectables</td>
<td>Initiate progestin-only injectables (including SAYANA Press) within seven days of the beginning of the next menstrual cycle. Initiate combined injectables within five</td>
</tr>
</tbody>
</table>
days after the beginning of the next menstrual cycle.

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD</td>
<td>Initiate during the next menstrual cycle. Note: if the woman intends to use an IUD as a long-term method then emergency insertion of a copper-bearing IUD may be an alternative to ECP use. However she must meet the screening criteria.</td>
</tr>
<tr>
<td>Natural Family Planning</td>
<td>May be initiated after the first normal menstrual period following ECP use. Should abstain from sex or use a non-hormonal method in the interim. If she is already a user of NFP, she should be counselled that LNG ECPs may delay ovulation and she should not count on having “safe” days for the rest of the cycle.</td>
</tr>
<tr>
<td>Implants (e.g., Jadelle®, Implanon NXT™)</td>
<td>Initiate within seven days of the beginning of next menstrual cycle.</td>
</tr>
<tr>
<td>Voluntary Surgical Sterilization (Female or Male)</td>
<td>Perform the operation only after informed free choice can be ensured. It is not recommended that clients make this decision under the stressful conditions that often surround ECP use. Defer female sterilization until after the first menstrual period, to ensure she is not pregnant. Interim contraception should be provided.</td>
</tr>
</tbody>
</table>

**Summary/Evaluation**

Levonorgestrel-ECPs can be provided and/or distributed safely and effectively by a variety of trained personnel and through clinical and non-clinical service delivery systems. Taking ECPs as soon as possible after unprotected sex reduces the risk of pregnancy. Advance supplies can greatly improve the conveniences of the method and help ensure that women have access to treatment as soon as they need it. Service providers should remember that sexual assault is an important indication for EC. In such cases, the victim needs counselling, and legal and long-term emotional support.
MODULE THREE
COUNSELLING

Counseling is one of the important bedrocks for any family planning programme. Communication between the provider and the client is believed to improve the understanding of the concept of FP and the benefits it offers. This makes this module a very important component of the training on ECPs. The module prepares the participants to help clients make Informed Choice on the use of ECPs.

Session 1: Values and Values Clarification

Session 2: Counselling for Emergency Contraceptive Pills
MODULE THREE: SESSION ONE
VALUES AND VALUES CLARIFICATION

Learning Objectives:
At the end of the session, participants will be able to:

- Define the terms ‘value’ and ‘values clarification’
- Clarify their own values to minimize provider bias

Session Overview

- Definition of the terms ‘value’ and ‘values clarification’
- Clarification of the participants’ own values to minimize provider bias

Methods:
- Brainstorming
- Illustrated Lecture
- Discussion

Materials:
- Markers/Flip Charts
- Lap top computer
- Projector
Definitions of Values

- Values are beliefs that are important to an individual.
- Values can be defined as principles, standards or qualities regarded as worthwhile or desirable.
- They are those things, which people believe in and attach importance to.
- Or they can be those things people are against.
- It is important to note that values influence people’s decisions and contributes to the achievement of their goals.

**Sources** from which an individual forms his or her values are:
- family,
- personality trait,
- peer groups, media,
- religion and
- society.

**Attitudes** are the views or opinions that are formed by values and beliefs

- Values differ and therefore it is important to have an understanding of the concept of values.
- Understanding values enables us to relate better to other people.
- Clarifying our own values enables us to relate appropriately with others.
- Values can be influenced by religion, education, culture, or personal experiences.

Values Clarification

- Values clarification refers to the sorting out of personal values from the values of others and those of the larger society.
- It is important for young people to think and express their opinions about particular issues and to recognize that their opinions may be different from others.
- Views about issues may change from time to time as people are exposed to different people and perspectives.

Steps in Values Classification

- Identification of personal values
- Prioritization of personal values
- Defense of personal values
- Use of values to guide behaviour

**Attitudes** are the views or opinions that are formed by values and beliefs.

Values clarification Group Exercise
This is an exercise designed to help participants clarify their own values and understand how their personal belief systems influence their behaviour, which can in turn, influence their clients. Understanding their own values will help participants avoid personal bias when counselling clients.

- The purpose of this game and the next is to demonstrate that individuals' values may differ greatly, even within a community, and that people have reasons for holding the values they do.
- It is not necessary to cover all statements, or obtain reasons for all of them. Use a few to illustrate the point of the exercise.

**Exercise Steps**

1. Tape papers labelled “Agree” and “Disagree” on opposite walls of the room.
2. Read a statement from the survey of sexual attitudes and ask the participants to go to the sign that best represents their feelings. (Refer to the next page for questions)
3. Ask a few participants from each of the groups to explain why he/she agrees or disagrees with the statement.
4. Repeat for a few statements.
5. Process the game by asking:
   a. Did any of the responses surprise you?
   b. How did people respond to different statements?
   c. How did you feel about other people’s responses? Why?

If the group is homogenous and there are many varying responses to the statements, discuss why people had different values.

*Be ready to address the possible responses from participants*

Some may be defensive, judgmental, ambivalent, afraid to express opinion, or angry at being forced to make a decision. Use this opportunity to have participants discuss these reactions. Why can it be so difficult to express our values and beliefs? What do we risk by doing so?

