



Emergency Contraception

for Conflict-Affected Settings



A Reproductive Health Response in Conflict Consortium
Distance Learning Module

The Reproductive Health Response in Conflict Consortium

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Members: American Refugee Committee
CARE
Columbia University, Mailman School of Public Health, Heilbrunn
Department for Population and Family Health
International Rescue Committee
JSI Research and Training Institute
Marie Stopes International
Women's Commission for Refugee Women and Children



Mission Statement

The Reproductive Health Response in Conflict (RHRC) Consortium is dedicated to the promotion of reproductive health among all persons affected by armed conflict. The RHRC Consortium promotes sustained access to comprehensive, high quality reproductive health programs in emergencies and advocates for policies that support reproductive health of persons affected by armed conflict.

The RHRC Consortium believes all persons have a right to quality reproductive health care and that reproductive health programming must promote rights, respect and responsibility for all. To this end, the RHRC Consortium adheres to three fundamental principles: using participatory approaches to involve the community at all stages of programming; encouraging reproductive health programming during all phases of emergencies, from the initial crisis to reconstruction and development; and employing a rights-based approach in all of its work, as articulated in the 1994 International Conference on Population and Development Program of Action.

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Table of Contents



About the Distance Learning Module	2
Introduction	4
Chapter 1 Emergency Contraception (EC)	6
Chapter 2 EC Pills	9
Chapter 3 EC IUDs	13
Chapter 4 EC Service Delivery in Conflict-Affected Settings.....	16
Frequently Asked Questions	21
QUIZ	23
EC Service Delivery Scenarios.....	25
Resources	28
Charts & Checklist for EC Service Delivery	31

Acronyms and Abbreviations

COC	Combined oral contraceptive	RHRC	Reproductive Health Response in Conflict (RHRC) Consortium
EC	Emergency contraception	STI	Sexually transmitted infection
ECP	Emergency contraceptive pill	UNFPA	United Nations Population Fund
GBV	Gender-based violence	UNHCR	United Nations High Commissioner for Refugees
IDP	Internally displaced person	WHO	World Health Organization
IUD	Intrauterine device		
MISP	Minimum Initial Service Package		
NGO	Nongovernmental Organization		



About the Distance Learning Module

Emergency Contraception for Conflict-Affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module has been developed to meet the need for increased awareness and knowledge about emergency contraception (EC) among health service providers working with refugee and internally displaced populations (IDPs).¹ A distance learning method helps to increase access to information about EC, promotes flexibility, assures quality information, empowers learners and is cost-effective.² Based on such advantages, the Reproductive Health Response in Conflict (RHRC) Consortium chose this method to provide practical information on EC to local projects in developing countries. The RHRC Consortium is working to mainstream EC by increasing awareness and knowledge and improving access to and demand for EC in appropriate program locations. (To learn more about the RHRC Consortium's activities around the world, please visit the website at www.rhrc.org.)

Who should use the EC distance learning module?



The module is ideal for providers working in conflict-affected situations who wish to learn about EC, need to refresh their current level of knowledge and/or would like to incorporate EC services into their reproductive health care programs. Appropriate users of this module include family planning staff, community health workers, health educators, counselors, trainers, program managers, nurses, doctors, midwives and other health care personnel working in conflict-affected settings. The module would also be useful in providing information and training to a multisectoral response team, which may include protection officers, non-governmental and government authorities, and other humanitarian partners in the education and community service sectors. The Resources section at the end of this module provides a list of learning materials useful for those needing more extensive background information on basic reproductive health topics.

What are the learning objectives of the EC distance learning module?



The module is a learning tool designed to provide basic information about EC that will help providers increase their knowledge about EC, better assess their clients' needs, be more sensitive to the issues underlying clients' needs and decisions and promote awareness within conflict-affected communities about EC. The main objectives of the module are to enable learners to:

- define EC
- explain how the two EC methods work and the difference between EC and abortion
- list reasons why displaced women and girls of reproductive age may need EC
- describe the appropriate uses of EC and how to use the methods correctly
- list possible side effects of EC and how to manage side effects
- list precautions and considerations for EC use

¹ Refugees have crossed an international border; the internally displaced are still in their own country. In this document, the term "refugee" refers to both categories.

² Long P, Kiplinger N. *Making It Happen: Using Distance Learning to Improve Reproductive Health Provider Performance*. INTRAH, the PRIME II project, 1999.

- ▣ explain the advantages, disadvantages and the effectiveness of EC
- ▣ discuss the important role of providers in making EC available to displaced populations
- ▣ describe some of the issues specific to providing services to displaced women and adolescents
- ▣ describe the role of counseling around issues of family planning, gender-based violence and sexually transmitted infections (STIs)/HIV
- ▣ know where to access other EC resources

How do I use the EC distance learning module?

The module is a self-instructional learning module, and will be available in English, French, Spanish, Portuguese and possibly other languages. The online version of the module is interactive and includes a quiz, case studies and links to additional web-based resources. The online module can be downloaded or printed for offline review.

Each section of the module consists of information that health workers need to know before providing EC services. The sections should be read and completed in sequence in order to gain the most complete understanding of EC. The information is also important to share during an education or counseling session with clients or potential EC users. After completing the module, learners can take the quiz to test their knowledge and browse through the Frequently Asked Questions (FAQs) that may help clarify some critical points about EC. The case studies provide a few examples of how providers may integrate EC services into their reproductive health programs. Learners can use the list of additional resources at the end of the module to further their knowledge and to obtain sample materials and fact sheets to offer their clients.

In what format is the EC distance learning module available?

The module is available online at www.rhrc.org, as well as on CD-ROM and in print. To order CDs or print copies, please send an email to info@rhrc.org.

Are there ways to provide feedback for improving the EC distance learning module?

In an ongoing effort to improve the module, we would like your suggestions to help make it a more helpful and enjoyable learning experience. Please submit your comments by sending an e-mail message to info@rhrc.org.

Thank you!



Introduction

Refugee and internally to

For women forcibly displaced by conflict, access to emergency contraception (EC) is not only a right, but also a critical need that can help to maintain and improve their reproductive health. Refugee and IDP women who are not granted access to EC are deprived of their right to reproductive health, as they may be forced to experience an unwanted pregnancy and may, as a result, suffer or die from childbirth or abortion complications.

While maternal mortality is a common cause of death among women living in resource-poor settings, the stressful living conditions of displaced women make delivering a child even more difficult and life threatening. By offering a “second chance” to those whose regular contraceptive method has failed, EC provides a woman or adolescent girl with the opportunity to avoid an unplanned or forced pregnancy and can reduce her risk of death or illness due to complications from childbirth or unsafe abortion.

War and conflict increase incidents of rape and other forms of gender-based violence (GBV); this dire reality is reflected in an increasing number of documented reports and research. Women and adolescents are especially vulnerable to sexual abuse committed by combatants. The use of rape as a weapon of war has been documented during the conflicts in Bosnia and Herzegovina, Rwanda and Sierra Leone. According to a recent study in Sierra Leone, war-related sexual violence was widespread among women who were internally displaced by the conflict. The prevalence of sexual violence, including rape, committed by combatants was found to be 9 percent during the past 10 years of war, equaling Sierra Leone’s lifetime prevalence of non-war-related sexual assaults. Research in Tanzania in 1997 found that almost 28 percent of Burundian refugee women of reproductive age had been raped since becoming refugees. A 1982 study of Guatemalan refugee women found that their most overwhelming fear was of being raped.

displaced women have a right and a need for emergency contraception.