**Survey of sexual Attitudes:** (Participants stand on their chosen sides)

1. As an individual, I feel that adolescents should not be given sex education
2. I believe that sexual activity should not occur before marriage
3. I believe that only women should be “faithful” to their husbands
4. I feel that men are not capable of being “faithful” to their wives
5. I feel that STIs are God’s punishment for pre-and extra-marital sexual activity
6. People with STIs should be quarantined
7. God decides how many children we should have.
8. Partner’s genitals can be pleasurable
9. Anything two consenting adults want to do with each other, that is not harmful, is acceptable sexual practice.

10. Controlling one’s fertility means women will have more time for self – development but it will mean the breakdown of the family because she will be like a man; too busy to maintain the responsibilities of wife and mother.

11. After menopause, women no longer have a need for sex.


13. HIV/AIDS affects only people who are promiscuous.

Summary

▪ In conclusion, the variation in values and person’s choice is a fact of life. No one is wrong or right.
▪ It is important to respect other people’s values because it is crucial in counselling – especially in sensitive areas such as Family Planning.
▪ If clients present with situations, which are difficult to handle because of our values, we should find a provider who can assist the client.
MODULE THREE: SESSION TWO
COUNSELLING ON EMERGENCY CONTRACEPTIVE PILLS

Learning Objectives:

By the end of the session, participants will be able to:

- Explain how and what to counsel a client on ECPs.
- Ensure privacy during counselling of a client for ECPs
- Discuss special issues related to counselling clients on the use of ECPs:
  - Stress
  - Frequent use
  - HIV and STIs
- Discuss and provide answers to frequently asked questions on ECP

Session Overview

- How and what to counsel a client on ECPs.
- Privacy during counselling of a client for ECPs
- Special issues related to counselling clients on the use of ECPs:
  - Stress
  - Frequent use
  - HIV and STIs
- Answers to frequently asked questions on ECP

Methods

- Brainstorming
- Illustrated Lecture
- Group work
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
- Samples of ECPs
LNG ECPs are suitable for non-prescription use and women may safely decide for themselves when to use them. Therefore, counseling should never be required for the use of LNG ECP use. However, it can be helpful if a woman welcomes it. Counselling is an integral and essential part of family planning service delivery. As with any contraceptive method, ECPs should be provided in a manner that is respectful of the client and responsive to her needs for information and counselling. All clients do not need counselling on every method at the time of contraceptive consultation on EC. Information must be tailored to suit the client’s needs. However, clients who are interested in learning about other methods when they visit for counselling on ECPs should be given information on these methods as well.

Three types of clients need to be educated on emergency contraceptive pills:

- Potential contraceptive users (those who are not yet using any method of family planning)
- Regular family planning clients, particularly those who use barrier methods, oral contraceptive pills, DMPA injections and traditional methods
- Clients who ask for emergency contraceptive pills

**Potential contraceptive users**

It is essential that all potential clients for contraception are informed about the benefits of family planning and provided option for contraceptive methods. While talking about all other contraceptive methods, there is a great opportunity for providers to inform clients about emergency contraceptive pills. Non-users of family planning methods should be informed about:

- The methods available for contraception
- Details about the family planning methods
- The scope of emergency contraceptive pills as a back-up support.

**Regular Family planning clients**

Users of barrier methods, Natural Family Planning (NFP) methods, DMPA injections and traditional methods must be told:

- How to use barrier methods and DMPA injections correctly
- When and how to use emergency contraceptive pills
What the side effects of emergency contraceptive pills are and how these should be managed.

What contraceptive options are available after using ECPs.

What should be done if a woman misses her menses more than 7 days from the expected date, after having emergency contraceptive pills.

Users of oral contraceptive pills must be told in particular:

- What to do if they miss three pills
- When and how emergency contraceptive pills should be used
- What should be done with the rest of the pills in the packet
- Why condoms should be used for any further intercourse
- What should be done if the menstrual cycle is delayed by more than 7 days from the expected date and
- How to come back to using oral contraceptive pills regularly once the next menstrual cycle starts.

Clients who have asked for emergency contraceptive pills

Counseling clients who have requested for emergency contraceptive pills after unprotected intercourse is simple. Five steps should be followed:

- Ask and assess (screening questions)
- Inform
- Explain
- Remind
- Return

- Ask screening questions to assess whether woman has come within 72-120 hours.
- If the client visits within the 72-120 hour time period:
  - she should be informed about the correct use of ECPs,
  - how emergency contraceptive pills work,
  - efficacy and failure, and
  - when emergency contraceptive pills are most effective.
Clients should be told NOT to take any extra pill(s) as this will NOT make them work better, and may result in more side effects. Many clients mistakenly believe that emergency contraceptive pills result in immediate menstruation. Clients should be told that emergency contraceptive pills do not result in immediate menses but will come at the expected time or few days earlier or later.

The next step is to remind the client about the side effects of emergency contraceptive pills and how these should be managed.

If the client is counseled before she takes the pills, she will find it easier to cope with the side effects.

- Moreover, the client needs to be told that emergency contraceptive pills are not 100 percent effective and can result in failure.
- The client should be reminded that emergency contraceptive pills should be used only in emergencies and not as a regular method of contraception as they are not as effective as regular contraceptives.
- Moreover, emergency contraceptive pills have a higher failure rate and more side effects than regular contraceptives.
- It is safe to take ECPs more than once and always more effective than using no method; women should be encouraged to use ECPs every time they are needed and should not be stigmatized for using them more than once.