Displaced women are also victims of another type of gender-based abuse – sexual exploitation – when men wielding power in the refugee, host and even humanitarian communities demand sex in exchange for safety, food or other commodities. As a consequence of war, women may be required to exchange sex for resources to support themselves and their families. To make matters worse, women in conflict settings often do not have access to regular family planning methods for protection against unwanted pregnancies. Such circumstances underscore the importance of making EC available for refugee and IDP women.

To address the reproductive health needs and rights of refugee women, EC should be made available from the beginning of a response to a humanitarian crisis. The Minimum Initial Service Package (MISP), which outlines the series of priority actions needed to respond to the reproductive health needs of populations in the early phase of humanitarian crises, includes EC as a component of the services to be provided to survivors of GBV. The MISP is included as a standard of humanitarian response in the new SPHERE guidelines, which were published in 2004. Staff training is especially critical in these settings and clear information on available services must be communicated immediately to newly arriving refugees, IDPs and others affected by conflict who may be unaware of EC as an option.





Chapter 1

Emergency Contraception³

1. What is emergency contraception?

Emergency contraception (EC) is a contraceptive method used by a woman after unprotected sexual intercourse to prevent an unwanted pregnancy.

There are currently two methods of emergency contraception: **oral emergency contraceptive pills** and **the copper-bearing intrauterine device (IUD)**.

Emergency contraceptive pills (ECPs) are sometimes referred to as “morning-after” or “postcoital” pills, but since these terms do not convey the correct timing for EC use, the preferred term is “emergency contraceptive pills.” ECPs should be used within 120 hours (5 days) after unprotected intercourse.⁴ Available types of ECPs are:

- ☐ Oral contraceptives containing only progestin (levonorgestrel)
- ☐ Combined oral contraceptives containing an estrogen (ethinyl estradiol) and a progestin (levonorgestrel) – also known as the Yuzpe method

Both of these types are available as dedicated EC products – higher-dose pills that are specially packaged for use as emergency contraception. If dedicated ECPs are not available, then increased doses of regular oral contraceptives are used as EC.

ECPs are not a substitute for regular family planning; *Chapter 2* describes how to use ECPs.

A copper-bearing IUD (The Copper T “TCu380A” or Multiload “MLCu-375”) can also be used as EC when inserted within seven days of unprotected intercourse.⁵ The IUD can remain in place to serve as a regular contraceptive for up to 5-10 years; it may be removed by a trained health provider whenever the client wishes. *Chapter 3* describes how to use a copper-bearing IUD for EC.

³ Adapted from “Module 5: Emergency Contraceptive Pills,” Pathfinder International, revised 2000 September; and “Emergency Contraception: A Guide for Service Delivery,” WHO, 1998.

⁴ International Consortium for Emergency Contraception, *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines*, Second Edition, 2003.

⁵ Ibid.



2. Who may need to use EC and what are the appropriate uses for EC?

There are several situations in which a woman or girl of reproductive age may need EC to avoid an unwanted pregnancy, as listed below.

- ☐ She has little or no awareness about contraception and has had unprotected sexual intercourse.
- ☐ She desires contraception, has had sexual intercourse and is not currently using regular contraceptive methods.
- ☐ She desires contraception, has had sexual intercourse and used her regular contraceptives incorrectly or inconsistently.
- ☐ She desires contraception and her contraceptive method has failed:
 - ☐ condom breakage or slippage
 - ☐ failure to abstain from sex during fertile days
 - ☐ expulsion of an IUD
 - ☐ failure of withdrawal method, when ejaculation has occurred in the vagina or on the external genitalia
 - ☐ failure to take oral contraceptives for 2 or more days
 - ☐ being late for a contraceptive injection
- ☐ She has been a recent victim of sexual assault and had no contraceptive protection.

While all women in situations of conflict are vulnerable to sexual violence, young female adolescents may be the group most in need of emergency contraceptive services. Adolescent refugees are often targeted for sexual exploitation and rape, yet there are relatively few programs that address the specific reproductive health needs of young people and even fewer that provide EC.

As with all health interventions, EC should be implemented in accordance with the cultural values of refugee communities and host country protocols. EC is one component of reproductive health care and communities need to receive full and impartial information and counseling on it as they do for all other forms of reproductive health care. Health workers may require additional training in EC if they are not familiar with its use, in order to ensure a sensitive and culturally appropriate response to women's needs. Furthermore, service providers who are not familiar with EC protocols in the host country should contact the local Ministry of Health to ensure that EC services are aligned with national laws and policies.

The box on the next page lists all of the countries where dedicated EC products are available; it does not distinguish between countries that are affected by conflict and those that are not. The list excludes countries where dedicated EC products are not yet registered and available, where copper-bearing IUDs may be used for EC, or where EC is prohibited. For more information on EC product availability in a particular country, please go to <http://ec.princeton.edu/worldwide/default.asp>.

List of Countries with Dedicated EC Products

Africa		Americas (North, Central, South)		Asia (East, Central, Southeast, Oceania)		Europe (East, Central, West)	
Algeria	Mali	Argentina	Jamaica	Australia	Lebanon	Albania	Latvia
Benin	Mauritania	Bolivia	Martinique	Azerbaijan	Malaysia	Armenia	Lithuania
Cameroon	Mauritius	Brazil	Mexico	Bangladesh	Mongolia	Austria	Luxembourg
Democratic Republic of Congo	Morocco	Canada	Nicaragua	China	Myanmar	Belarus	Moldova
Egypt	Namibia	Chile	Paraguay	Fiji	New Zealand	Belgium	Montenegro
Gabon	Nigeria	Colombia	Peru	French Polynesia	Pakistan	Bulgaria	Netherlands
Ghana	Reunion	Cuba	Seychelles	Hong Kong	Singapore	Czech Republic	Norway
Guinea-Bissau	Sierra Leone	Dominican Republic	Trinidad/Tobago	India	Sri Lanka	Estonia	Poland
Ivory Coast	Senegal	El Salvador	United States	Indonesia	Taiwan	Finland	Portugal
Kenya	South Africa	Guadalupe	Uruguay	Israel	Tajikistan	France	Romania
Madagascar	Tunisia		Venezuela	Japan	Thailand	Georgia	Russia
	Uganda			Kazakhstan	Turkmenistan	Germany	Serbia
	Zimbabwe			Korea	Uzbekistan	Greece	Slovakia
				Kyrgyzstan	Vietnam	Hungary	Spain
					Yemen	Iceland	Sweden
						Italy	Ukraine
							United Kingdom

Source: International Consortium for Emergency Contraception. www.cecinfo.org/html/res-product-issues.htm and The Emergency Contraception Website www.not-2-late.com. Last updated 2003.