- Although users of emergency contraceptive pills do not require routine follow-up, clients should be asked to come back to the clinic if their menses is delayed by more than a week, or if the menses is too light in terms of color.

- Clients who would like to discuss emergency contraceptive pills in detail, or would like to talk about future contraception, or has any other concern, should also be asked to come back.

  - It is crucial that the client should not rely totally on emergency contraceptive pills for her contraceptive needs.
  - Service providers should try and encourage the client to return to a regular method or to her previous method rather than continue to use emergency contraceptive pills. There are many regular contraceptive options that a client can use after emergency contraceptive treatment.

COUNSELLING TIPS

- As with any contraceptive method, ECPs should be provided in a manner that is respectful of the client and responsive to her needs for information and counselling.
- During counselling, the provider should:

  - Reassure all clients, regardless of age or marital status that all information will be kept confidential.
- Be supportive of the client’s choices and refrain from making judgmental comments or indicating disapproval through body language or facial expressions while discussing ECPs with clients. Supportive attitudes will help set the stage for follow-up counselling about regular contraceptive use and sexually transmitted infection (STI) prevention.

- Actively involving the client in the counselling process may be more effective in ensuring compliance rather than simply providing her with information. This active involvement may include:
  - Asking her what she has heard about ECPs
  - Discussing her experience with other contraceptive methods (particularly the incident that led to ECP use).
  - Validating or correcting her ideas as appropriate.

- Whenever possible, ensure that counselling is conducted in a private and supportive environment.
  - In situations where it is difficult to maintain privacy (for example, in pharmacies), give the method to the client with appropriate verbal and printed instructions and advise her to attend a clinic or contact a health care/family planning provider for counselling about regular contraceptive methods.

- Reassure the woman that all information will be kept confidential, including the fact that she has received ECP treatment.

**Counselling on Special Issues related to Counselling Clients for the use of ECPS**

**Stress**

- Clients may feel particularly anxious after UPSI due to:
  - Fear of becoming pregnant
  - Worry about missing the 72-hour window opportunity for EC
  - Embarrassment at failing to use contraceptive effectively,
  - General embarrassment about sexual issues,
  - Rape-related trauma,
  - Concern about AIDS, or a combination of these factors.

- For this reason, maintaining a supportive atmosphere during counselling is especially important.
**Frequent Use**

- Emphasize that ECPs are for emergency only. They are not recommended for routine use because of the increased possibility of failure compared to regular contraceptives and the increased incidence of nausea, vomiting or other side effects.

**NOTE:** Although frequent use of ECPs is not recommended, repeated use poses no health risks to users and should never be cited as a reason for denying women access to treatment.

**HIV and STIs**

- Clients may be very concerned about possible infection, especially in cases of rape. Counselling on this topic should be provided along with STI diagnostic services (or referrals) and information about STI/HIV preventive measures.

- Clients must understand that ECOs offer no protection against STIs, including HIV/AIDS.

**Counselling about other Contraceptive methods**

- Whenever possible, clients requesting ECPs should also be offered information and services for regular contraceptives. However, not all clients want contraceptive counselling at the time of ECP treatment.

- Thus, while counselling related to the use of regular contraceptives is recommended to all ECP clients, it should not be a prerequisite for providing ECP services.

- Clients who are interested in learning about other methods should receive information and counselling:
  - At the time of the ECP visit,
  - At a follow-up appointment scheduled at a more convenient time, or
  - Should be referred to a family planning clinic if other FP methods are not available (i.e., pharmacies, etc.)

- If the reason for requesting EC is that a regular contraceptive method was not used, or was used incorrectly, discuss how it can be used consistently and correctly in the future.

- Women should be provided at least a temporary method, such as condoms, whenever possible, to use in the immediate future.
FREQUENTLY ASKED QUESTIONS ABOUT ECPS

Are emergency contraceptive pills safe?

YES. Emergency contraceptive pills can be given even to women who cannot use oral contraceptive pills regularly, such as those with a history of hypertension, or severe migraine. This is because emergency contraceptive pills are taken for a short span of time and, consequently, will have fewer side effects than that of oral contraceptive pills. It will not have side effects that may have developed due to use of oral contraceptives for long periods.

How will emergency contraceptive pills affect a woman’s menses?

Emergency contraceptive pills have no significant impact on a woman's menses. Only 10-15 percent of the women who use emergency contraceptive pills will have menstrual problems. A woman's menses will be at about the expected time, or at most a week early or late (usually 2-3 days). In a few cases, menstrual flow might be heavier, lighter or more spotty than usual.

Will emergency contraceptive pills protect a woman from future unprotected intercourse?

NO. Emergency contraceptive pills do not protect a woman from any future unprotected intercourse.

Will emergency contraceptive pills harm an existing pregnancy or a pregnancy caused by the failure of emergency contraceptive pills?

NO. Available studies show that emergency contraceptive pills do not have an adverse effect on pregnancy.

Can emergency contraceptive pills be taken if there is problem in the leg (such as varicose veins)?

YES. As the dose of hormones in emergency contraceptive pills is relatively low, the short exposure to does not appear to alter blood-clotting mechanisms, as against combined oral contraceptives, which are used over a longer period.

How many times can one take emergency contraceptive pills in a month?

Emergency contraceptive pills are not intended for repeated use. However, given that there is little likelihood that limited repeated use will cause harm, emergency contraceptive pills should not be denied only because a woman has used them before,
even within the same menstrual cycle. They should not be taken more often than once every 24 hours, however. All women who use emergency contraceptive pills, particularly those who use them repeatedly, should be informed that emergency contraceptive pills are less effective and have more side effects than regular contraceptives. They should also be briefed on how to avoid contraceptive failure in future.

_How soon after emergency contraception should a regular contraceptive be started?_

Regular contraceptive methods (such as condoms and pills) can be resumed immediately after emergency contraceptive treatment. Alternatively, clients could switch over to condoms till the start of the next menstrual cycle. Other regular contraceptives such as IUD, implants, etc. can be started immediately (if pregnancy can be ruled out) or within 7 days of the next menstrual period.

_What should be done if menses is delayed by more than 7 days after using emergency contraceptive pills?_

The woman should undergo a pregnancy test.

_Do emergency contraceptive pills increase the risk of an ectopic pregnancy?_

NO. Emergency contraceptive pills neither prevent nor increase the chance of an ectopic pregnancy (a pregnancy that develops outside the uterus but inside the fallopian tube/abdomen).

_Is emergency contraception the same as abortion?_

NO. Emergency contraception and abortion are entirely different. Emergency contraceptives only prevent pregnancy from unprotected sex by preventing or delaying ovulation. In an abortion, a fertilized fetus is removed.

_Are emergency contraceptive pills and RU 486 the same?_

NO. Emergency contraceptive pills are used to prevent pregnancy. Mifepristone or RU 486 is abortive and is used to abort an established early pregnancy. However, RU 486 can also be used as emergency contraceptive.

_If a woman vomits within two hours of taking a dose of emergency contraceptive pills, what should she do?_

She should repeat the emergency contraceptive pills.
Do women need to use emergency contraceptive pills during the "infertile period"?

Studies have shown that intercourse can result in fertilization only during a five-seven-day period around the time of ovulation. Theoretically, emergency contraceptive pills are not needed if unprotected intercourse occurs at other times of the cycle because the possibility of becoming pregnant even without emergency contraceptive pills would be negligible. However, in practice, and for the family planning program, it is often difficult to determine with certainty whether a specific act of intercourse occurred on a fertile or infertile day of the cycle. This is particularly true for illiterate women. Therefore, emergency contraceptive pills should be provided if unprotected intercourse has taken place on any day of the cycle (within 72-120 hours) and the client feels that she is at risk of becoming pregnant. In situations where unprotected intercourse is unlikely to result in pregnancy, the client's anxiety level, the availability of the commodity and the resources of the client should be taken into account when taking a decision.

Can women use emergency contraceptive pills before intercourse?

NO. Clients should be discouraged from using emergency contraceptive pills before intercourse. No data are available on how long the contraceptive effect of emergency contraceptive pills persists after the pills have been taken. Presumably emergency contraceptive pills taken immediately before intercourse are as effective as pills taken immediately afterwards. However, if a woman has the opportunity to plan to use a contraceptive method before intercourse, a regular method other than emergency contraceptive pills, such as condoms, is recommended.

Can emergency contraceptive pills be used after more than one unprotected act of intercourse within 72 hours?

Clients should be informed that, as the interval between the earliest unprotected sexual act(s) and the use of emergency contraceptive pills lengthens, the efficacy of emergency contraceptive pills will be lower. Clients should be encouraged to use emergency contraceptive pills as soon as possible after unprotected intercourse rather than wait until they have had a series of episodes of unprotected intercourse. Only one regimen for emergency contraceptive pills should be given at a time, regardless of the number of prior episodes of unprotected intercourse.

Can emergency contraceptive pills be used more than 72 hours after unprotected intercourse(s)?

Studies show that the efficacy of treatment declines with time, so that there is declining effectiveness as the 72 hours progress. However, experts suggest that emergency contraceptive pills probably retain some limited efficacy even after that period.
emergency contraceptive pills pose no danger either to the woman or to the embryo, it is reasonable to provide women emergency contraceptive pills even after 72 hours even if emergency contraceptive pills fail. However, the client should be informed about the possibility of pregnancy, if the method fails or if she is already pregnant.

**Can emergency contraceptive pills be taken when a woman is breastfeeding?**

A woman who is less than six months postpartum, exclusively breastfeeding and who has not had a menstrual period since delivery is unlikely to ovulate and, therefore, may not need emergency contraceptive pills. However, a woman who is providing supplementary feeding to her infant or who has had menses since delivery, even a single time, may be at risk of pregnancy. A single treatment with combined emergency contraceptive pills is unlikely to have a serious effect on the quantity and quality of milk she produces. Some hormones may get absorbed into the breast milk but they are unlikely to affect the infant adversely. The amount of hormone that goes into the infant's body is almost same as the infant would normally take from the mother's body through breast milk. However, for women who are breastfeeding, progestin-only emergency contraceptive pills are more suitable and they do not change the quantity and quality of breast milk.

**Can emergency contraceptive pills be given while the status of pregnancy is unclear?**

Emergency contraceptive pills may be given when a woman's pregnancy status is unclear and a pregnancy test is not available, as there is no evidence suggesting that emergency contraceptive pills harm the woman or an existing pregnancy. However, a client should be informed that she might already be pregnant and, in such cases, emergency contraceptive pills will not be effective.