3. What are the possible consequences of not using EC?

Without EC, women forcibly displaced by conflict may have to endure unplanned or forced pregnancies, unsafe abortions and/or obstetric complications – all of which increase a woman's risk of illness or death. Young women are at a higher risk of negative outcomes because their bodies are not yet fully developed. In addition, women and girls may suffer psychological and emotional consequences without access to EC.

Chapter 2

Emergency Contraceptive Pills⁶

1. How do Emergency Contraceptive Pills work?

Emergency Contraceptive Pills (ECPs) are essentially regular oral contraceptive pills that are in higher doses, although ECPs differ in many important aspects from regular pills. While the exact way in which ECPs work is not known, research has suggested that the modes of action may depend on the time during the menstrual cycle when the woman had unprotected intercourse and when ECPs are taken, and may likely include one or more of the following:

- ▣ inhibiting or delaying ovulation by suppressing hormones
- ▣ preventing fertilization by interfering with the movement of sperm or egg
- ▣ inhibiting transport of the fertilized egg to the uterus
- ▣ preventing implantation by making the endometrium unreceptive

All four modes of action demonstrate that emergency contraceptives act before the implantation of a fertilized egg. ECPs do not disrupt or damage an established pregnancy following implantation and thus they are not considered a form of abortion by authoritative agencies such as the World Health Organisation (WHO).⁷

2. How effective are ECPs?

Both progestin-only and combined oral contraceptive types of ECPs are effective, although in direct comparisons the progestin-only regimen has been shown to be substantially more effective than the combined regimen.⁸ The pregnancy rate after a single act of unprotected sex in the second or third week of the menstrual cycle is 8 percent. With the use of ECPs, the chances of becoming pregnant are reduced to less than 2 percent. Research has shown that the progestin-only regimen reduces the risk of pregnancy by between 60 to 93 percent or more after a single act of intercourse, and the combined regimen reduces it by 56 to 89 percent.⁹ ECPs are most effective the sooner they are taken, and should be taken no later than 120 hours after unprotected intercourse.

Although ECPs are effective for emergency situations, they are not appropriate for regular use. The pregnancy rate of ECPs used frequently as a substitute for regular contraception would be much higher than the pregnancy rate of regular hormonal contraceptive pills in standard dosage.

⁶ Adapted from "Module 5: Emergency Contraceptive Pills" in *Comprehensive Reproductive Health and Family Planning Training Curriculum*, Pathfinder International, revised 2000 September; and *Emergency Contraception: A Guide for Service Delivery*, WHO, 1998.

⁷ *Emergency Contraception: A Guide for Service Delivery*, WHO, 1998.

⁸ International Consortium for Emergency Contraception, *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines*, Second Edition, 2003.

⁹ *Ibid.*



3. What are the side effects of ECPs? How are the side effects managed?

Side effects	Management of side effects
Nausea: Nausea is the most common side effect of ECPs. About 50 percent of women using COCs and 20 percent of women using progestin-only pills for EC experience nausea. It usually does not last more than 24 hours.	If available, a single 50 mg dose of meclizine may be offered one hour before the first dose of ECPs to help reduce the risk of nausea and vomiting. Clients should be warned that meclizine may cause drowsiness. The effectiveness of lower doses of meclizine and other antiemetics has not been studied. Evidence does not suggest that taking ECPs with food will alter the risk of nausea. ¹⁰
Vomiting: Vomiting occurs in 20 percent of women using COCs and 5 percent of women using progestin-only pills. Vomiting within 2 hours of taking ECPs can reduce the effectiveness of the ECPs.	Repeat the dose if vomiting occurs within two hours of taking the pills. If vomiting is severe, the repeat dose may be administered vaginally. ¹¹
Irregular uterine bleeding: Spotting may occur in some women; menstrual periods typically arrive on time or slightly early.	If menstruation is delayed by more than a week, a pregnancy test should be performed.
Other side effects: Other side effects that have been reported with EC include breast tenderness, headache, dizziness, and fatigue. These side effects usually do not last more than 24 hours.	Non-prescription pain relievers, like aspirin or paracetamol, can be used to reduce discomfort.

For a more detailed guide on ECP service provision, including the management of problems or side effects, please refer to Chapters 5 and 6 of *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff* or Chapter 12 of *Contraceptive Technology*.



4. What are the precautions and considerations for use of ECPs?

ECPs are considered very safe. The hormonal dose in ECPs is small and does not appear to alter blood-clotting mechanisms with its short exposure of estrogens and/or progestins. EC using COCs has not been associated with fetal malformations or congenital defects, nor does it seem to increase the possibility that a pregnancy following EC use will be ectopic. Finally, no deaths or serious medical complications have been reported as a result of ECPs, a method that has been used for more than 20 years. EC is not intended for use as a regular method of contraception.

Concerning pregnancy:

- ☑ A pregnancy test is not needed when a woman is considering ECPs.
- ☑ If a woman does not know if she is pregnant, ECPs may be taken as there is no evidence suggesting harm to the woman or an existing pregnancy.
- ☑ A woman who has a previously confirmed pregnancy should not take ECPs, since they will not be effective.

¹⁰ Consortium for Emergency Contraception. *Expanding Global Access to Emergency Contraception*. October 2000, p.42.

¹¹ International Consortium for Emergency Contraception. *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines*, Second Edition, 2003.



5. What are the advantages and disadvantages of using ECPs?

The advantages and disadvantages associated with ECPs include:

Advantages	Disadvantages
<ul style="list-style-type: none"> ☑ Safe and effective ☑ Easy to use ☑ Few or temporary side effects ☑ Safer and less invasive than surgical pregnancy termination if unwanted pregnancy follows unprotected sex ☑ An option for breastfeeding women ☑ Not associated with birth defects ☑ Reduces the need for abortions 	<ul style="list-style-type: none"> ☑ Should be taken within 120 hours after unprotected sex ☑ Can cause minor side effects ☑ Does not provide ongoing protection against pregnancy ☑ Does not protect against STIs/HIV ☑ Requires a prescription in some countries/states ☑ May be difficult for women not able to swallow pills easily

While health workers may have the advantage of serving a well-defined community that is open to guidance and support during an emergency situation, there are several specific challenges to providing ECPs in conflict-affected settings:

Challenges to ECP administration in conflict-affected settings
<ul style="list-style-type: none"> ☑ Difficulty in implementing the MISIP, because of logistics, funding or administrative constraints ☑ Lack of knowledge of EC as an option by both emergency relief workers and members of the displaced population ☑ Lack of time to educate emergency relief workers and members of the displaced population on EC as an option ☑ Lack of knowledge about EC provision by health workers (both emergency relief health workers and health workers within the displaced population) ☑ Lack of time to educate health workers on EC provision ☑ Difficulty identifying health workers in the early days of an emergency from within the displaced population ☑ Difficulty in dispensing pill dosages by health workers not experienced in EC provision if a dedicated ECP product (a product specially packaged for EC) is not available



6. What are the different ECP regimens?

As mentioned in the previous chapter, there are two types of ECPs:

- ☑ Oral contraceptives containing only progestin (levonorgestrel)
- ☑ Combined oral contraceptives (COCs) containing an estrogen (ethinyl estradiol) and a progestin (levonorgestrel) – also known as the Yuzpe method

Dedicated ECP products are specially packaged with the appropriate higher dosages of the two types listed above. While both ECP types are effective, the preferred method is the progestin-only contraceptive, due to its higher efficacy rate and lower risk of nausea and vomiting.