**If knowledge of emergency contraceptive pills becomes widespread, could incorrect use or overuse of these pills become a problem?**

Misuse is not likely. Even in countries where emergency contraceptive pills are easily available, they have not been misused. World Health Organization suggests that making emergency contraceptive pills readily available with accurate instructions through established family planning services, whether clinic, pharmacy or community based, will help to reduce any risk of incorrect use or overuse and will ensure appropriate follow-up counseling and contraceptive services.

**Do emergency contraceptive pills interact with other drugs?**

There is no specific data available about the interaction of emergency contraceptive pills with other drugs that the client may be taking. However, it seems reasonable that drug interactions would be similar to those with regular oral contraceptive pills. Women taking drugs that may reduce the effectiveness of oral contraceptives including but not limited to Rifampicin and certain anticonvulsant drugs should be advised that the effectiveness of emergency contraceptive pills may be reduced. In this case, she may increase the amount of hormone in each dose.
MODULE FOUR
MANAGEMENT OF SIDE EFFECTS ASSOCIATED WITH THE USE OF EMERGENCY CONTRACEPTIVE PILLS

Learning Objectives:

By the end of the session, participants will be able to:

- List the side effects of LNG-ECPs.
- Discuss the management of the side effects of LNG-ECPs

Session Overview

- Side effects of LNG-ECPs.
- Management of the side effects of LNG-ECPs

Methods

- Brainstorming
- Illustrated Lecture
- Case studies
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
CONTENT

Side Effects of ECPs

The main side effects reported for ECPs include:

- Nausea and vomiting
- Bleeding disturbances or spotting
- Other possible effects include headaches, dizziness, fatigue, and breast tenderness.

Most side effects generally disappear within 24 hours of taking the pills.

Nausea

About 23% of women using LNG-ECPs will experience nausea. Symptoms are usually limited to the first three days after treatment.

Management

With the LNG-only regimen of ECPs, nausea and vomiting are uncommon, such that it is not routinely warranted to use an antiemetic (anti-vomiting) drug. It is very difficult which women will have nausea and vomiting. There is no evidence that taking ECPs with food reduces the risk of nausea. However, the psychological effect of the provider suggesting that the woman take the regimen with some culturally appropriate food (boiled potatoes, rice, dry crackers, or bread) may reassure her stress, help her to withstand any nausea that may occur, and avoid vomiting.

Vomiting

Occurs in about 6% of women using the LNG-regimen.

Management

If vomiting occurs within one hour of taking ECPs, the dose should be repeated. In cases of severe vomiting, vaginal administration of the pills can be used.

Irregular vaginal bleeding or spotting

A small number of women will have irregular bleeding or spotting after taking ECPs. Irregular bleeding should not be confused with menses, which is the woman’s much anticipated evidence that she is not pregnant. Most women will have their menses within one week, before or after the expected time.
Management

Inform the women that ECPs do not bring on menses immediately (a common misconception among ECP users). If the menstrual period is delayed by more than one week after the expected date, the possibility of pregnancy should be considered and a pregnancy test performed. If the provider cannot offer the services, advise her to seek pregnancy testing and appropriate care.

Other side effects of ECPs

These may include breast tenderness, headache, abdominal pain, dizziness, and fatigue. These side effects usually do not occur more than a few days after treatment, and they generally do not last more than 24 hours.

Management

Aspirin, ibuprofen, acetaminophen or another non-prescription pain reliever can be used to reduce discomfort due to headaches or breast tenderness.

NOTE:

Ectopic pregnancy

All contraceptive methods reduce the absolute risk of ectopic pregnancy by preventing pregnancy in general. A systemic review of world literature found that 1% of pregnancies occurring after the use of the levonorgestrel ECP regimen were ectopic. These figures are similar to the risk that pregnancies not exposed to ECPs will be ectopic. Thus, the review concluded that the levonorgestrel ECP regimen does not increase the chance that a pregnancy will be ectopic.

Summary

- Side effects after taking LNG ECPs are rare.
- The side effects reported for ECPs include:
  - Nausea and vomiting
  - Bleeding disturbances or spotting
  - Other possible effects include headaches, dizziness, fatigue, and breast tenderness.
- Most side effects generally disappear within 24 hours of taking the pills.
- To reduce the effects of nausea, ECPs can be taken with food. If a woman vomits less than two hours after taking a dose of ECPs, the dose should be repeated.
- In cases of severe vomiting, (rare in LNG-ECP but may occur in the Yuzpe regimen), EC can be administered vaginally.
- Levonorgestrel ECP regimen does not increase the chance that a pregnancy will be ectopic.
MODULE FIVE
ADDRESSING THE NEEDS OF SPECIFIC POPULATIONS

Learning Objectives:

By the end of the session, participants will be able to:

- Identify the populations with specific needs for ECPs.
- Discuss the role of ECPs in rape survivors
- Explain the provision of ECPs for Young Women
- Discuss the provision of ECPs to women living in humanitarian settings

Session Overview

- Identification of the populations with specific needs for ECPs.
- Role of ECPs in rape survivors
- Provision of ECPs for Young Women
- Provision of ECPs to women living in humanitarian settings

Methods

- Brainstorming
- Illustrated Lecture
- Case studies
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
Identification of populations with specific needs

Unintended pregnancy can place a burden on any woman, no matter what her situation. However, there are women in certain situations who are more vulnerable, both individually and socially, for whom EC can play an especially important role in maintaining their physical and psychological health by preventing an unintended pregnancy. In this section we review three of the populations whose needs may be better met by providing ECPs through specific delivery systems:

- survivors of rape,
- unmarried young women, and
- women living in refugee settings.

Rape survivors

Pregnancy resulting from rape is almost always unintended and traumatic. As a general principle, ECPs should be made available to all female survivors of rape:

- who are of reproductive age or
- who show signs of secondary sexual characteristics,
- who are not pregnant, and
- who are not consistently using an effective form of contraception.

A pregnancy test is not required prior to providing EC after rape, but pregnancy can be ruled out by using a simple checklist. In any case, providers should assure clients that even if the woman is pregnant; using ECPs will not harm the fetus. As EC must be administered within 120 hours of the rape and is most effective if used as early as possible, any education messages about post-rape services should emphasize the critical importance of obtaining ECPs (and in high HIV prevalence settings, HIV PEP also) as soon as possible after the rape.

Where to provide ECP Information and Services to Rape Survivors

The narrow window of opportunity to reduce the risk of a pregnancy after rape requires that ECP information and services are provided at the first point of contact (FPC) with a rape survivor, or as soon as possible afterwards. The first point of contact varies considerably, but is usually either:

1. the place where the crime is first reported, most often at a police station, social services or public prosecutor offices, legal aid agencies or women’s refuges; or
2. at the place where the survivor goes for treatment (either before or after reporting the crime), such as outpatient or emergency units at health facilities. Some countries have, or are developing, specialist centers that can provide all medical, legal, psychological, and other support for survivors at one point of contact (e.g.
the Thuthuzela Rape Centers in South Africa.\textsuperscript{50}

In several countries (e.g. Ecuador, Guatemala, Mexico, and Zambia), ECP counseling and services have been introduced in police precincts and rape care centers. Experience shows that staff in these centers require more extensive training in counseling rape survivors than health staff and may require special approvals and support from the health sector. Having this service included in guidelines and protocols is essential for ensuring that the staff consistently deliver the services. When the ECPs themselves are not provided, these FPCs should:

- refer survivors to pharmacies or clinics where they can obtain the pills and
- be provided written instructions on how to use them or,
- if available, to rape care centers where a broader set of needs can be cared for.\textsuperscript{48,49,51}

Knowledge and Skills expected of Providers offering ECP to Rape Survivors

Establishing ECP services for rape survivors at these FPCs may require training providers as community-based or employer-based contraceptive distributors under national guidelines. At a minimum, staff and managers should be trained on the following:

- The characteristics of ECPs
- Identifying which rape survivors should be provided with ECPs
- Counseling survivors about their options and providing ECPs or a referral for them
- After provision, referring for STI/HIV PEP and medical and psychological trauma management (if not already received)
- Depending on the individual's preference and the national legal framework, opening or a referral for opening a criminal case.

Provision of ECPs at the FPC is strongly recommended over referring to another location because of the critical need for its immediate use, especially in situations that lack readily available transportation.\textsuperscript{48,49,52,53}

Other Consequences of Rape

Female survivors of sexual violence often sustain physical injuries and after the assault are more likely than other women to have unintended pregnancies, report symptoms of reproductive tract infections, have multiple partners, and be less likely to use condoms and other contraceptives.\textsuperscript{54} EC is only one component of a comprehensive post-rape care “package” of services necessary to reduce the range of possible consequences of sexual violence. As far as is possible, a comprehensive and integrated care package should be
available, either in a single venue (e.g. the Thuthuzela model) or, more commonly, through a system of coordinated referrals among specialized units.

Young women

Young people are defined by WHO as those aged between 10 and 24 years, thereby including both adolescents (aged 10-19 years) and youth (aged 15-24 years). For most young people, this is a time of sexual initiation and experimentation, often characterized by infrequent, unplanned, and sometimes non-consensual encounters.

By its very nature, this type of sexual activity is frequently unprotected or insufficiently protected against both pregnancy and STIs. Ensuring access to and use of ECPs can be a critical component in any RH programme’s efforts to reduce unintended pregnancies among this population. Young people may thus constitute an important and growing population to be reached with ECP services by a national RH programme. Evidence from Kenya suggests that young people constitute as many as 80% of all public sector ECP clients, and 49% of those purchasing the method from pharmacies.48

Where to obtain Information and Services

Young people are not a homogeneous population, even within a particular country setting, and so ECP programming strategies to reach them need to be flexible. In most situations, ECP information and services should be made available through the same structures and programs as other youth reproductive health information and services, such as:

- adolescent-friendly clinics,
- community-based programmes and,
- in some settings, school-based programmes.

Because many adolescents may feel shy, distrust established services, lack money, and have less knowledge than older people, it is even more important that ECP services for young people have the recommended characteristics of quality contraceptive services in general, including:

- Privacy and confidentiality
- Easy accessibility
- Reasonably priced services and supplies
- Convenient and flexible schedules
- Sensitive and approachable staff trained to counsel adolescents

Strategies for making ECPs readily available to Young Women

ECP programming for adolescents through existing structures requires:

- planning,
- budgeting, and
- undertaking activities that enable the inclusion of messages and informational materials within communications strategies,
- training of existing staff, and
- easy delivery and maintenance of commodity supplies.

For example:

- Within secondary schools, information about ECPs could be included within a broader curriculum covering sexual and reproductive health, or in special ECP-focused sessions that include this topic could be held for students, teachers, and parents.