Each type of contraceptive has different regimens, with both high and low doses. The charts and descriptions below detail the regimens for each type of ECP. For all regimens, ECPs should be taken as soon as possible after intercourse but optimally within 120 hours.¹¹

Progestin-only Emergency Contraceptive Pills	First Dose = no later than 120 hours after unprotected sex	Second Dose = 12 hours after the first dose
HIGH DOSE: ¹² pills with 750 µg (0.75 mg) levonorgestrel	2 pills only	--
HIGH DOSE: pills with 750 µg (0.75 mg) levonorgestrel	1 pill	1 pill
LOW DOSE (mini): pills with 30 µg levonorgestrel	25 pills	25 pills

Progestin-only Emergency Contraceptive Pills

HIGH DOSE: When progestin-only EC is available in pills containing 750 µg levonorgestrel, two pills can be taken in one dose no later than 120 hours (5 days) after unprotected sex. Alternatively, the first dose of one pill should be taken no later than 120 hours after unprotected sex. The second dose of one pill must be taken 12 hours after the first dose.

LOW DOSE (mini): When the progestin-only contraceptive is only available in mini-pills containing 30 µg levonorgestrel, the first dose of 25 pills should be taken no later than 120 hours after unprotected sex. The second dose of another 25 pills must be followed 12 hours after the first dose. *Note: This refers to standard contraceptive progestin-only mini-pills*

Combined Oral Contraceptive Pills	First Dose = no later than 120 hours after unprotected sex	Second Dose = 12 hours after the first dose
HIGH DOSE: pills with 50 µg ethinylestradiol and 250 µg levonorgestrel (or 500 µg norgestrel)	2 pills	2 pills
LOW DOSE: pills with 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg norgestrel)	4 pills	4 pills
LOW DOSE: pills with 20 µg ethinylestradiol and 100 µg levonorgestrel	5 pills	5 pills

Combined Oral Contraceptive (COC)

HIGH DOSE: When COCs are available in specially packed pills or as high dose pills containing 50 µg of ethinylestradiol and 250 µg levonorgestrel (or 500 µg norgestrel), the first dose of two pills should be taken no later than 120 hours after unprotected sex. The second dose of two pills must be taken 12 hours after the first dose.

LOW DOSE: When only low-dose COC pills containing 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg norgestrel) are available, the first dose of four pills should be taken no later than 120 hours after unprotected sex. The second dose of four pills must be taken 12 hours after the first dose. Alternatively, when only low-dose COC pills containing 20 µg ethinylestradiol and 100 µg levonorgestrel are available, the first dose of five pills should be taken no later than 120 hours after unprotected sex. The second dose of five pills must be taken 12 hours after the first dose. *Note: This refers to standard combined oral contraceptive pills. Use 4 or 5 of the 21 hormone-containing pills for each dose of EC. The last 7 pills from a 28-pill pack cannot be used for EC as – these pills do not contain hormones.*

For updated information on ECP formulations, please refer to the International Consortium for Emergency Contraception website at www.cecinfo.org/html/fea-ecpformulations.htm.

¹¹ International Consortium for Emergency Contraception, Emergency Contraceptive Pills: Medical and Service Delivery Guidelines, Second Edition, 2003.

¹² A recent study found that a 1.5 mg single levonorgestrel dose can substitute two 0.75 mg doses taken 12 hours apart. See Von Hertzen H, et al. "Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial." *The Lancet* 2002 Dec 7; 360:1803-1810.

Chapter 3

Emergency Contraceptive Intrauterine Devices¹³

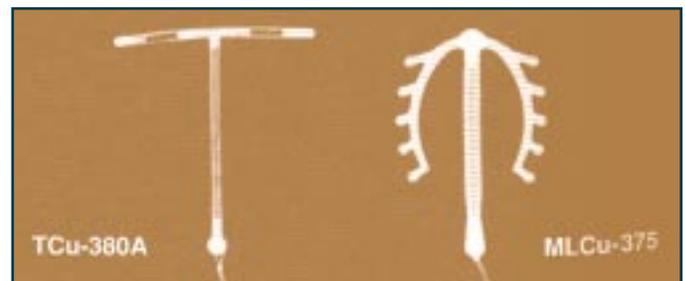
1. How does the copper-releasing intrauterine device work?

The exact ways in which the intrauterine device (IUD) works to prevent pregnancy are not clearly known and may depend on the time during the menstrual cycle when the IUD is inserted. Some research studies indicate that the copper-bearing IUD acts primarily by preventing fertilization, likely interfering with the movement of the egg and sperm and also decreasing the number of sperm reaching the fallopian tube.¹⁴ However, as the research has not been conclusive,¹⁵ it is possible that IUDs may also work by preventing implantation of the fertilized egg into the endometrium.

2. How effective are IUDs?

The IUD is a highly effective method for emergency contraception when used within seven days of unprotected sexual intercourse.¹⁶ The pregnancy rate reported among women using the copper-releasing IUD as an emergency contraceptive is around 1 percent. Unlike ECPs, which must be taken within 120 hours of unprotected sex, the IUD is effective if inserted within seven days of unprotected intercourse. Its efficacy in preventing pregnancy is reduced if inserted after the 7-day period. Once inserted, the IUD should remain in place until the client's menstrual period begins, indicating she has not become pregnant, or the client shows signs of pregnancy. The IUD can also remain in place to serve as a regular contraceptive for up to 5-10 years; it may be removed by a trained health provider any time the client wishes.

If the client has not had a menstrual period by a week after it was expected, has irregular bleeding or lower abdominal pain, or suspects she may be pregnant, she should seek follow-up care. In this case, it is recommended that the client takes a pregnancy test and is examined to exclude the possibility of an ectopic pregnancy. If she is pregnant and wishes to continue the pregnancy, the IUD should be removed by a trained health provider. Explain that there is a small risk of miscarriage, but that the risk to the pregnancy when leaving the IUD in place is much greater.



¹³ Adapted from *Emergency Contraception: A Guide for Service Delivery*, WHO, 1998; and Stewart GK. "Intrauterine Devices (IUDs)", *Contraceptive Technology*, 17th revised edition, 1998.

¹⁴ *Emergency Contraception: A Guide for Service Delivery*, WHO, 1998.

¹⁵ Rivera R, et al. The mechanism of action of hormonal contraceptives and intrauterine contraceptive devices. *Am J Obstet Gynecol* 1999; 181(5):1263-1269.

¹⁶ Planned Parenthood. *Emergency Contraception: Patient Information*.



3. What are the side effects of IUDs? How are the side effects managed?

Side effects	Management of side effects
Cramping : Cramping may occur for the first 24 to 48 hours after IUD insertion.	The client should take pain relief tablets such as aspirin or paracetamol. If the pain persists beyond 3-5 days, the client should contact the health care provider for follow-up care.
Heavy flow, spotting, bleeding : Spotting or heavy bleeding is common during the first three months after IUD insertion. Prolonged heavy bleeding may cause anemia.	The client should contact the health care provider for appropriate follow-up care.
Vaginal discharge : Vaginal discharge may occur during the first few weeks after IUD insertion.	If the discharge is heavy or accompanied by pelvic pain and/or fever, the client should contact the health care provider immediately.
Other signs or symptoms : Other problems may include fever and/or chills; pelvic pain or tenderness; excessive abnormal bleeding; the IUD threads cannot be felt.	If the client experiences any of these side effects, she should contact the health care provider. These symptoms may indicate a possible complication.

For a more detailed guide on IUD service provision, including the management of problems or side effects, please refer to Chapter 12 of *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff* or Chapter 21 of *Contraceptive Technology*.



4. What are the precautions and considerations for use of IUDs?

Before IUDs are offered to refugee and IDP women as a method for EC, it is critical that service providers are able to ensure hygienic conditions in the health facility and capable of addressing the practical constraints inherent in emergency settings. Furthermore, clinicians offering IUD services must be specifically trained in the insertion of these devices, due to the potential for complications.

According to WHO's eligibility criteria for IUD insertion, women with any of the following conditions are not eligible to use an IUD for EC:

- ☐ an established pregnancy (It is important to determine that a woman is not pregnant before inserting an IUD.)
- ☐ puerperal or post-abortion sepsis (current or within last 3 months)
- ☐ pelvic inflammatory disease (current or within last 3 months)
- ☐ a sexually transmitted infection (STI) (current or within last 3 months)
- ☐ purulent cervicitis
- ☐ confirmed or suspected malignancy of the genital tract
- ☐ congenital uterine abnormalities or fibroids distorting the cavity in a manner incompatible with proper IUD placement
- ☐ malignant gestational trophoblastic disease
- ☐ known pelvic tuberculosis
- ☐ unexplained vaginal bleeding (which may indicate a serious condition)

Clinical judgment of IUD use for EC is required in all circumstances, but there are two conditions in particular that warrant additional consideration before an IUD is inserted. These conditions are highly prevalent in conflict-affected settings:

- ▣ **Risk of STIs:** When a woman is at high risk of an STI, ECPs may be a better option than the IUD. Other interventions such as STI screening and prophylactic antibiotic treatment should also be provided at the time of IUD insertion if possible.
- ▣ **Rape:** Victims of sexual abuse may find an IUD insertion emotionally traumatic. They may have contracted an STI. Therefore, ECPs may be the preferred option.

When ECPs are not available, acceptable or effective because more than 120 hours have elapsed since unprotected intercourse, an IUD insertion might be considered for women at high risk of STIs or who have been victims of rape. However, the client choosing the IUD must be advised to switch to another contraceptive method at her next menstrual period.



5. What are some of the advantages and disadvantages of using IUDs?

The advantages and disadvantages associated with IUD insertion for EC include:

Advantages	Disadvantages
<ul style="list-style-type: none"> ▣ Safe and effective ▣ Useful option for women who present after 120 hours and are too late for ECPs ▣ Can be continued for use as regular contraceptive method ▣ Easy to use and lasts for 10 years if kept in as ongoing contraceptive method ▣ Easy for women not able to swallow pills easily ▣ An option for breastfeeding women ▣ Reduces the need for abortions 	<ul style="list-style-type: none"> ▣ Requires insertion and removal by a well-trained clinician ▣ Requires hygienic conditions for insertion ▣ Can cause side effects ▣ Can cause serious health problems which can make a woman sick or infertile ▣ Does not protect against STIs/HIV ▣ Must be inserted within 7 days after unprotected sex ▣ Cannot be used if woman has an STI

While health workers may have the advantage of serving a well-defined community that is open to guidance and support during an emergency situation, there are several specific challenges to providing IUD services in conflict-affected settings:

Challenges to IUD administration in conflict-affected settings
<ul style="list-style-type: none"> ▣ Lack of knowledge of IUDs as an EC option by both emergency relief workers and members of the displaced population ▣ Lack of time to educate emergency relief workers and members of the displaced population on IUDs as an EC option ▣ Lack of knowledge about EC provision by health workers (both emergency relief health workers and health workers within the displaced population) ▣ Lack of time to educate health workers on EC provision ▣ Difficulty identifying health workers in the early days of an emergency from within the displaced population ▣ Difficulty in assuring stable and hygienic conditions during emergency situations ▣ Difficulty in assuring access to IUD removal by a trained health provider for repatriating populations



Chapter 4

Emergency Contraception Service Delivery in Conflict-Affected Settings¹⁷

Providing EC services in conflict-affected settings requires awareness and understanding of a number of important issues. The components of EC service delivery listed in the following sections pay particular attention to the unique needs of displaced women and girls.

The health worker has an important role in making EC available in displaced settings. In order to make an informed choice for using EC, refugee and IDP women need clear, nonjudgmental information, supportive counseling, trained providers, a reliable supply of ECPs and IUDs and follow-up care.

1. Information, advocacy and outreach

Refugee women and adolescents need accurate, objective and culturally appropriate informational and educational materials about EC. Several fact sheets and brochures are already available for communities in both developed and less-developed countries; these materials can be easily adapted to refugee and IDP contexts. For examples of IEC materials, please refer to the *Resources* section, which includes a list of online sources with downloadable client materials. The International Consortium for Emergency Contraception has provided an aid called *Adapting Resource Materials for Local Use* that may be particularly useful for adapting existing documents to a local context (www.cecinfo.org/files/Adapting-materials.rtf).

Additionally, the Northwest Emergency Contraception Coalition has produced *Emergency Contraception: Client Materials for Diverse Audiences*, available in 13 languages (www.path.org/resources/ec_client-mtrls.htm). Other resources should be available at local nongovernmental organizations (NGOs) and family planning agencies, which will have information and materials that are in languages appropriate for that particular setting.

To increase awareness of EC and availability of services among refugee women, materials and educational sessions should clearly communicate the following points:

- ▣ what EC is and why a woman may need it
- ▣ how EC works, its safety and efficacy
- ▣ the possible side effects of EC
- ▣ what EC does not do
- ▣ where women can access prompt EC and other related reproductive health services, including counseling related to family planning, GBV and STI/HIV
- ▣ how one can avoid the need for EC in the future

¹⁷ Adapted from "Module 5: Emergency Contraceptive Pills," Pathfinder International, revised 2000 September; and *Emergency Contraception: A Guide for Service Delivery*, WHO, 1998.

Information on EC should be included along with other health information in the orientation sessions for newly arriving refugee and IDP women. In the early days and weeks of a humanitarian emergency, it is helpful to identify midwives and traditional birth attendants to discuss sexual violence and EC. While information is requested from them about their emergency needs (for example, delivery supplies), they can also be informed about EC and given a supply for survivors of sexual violence. Education and advocacy efforts to improve both community and provider knowledge about EC should be ongoing, aiming for a high level of awareness of EC and available services among the targeted population. Information on EC (what it is and where it is available) should be given to all relief workers so that they are informed and can thus inform women appropriately.