- In tertiary, and some secondary education facilities, existing student health services can be equipped to provide ECPs, along with counseling and services for contraception and STI/HIV prevention.

Integrating ECP services with related youth-focused activities can also be an effective way to increase the range and impact of ECP messages, although a stand-alone project or programme on ECPs for adolescents and youth may not be acceptable or feasible in many countries.

Further methods of reaching young people with information about ECPs include:

- identifying and using media and information channels that are accessible to the youth population. For example, newspapers, hotlines, youth journals, websites and advertisements for events attended by youths.
- making ECPs an over-the-counter (OTC) product available to young people. This would dramatically reduce medical barriers in accessing ECPs.
- encouraging and training pharmacists to stock ECPs and to disseminate correct information to their clients, particularly youth.

Women living in humanitarian settings

Relatively little is known about how best to provide reproductive health services, including ECPs, in humanitarian settings. Service delivery to refugees and internally displaced persons (IDPs) tends to be adapted from models designed for stable communities, and there is little information about how these service delivery models are best used or adapted to the needs of refugees or IDPs. Moreover, the reproductive health status and needs of a refugee woman living long-term in a stable camp setting may be very different from those of refugees during the emergency phase of a crisis, or from IDPs and other war-affected groups. This section reviews some of the issues associated with programming ECPs in such settings.

Types of Reproductive Health Services, including ECPs, required by Women in Humanitarian Settings
Humanitarian emergencies may flare up in a short time period, and, by their very nature, may not allow time for intensive and comprehensive training of providers, which can include medical and paramedical staff as well as traditional birth attendants and trained field staff and volunteers. Ideally, providers should be trained and sensitized in advance, or, if necessary, by a dedicated RH advisor after the response begins. Medical staff should be trained to provide ECP counseling, STI screening, and prophylactic treatment to rape survivors, along with necessary trauma treatment.

Response programmes may be required to be creative when sourcing providers of information and counseling. In the Kibondo camps of Tanzania, leaders elected by refugee women in the camps were trained to do community education and to counsel rape survivors. Traditional birth attendants and social services paraprofessionals were given violence-sensitivity training, which includes basic information on ECPs.

ECPs should be available right from the beginning of a response to a humanitarian crisis. WHO’s Inter-Agency Working Group for Reproductive Health in Refugee Situations has developed a Minimum Initial Service Package (MISP) to address the reproductive health needs of displaced women and girls, which includes ECP as one of the services to be provided. WHO has also included ECPs in the “New Emergency Health Kit,” a package of basic commodities delivered immediately to every newly identified emergency site. Programme staff working in emergency settings should be aware of the need to source, order, and distribute ECPs early in the emergency, tasks that may be neglected in the hectic first days.

**Barriers to providing ECPs in humanitarian settings**

The key barriers to providing ECPs in humanitarian settings are similar to those in the general population –

- women’s (and health providers’) lack of knowledge about ECPs,
- stigmatization of users,
- inadequate supplies, and
- provider insensitivity or bias.

As in the general population, these barriers lead to under-utilization. Data from refugee camps in seven countries show that 54 percent of female rape survivors did not receive ECPs within 120 hours of an incident in 2007. With this in mind, it is important to consider that to ensure compliance, one-dose dedicated ECPs may be more appropriate for transient clients.

Limited understanding and knowledge of ECPs in refugee camps often mirrors that of the pre-crisis population.

A study in Kakuma camp in Kenya found that, as in the general population, ECPs were widely perceived to be abortifacients. Moreover, of the 34 percent of women and 27
percent of men who were aware of rape cases, only 11 percent knew that emergency contraception was available through the camp health services, demonstrating the need for greater information to be disseminated among refugee populations. After providing training on EC to professional service providers, women’s support group leaders, community health leaders, community health workers, and family planning promoters in Kakuma, knowledge about the method more than doubled in the refugee population, from 15 to 35 percent.

A humanitarian response team may need to consider national laws and protocols in advance, and take timely steps to advocate for change, if appropriate. For example, NGOs in Sudan say that they do not advertise services for rape survivors because Sudanese law (Article 48) prevents doctors from treating rape survivors without a referral from the police department. Doctors and health personnel can be arrested for violating this law and some have been threatened, to prevent them from providing services. In Kakuma camp in Kenya, despite trained providers increased knowledge about EC among refugees, EC services could not be institutionalized and contraceptive services continued being provided as they had been before the training.

SUMMARY

Emergency contraception must be readily available to rape survivors, young women and those living in humanitarian settings (e.g., IDPs) as both a human rights and public health imperative. To add to their physical and psychological trauma, victims of rape and women living in humanitarian settings also risk unwanted pregnancy and exposure to sexually transmitted infections (STIs), including HIV/AIDS.
MODULE SIX
PRIORITY AREAS AND ROLES IN EMERGENCY CONTRACEPTION PROGRAMMING IN NIGERIA

Learning Objectives:

By the end of the session, participants will be able to:

- Identify the priority areas for EC programming in Nigeria
- Discuss the roles and responsibilities of the health sectors in EC programming in Nigeria

Session Overview

- Identification of the priority areas for EC programming in Nigeria
- Roles and responsibilities of the health sectors in EC programming in Nigeria

Methods

- Brainstorming
- Illustrated Lecture
- Discussion

Materials

- Flip chart/Markers
- LCD Projector
- Laptop
Priority areas in EC programming in Nigeria