2. Screening

The purpose of screening the client is to determine whether she needs, wants and is eligible for EC. The client is eligible for ECP if she is known not to be pregnant already and if her first instance of unprotected sex during the current menstrual cycle occurred within the last 120 hours. If more than 120 hours have passed, the woman may also be evaluated for a possible EC IUD insertion.

Due to situations of forced displacement, episodes of violence and other highly stressful experiences, a refugee or IDP woman may not remember the date of her last menstrual period or may not have had a regular menstrual cycle in recent weeks. In these cases, the client should be given a pregnancy test to determine whether she is already pregnant and therefore ineligible for EC. If, however, a pregnancy test is not possible or available, ECPs (not IUDs) may still be offered to the client, provided that she knows the possibility of an existing pregnancy has not been ruled out and understands that the ECPs may not be effective.

A sample screening protocol is provided below to help guide providers in screening for potential EC clients.

Sample Screening Protocol for Emergency Contraception

If a woman requests emergency contraception, ask the following questions:	
1. What was the first day of your last menstrual period?	
Date: _____ - Is this less than 4 weeks ago?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Was this period normal in both its length and timing?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had unprotected sex during the last 5 days?	
<input type="checkbox"/> Yes	Date: _____ Time: _____
<input type="checkbox"/> No If the answer is No, go to question 4.	
If the response is yes to all 3 questions, you may offer ECPs to the woman.	
4. Have you had unprotected sex during the last 7 days?	
<input type="checkbox"/> Yes	Date: _____ Time: _____
If you are sure the woman is not pregnant, you may offer to insert a copper-bearing IUD for emergency contraception, provided that there is a clinician with the appropriate skills available and that hygienic conditions can be ensured.	
<input type="checkbox"/> No If the answer is No, it has been more than 7 days, she may already be pregnant. Provide counseling and support.	

3. Counseling

Counseling is a critical component of reproductive health services, and the quality of counseling services can be improved when providers are trained in communication and counseling skills. Providers who counsel clients about EC should be careful to withhold judgmental comments and refrain from expressing disapproval of a client's decision. Keys to providing good quality counseling for EC include:

- ▣ providing trained providers with good communication and counseling skills
- ▣ showing respect and sensitivity for client needs and concerns
- ▣ offering clear, accurate and balanced information for the client to make an informed choice
- ▣ ensuring confidentiality of client information and choice

The use of EC in displaced settings involves related issues that should be addressed when counseling a potential EC user. Special considerations for EC use in refugee and IDP populations are listed below.

Family planning

Because EC is appropriate for emergency use only, clients should be offered information on other contraceptive methods that they can use on a regular basis. However, it is important to inform clients that while EC should not be used as a regular contraceptive method, its recurrent use will not pose a health risk.

Women who have opted for the IUD as their preferred emergency contraceptive (when appropriate and possible) should be made aware that this IUD can serve as their regular family planning method, for a maximum of 5-10 years. (The Copper T is approved up to 10 years; the Multiload is approved up to 5 years; in many settings, the Multiload is the only available IUD.)

Resources on family planning that would be useful for health care workers include:

- ▣ “Chapter 6: Family Planning.” *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. The Inter-agency Working Group on Reproductive Health in Refugee Situations, 1999.
- ▣ *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff*. Johns Hopkins Population Information Program, January 2001.

Gender-based violence

GBV, including sexual violence, is a traumatic experience that many women and adolescents experience during times of war. The consequences of GBV should be addressed with appropriate medical, psychosocial and legal services. Providers should treat survivors with sensitivity and respect, ensuring privacy and confidentiality.

For current guidelines and protocols for responding to GBV in conflict-affected settings, please refer to the following resources:

- ▣ “Chapter 4: Sexual and Gender-based Violence.” *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. The Inter-agency Working Group on Reproductive Health in Refugee Situations, 1999.
- ▣ *Clinical Management of Survivors of Rape: A guide to the development of protocols for use in refugee and internally displaced person situations*. WHO/UNHCR Geneva, 2002.

- ▣ *Guidelines on the Protection of Refugee Women*. UNHCR Geneva, July 1991.
- ▣ *Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response*. UNHCR Geneva, May 2003.
- ▣ *Gender-based Violence Tools Manual for Assessment & Program Design, Monitoring & Evaluation in Conflict-Affected Settings*, Reproductive Health Response in Conflict Consortium, 2004.
- ▣ *Gender-Based Violence: Emerging Issues in Programs Serving Displaced Populations*. JSI Research and Training Institute on behalf of Reproductive Health for Refugees Consortium, September 2002.

STIs/HIV/AIDS

Clients should receive information and counseling on the risks of STI/HIV/AIDS and ways to prevent infections. Condoms and services or referrals for STI/HIV/AIDS screening and treatment should be offered to the client when available. Providers should also make clear that EC methods, both pills and IUDs, do not offer protection against STIs and HIV/AIDS.

For more information on providing STI/HIV/AIDS services to displaced populations, the following resources would be useful:

- ▣ *Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings*. Reproductive Health Response in Conflict Consortium, 2004.
- ▣ *A Short Course on HIV/AIDS Prevention and Control for Humanitarian Workers: A Companion to the International Rescue Committee's Manual, Protecting the Future*. Reproductive Health Response in Conflict Consortium, 2004.
- ▣ *Protecting the Future: HIV Prevention, Care and Support among Displaced and War-affected Populations*. International Rescue Committee, Kumarian Press, 2003.
- ▣ *Refugees and AIDS: What should the humanitarian community do?* Women's Commission for Refugee Women and Children, 2002.
- ▣ "Chapter 5: Sexually Transmitted Diseases, including HIV/AIDS." *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. The Inter-agency Working Group on Reproductive Health in Refugee Situations, 1999.
- ▣ *Guidelines for HIV Interventions in Emergency Settings*. UNHCR/WHO/UNAIDS Geneva, 1995.

Stress, anxiety, depression and other psychosocial issues

Clients may suffer from stress, anxiety and depression due to any number of factors, such as fear of becoming pregnant, concern about HIV status, embarrassment about sexual issues, war-related trauma, loss of family members and friends, as well as other life pressures inherent in conflict-affected situations. Providers should refer clients with psychosocial problems to counseling services when available.

4. Supplies

Dedicated products for EC are easiest to use and prescribe, as they contain exact dosages and instructions for correct use. These specially packaged products are available in *The New Emergency Health Kit 98* and *The Reproductive Health Kit for Emergency Situations*. Order information for each kit is provided below.

▣ *The New Emergency Health Kit 98*

To order the kit:

IDA Foundation
P.O. Box 37098
1030 AB Amsterdam
The Netherlands
Tel: + (31 20) 403.30.51
Fax: + (31 20) 403.18.54
E-mail: info@ida.nl
Website: www.ida.nl/en-us/

To order the NEHK 98 Booklet:

World Health Organization
Department of Emergency & Humanitarian Action
20 avenue Appia
1211 Geneva SWITZERLAND
Tel: + (41 22) 791.22.05
Fax: + (41 22) 791.48.44
Email: guittonc@who.int
Website: www.who.int/disasters/tg.cfm?doctypeID=12

▣ *The Reproductive Health Kit for Emergency Situations*

To order the RH Kit or for more information:

UNFPA Procurement Service Section
220 East 42nd Street
New York NY 10017 USA
Tel: + (1-212) 297.5398
Fax: + (1-212) 297.4916
E-mail: hru@unfpa.org

However, if dedicated ECPs are not available, then regular oral contraceptive pills can be substituted for EC purposes. Please see *Chapter 2: Emergency Contraceptive Pills (ECPs)* for specific pill regimens.

IUDs are also available in *The New Emergency Health Kit 98* and *The Reproductive Health Kit for Emergency Situations*.

5. Follow-up care

Health care providers should monitor EC clients' follow-up medical care, and referrals for further testing and treatment services, such as STIs/HIV, should be provided as needed. Follow-up care for women who have not become pregnant is not always necessary, but is recommended to address clients' reproductive health concerns.

Providers should offer family planning and HIV prevention information and commodities to women to help them develop strategies to reduce their risk of pregnancy and STI/HIV infection. Women who choose an EC IUD and wish to continue with the IUD as their regular method of contraception should visit the health clinic for regular check-ups. For more information on IUD services, including the management of problems or side effects, please refer to Chapter 12 of *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff* or Chapter 21 of *Contraceptive Technology*.

Follow-up is also strongly recommended for clients needing further counseling or psychosocial care, particularly in cases involving GBV. If a client wishes to report a sexual assault, providers should refer her to appropriate personnel to help her secure legal assistance or protection. For more information on medical and psychosocial service provision for rape survivors, please refer to *Clinical Management of Survivors of Rape: A guide to the development of protocols for use in refugee and internally displaced person situations*.

Frequently Asked Questions

1. How is emergency contraception different from abortion?

EC acts by preventing fertilization or by preventing the implantation of a fertilized egg, whereas an abortion disrupts or damages a fertilized egg that has already implanted onto the uterus lining. EC prevents pregnancy and helps to prevent the need for an abortion.

2. Is emergency contraception harmful to a fetus?

ECPs are not harmful to an existing pregnancy nor will they induce an abortion. Therefore, ECPs can be used by women whose pregnancy status is unclear. If the woman is already pregnant, the fetus will not be affected following ECP use.

However, IUDs used for EC can be harmful to an existing pregnancy. Therefore, a woman with an established pregnancy is not eligible for using an IUD.

3. Can regular contraception be initiated after ECPs?

Condoms and other barrier methods can be used immediately after taking ECPs. Regular hormonal contraceptive methods can be initiated either immediately or with the next menstrual cycle. An EC client who is interested in starting or continuing a regular contraceptive method should receive family planning counseling, and should be advised to use condoms or not have sex until she begins using the regular contraceptive method.

4. Are ECPs effective in preventing pregnancy if taken more than five days (120 hours) after a woman has unprotected sex?

Research studying the effectiveness of ECPs within 120 hours shows an increasing risk of pregnancy as the 120-hour period progresses. The efficacy of ECPs taken after 5 days has not been investigated. In this event, it is important that the woman understands that her chances of pregnancy will be lower if ECPs are taken sooner rather than later. A more effective option would be to insert an IUD if the woman is eligible.

5. May women who breastfeed use ECPs?

Yes. A woman who has had her menstrual period since giving birth and is not exclusively breastfeeding may safely use ECPs. A woman who has not had her menstrual period since giving birth and who is exclusively breastfeeding her newborn is not at risk of pregnancy for up to six months after giving birth and may not need EC.

6. What can a health care provider do if there is no special ECP product available?

When no special ECP product is available, providers can administer higher doses of regular oral contraceptive pills for emergency purposes. For specific dose regimens using progestin-only contraceptives or combined oral contraceptives (COCs), you may refer to the ECP Regimen Charts, which are found in the [Charts and Checklist for EC Service Delivery](#) section at the end of this document.

Using standard contraceptive progestin-only pills:

- ▣ When the progestin-only contraceptive is only available in mini-pills containing 30 µg levonorgestrel, the first dose of 25 pills should be taken no later than 120 hours after unprotected sex. The second dose of another 25 pills must be followed 12 hours after the first dose.

Using standard COCs:

- ▣ When only low-dose COC pills containing 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg norgestrel) are available, the first dose of four pills should be taken no later than 120 hours after unprotected sex. The second dose of four pills must be taken 12 hours after the first dose.
- ▣ Alternatively, when only low-dose COC pills containing 20 µg ethinylestradiol and 100 µg levonorgestrel are available, the first dose of five pills should be taken no later than 120 hours after unprotected sex. The second dose of five pills must be taken 12 hours after the first dose.

When using regular oral contraceptive pills, the last 7 pills from a 28-pill pack cannot be used for EC as these pills do not contain hormones.

Copper-bearing IUDs may also be an option for women who do not have access to ECPs. However, providers must first screen clients to eliminate women who are already pregnant or who have reproductive tract infections, including HIV/AIDS.

7. How are ECPs and regular pills different?

While ECPs are essentially regular oral contraceptive pills that are in higher doses, ECPs differ in many important respects from regular pills. Providers should be aware of these important differences and have clear guidelines on how and when to offer ECPs.

- ▣ ECPs are high doses of regular progestin-only pills containing levonorgestrel, or increased doses of combined oral contraceptives containing ethinylestradiol and levonorgestrel.
- ▣ Regular pills can be used for emergency contraception if specially packaged ECPs are not available. When regular contraceptive pills are used for EC, the doses are higher.
- ▣ ECPs must be taken within 120 hours of unprotected sex, while oral contraceptive pills for ongoing family planning are taken regularly once a day.

8. Can ECPs be given in conjunction with STI prophylaxis treatment?

According to the WHO Clinical Management of Survivors of Rape, there are no known contraindications to providing ECPs at the same time as antibiotics. Please refer to this WHO resource for more information on prescribing STI prophylaxis treatment.

9. Will inserting an IUD harm an established pregnancy?
- a. Yes
 - b. No
10. Emergency IUD insertion should not be considered for a woman who has a sexually transmitted infection (STI).
- a. True
 - b. False
11. What are some of the expected side effects of IUD insertion? (Choose all that apply.)
- a. Nausea
 - b. Vomiting
 - c. Cramping
 - d. Spotting or heavier menstrual bleeding
12. How long can an IUD remain in place to serve as the client's regular contraceptive method?
- a. 0 years – the IUD must be removed immediately after menstruation begins
 - b. 1-2 years
 - c. 3-4 years
 - d. 5-10 years
13. What should the provider do if rape or sexual abuse is suspected?
- a. Inform the client that you will support her if she wishes to report the offense to protection authorities, but allow her to make her own decision
 - b. Maintain confidentiality
 - c. Offer or refer client for counseling and STI/HIV services
 - d. All of the above
14. What additional services should be offered (or referred) during follow-up of an EC client who discovers she is pregnant?
- a. Clinical services
 - b. STI/HIV prevention and care
 - c. Psychosocial care and counseling
 - d. All of the above
15. When is the appropriate time to initiate EC services in a conflict-affected setting?
- a. At the outset of an emergency response
 - b. After early mortality rates have stabilized
 - c. After all other health services are in place
 - d. After refugee populations have been settled into camps



EC Service Delivery Scenarios

- 1. Anna is a 31-year-old IDP woman who tells you she had sex 6 nights ago with her husband, but the condom broke. Already caring for three children, the couple does not want to have any more. Because of transportation problems, Anna was not able to get to the clinic until today. She wants to know if there's anything that can prevent a possible pregnancy. How would you handle this client's situation?**

Because Anna and her husband had unprotected intercourse more than 120 hours ago, ECPs would not be the most effective method for preventing pregnancy. To date, there has been no research investigating whether ECPs are effective after the 120-hour period.