Emergency contraception (EC) has been proven effective for over 30 years yet remains greatly underutilized in Nigeria where it can serve the goals of reducing unwanted pregnancies, unsafe abortion and related morbidity, and as a back-up to condom use and a bridge to longer-term contraceptive methods if made more widely known and available. As stakeholders continue to work to introduce and expand EC provision in the public, private and non-governmental (NGO) programmes in Nigeria, there are several important considerations to ensure that the services are of high quality. These were referred to as “Priority Areas” that guided stakeholders to develop their recommendations for the National Guidelines on EC. These priority areas include:

- Procurement
- Availability
- Distribution
- Pricing
- Promotion
- Awareness/Communication
- Demand Generation
- Training and Service provision
- Integration into FP services
- Access and User considerations

Roles and Responsibilities

The “total market” for ECPs should be encouraged: the private/commercial sector, social marketing sector, and public sector all have important roles to play in making ECPs available to women who need them. Care should be taken not to undermine market forces, for instance by allowing public sector, subsidized product to “leak” into the private marketplace.

A. Roles of different sectors providing EC in Nigeria.

Public sector

- Creating an enabling policy environment to increase access to and awareness of EC (including promotional efforts).
- Providing regulatory framework for EC access, distribution and registration.
- Coordination of all interventions of stakeholders and partners for EC in Nigeria.
- Integration of all interventions of stakeholders and partners for EC in Nigeria to report and share data centrally.
- Integration of EC procurement into the national integrated logistic MIS.
- Monitoring and evaluation of EC interventions in Nigeria.
- Integration of EC into FP training for providers.
- Creating and following up with awareness for EC programing.
- Promoting and encouraging funding for local production of EC’s to increase availability and access.
- Regulate the market to ensure that available products are of high quality and that counterfeited products are stopped at the border.

**Private/Commercial Sector and Social Marketing Sector**

- Creation of demand for branded EC.
- Supporting innovation for improved demand and supply for EC.
- Promotion of social marketing
- Provision of generic messaging for EC demand creation.
- Possibly provision of subsidized EC for the relevant market segments.
- Provision of support to the government by private organizations (especially partners) on EC distribution for wider coverage.

**Donors**

- Support FMoH procurement requests for ECPs
- Broker multi-sectoral partnerships for coordinated ECP response in advocacy; messaging
- Support NGOs and technical assistance agencies to continue to improve access to EC in Nigeria.

**Other Agencies**

- Engaging in advocacy aimed at creating better enabling environment for EC programming e.g. CSOs.
- Dissemination of research findings on EC to all stakeholders.

**B. Roles of cadres of health care workers for EC provision in Nigeria**

Different cadres of health workers have different essential roles in the procurement, distribution and provision of emergency contraception such as client educators, advocates, and support. Roles of different cadres of service providers are defined in the National Task Shifting Guidance.

**Physicians**

- Create awareness on availability of EC
- Ensure availability of EC in the consulting rooms especially in the Accident and Emergency Units
- Give information/counselling about EC and provide when necessary.

**Pharmacist/Pharmacist Technician**

- Ensure regular supply and availability of ECPs
- Ensure ECPs are distributed accordingly
- Monitor expiry dates of EC products
- Counsel and offer ECPs to clients and if necessary refer

**Nurses/Midwives**

- Create awareness on availability of EC
- Ensure regular supply and availability of EC
- Ensure ECPs are distributed accordingly using management tools
- Monitor expiry dates of EC products
- Counsel and prescribe EC to clients and refer if necessary
- Track record of EC usage

**Community Health Officers/Community Health Extension Workers (CHOs/CHEWs)**

- Create awareness on availability of ECPs
- Ensure regular supply and availability of ECPs
- Ensure EC is distributed accordingly using appropriate management tools
- Monitor expiry dates of EC products
- Counsel and prescribe ECPs to clients and refer accordingly when necessary
- Track record of ECP usage

**Community Based Distributors (CBDs)**

- Create awareness on availability of EC
- Mobilize clients for EC and other family planning methods
- Ensure EC is distributed accordingly using appropriate FP data tool
- Monitor expiry dates of EC products
- Counsel and prescribe ECPs to clients and refer accordingly
- Give proper accountability of ECP usage

**C. Roles of non-clinical workers for EC provision in Nigeria**

- Quick referral of sexual assault survivors
- Quick provision of EC to victims of sexual assault - including Police stations, police hospitals

**SUMMARY**

The ultimate goal is to ensure that ECPs become a standardized method within the range of services being made available in the national family programme. The steps that may be needed to establish and sustain high-quality integrated EC/FP services should include a broad range of interventions across different levels of the health system. Comprehensive approaches are needed to address changes at policy, facility, provider, and community level. Although the relative importance of each of these is not known, they all have the potential to contribute to high-quality, sustainable services. However, close monitoring of roles and services at all levels has crucial values and must be sustained.
REFERENCES AND RESOURCE MATERIALS

REFERENCES


47. Family Health International (FHI). How to be reasonably sure a client is not pregnant: a checklist. 2007. Research Triangle Park, North Carolina: FHI.


RESOURCE MATERIALS


8. WHO Emergency Contraception Factsheet#244. [http://www.who.int/mediacentre/factsheets/fs244/en/](http://www.who.int/mediacentre/factsheets/fs244/en/)