Therefore, if you provide IUD insertions at your health care facility, inform Anna that she could be eligible for IUD use, another method of EC that may be more effective at this time. Tell Anna about how an EC IUD works, its effectiveness and possible side effects. Explain that the IUD may be kept in place for use as a regular contraceptive method.

If Anna wishes to be considered for an IUD, you may offer her the method if the following conditions are met:

- She is not pregnant.*
- You are a trained health provider who knows how to properly insert an IUD.*
- Anna and her husband do not have an STI or HIV.*
- Anna has access to a health care facility for IUD removal (if she so chooses).*
- You are able to follow universal precautions and have a supply of IUDs at the health facility.*

Recommend Anna to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant or has other concerns.

- 2. Faith brings her 14-year-old sister Ruth to you because Ruth was raped yesterday on her way home from school in the refugee camp. The family has not yet reported the incident. Faith wants to know if there's anything that can be done to prevent Ruth from getting pregnant. How would you handle this client's situation?**

Assure Ruth and Faith that something can be done to prevent an unwanted pregnancy. Tell Ruth how ECPs work, their effectiveness and possible side effects. If Ruth chooses ECPs, explain the correct use of the method, review the written instructions with her and give her a copy. If she wishes, help Ruth choose a regular contraceptive method that is suitable for her.

According to WHO recommendations, an IUD insertion may be emotionally traumatic for rape victims. However, if you provide IUDs at your health care facility, and if ECPs are unavailable or unacceptable, an IUD insertion for EC can be considered. If Ruth chooses to use the IUD, she must be advised to switch to another contraceptive method at her next menstrual period.

Also gently explain that because Ruth was raped, she may have sustained physical injuries or have been exposed to an STI, even HIV. Offer her an appropriate medical examination, including a review for associated injuries and STI screening or treatment, either at your facility or through referral. Advise Ruth to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, needs or wants further tests or treatment for STIs or has other concerns. Ask if Ruth or Faith would like a referral for social services.

3. Ming is a 25-year-old refugee woman who took her first dose of ECPs six hours ago. She is very nauseated and thinks that she will vomit the second dose. Concerned, she returns to the health facility in the camp and asks you for advice. How would you handle this client's situation?

If available, a single 50 mg dose of meclizine may be offered to Ming to help reduce the risk of nausea and vomiting when she takes the second dose of ECPs. Meclizine has been proven to be effective in reducing nausea and vomiting, but Ming should be warned that it may cause drowsiness. While lower doses of meclizine and other antiemetics may also prevent nausea and vomiting, they have not been studied.¹⁸

If she vomits the second dose within one hour of taking it, she may want to repeat the second dose of pills by placing them high into her vagina, where the medicine will be absorbed through the vaginal wall.

4. Fatmeh is an 18-year-old who has come to you asking about EC, saying she heard about it from friends and thinks she might need it. She tells you she had sex last night with an older man, whom she has been seeing lately in exchange for food and money. They had always used a condom before, but the man refused this time and offered her more money if they did not use a condom. Fatmeh does not want to become pregnant but is scared to try EC because she thinks it is dangerous. How will you address this client's needs?

Assure Fatmeh that something can be done to help her prevent an unwanted pregnancy. Tell her about how ECPs work, their effectiveness, characteristics of ECPs and possible side effects. If Fatmeh chooses to use ECP, explain the correct use of the method, review the written instructions with her and give her a copy. If she wishes, help Fatmeh choose a regular contraceptive method that is suitable for her. Also explain that because her partner does not want to use condoms, she may be at a risk of STIs, even HIV/AIDS. Explain how and where she can be tested and counseled about STIs, including HIV, and how she can protect herself from becoming infected in the future.

If you provide IUD insertions at your health clinic, you may also tell Fatmeh about IUD use for EC – how it works, its effectiveness and possible side effects. If Fatmeh chooses to use the IUD, explain that the IUD may be kept in place for use as a regular contraceptive method; however, it will not protect her from STIs, including HIV. If she does not wish to continue using the IUD, she should be advised to return during or soon after her next menstrual period for its removal.

Recommend Fatmeh to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant or has other concerns. Refer her to social services to address her situation of being forced to trade sex for her daily survival.

¹⁸ Consortium for Emergency Contraception. *Expanding Global Access to Emergency Contraception*. October 2000, p.42.

- 5 • Florence is a 45-year-old refugee woman who was gang-raped along with her daughter and two women friends while they were searching for fuel outside the refugee camp. Five days later, she comes to the health center because she needs relief for the wound on her hip she sustained during the ordeal. She relays to you everything that happened. How would you handle this client's situation?**

First, listen calmly and reassure her. Follow an established protocol on the clinical management of rape survivors and complete standard incident report form. During this medical counseling session, assess Florence's risk of unwanted pregnancy. If Florence wants to prevent a pregnancy, clearly explain her options. Explain to Florence that ECPs would be effective in preventing pregnancy and then allow her to make an informed decision as to whether she wants to use ECPs at this time. Tell her about how ECPs work, their effectiveness and possible side effects. Explain the correct use of the method, review the written instructions with her and give her a copy. If she wishes, help Florence choose a regular contraceptive method that is suitable for her.

According to WHO recommendations, an IUD insertion may be emotionally traumatic for rape victims. However, if you provide IUD insertions at your health care facility, and if ECPs are unavailable or unacceptable, you should inform Florence that she could be eligible for IUD use, an EC method that may be more effective at this time. If Florence chooses to use the IUD, she must be advised to switch to another contraceptive method at the next menstrual period.

Also gently explain that because Florence was raped, she may have been exposed to an STI, even HIV. As part of an established protocol on the clinical management of rape survivors, offer her an appropriate medical examination, including a review for associated injuries and STI screening or treatment, either at your facility or through referral. Advise Florence to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, needs or wants further tests or treatment for STIs or has other concerns. Refer Florence to existing GBV services. Ask Florence if she would suggest to her daughter and friends that they also receive medical care and social services today. Florence's daughter and friends could also be at risk of pregnancy and still be in time to receive EC.

- 6 • Joyce is a 21-year-old woman living in a refugee camp. She and her 23-year-old boyfriend had sexual intercourse for the first time two days ago. While she is happy about how her relationship is going with her boyfriend, she is worried that she might become pregnant. She has been nervous about visiting the health center at the camp, but finally decides to go and ask some questions about preventing pregnancies. How will you address Joyce's concerns?**

Assure Joyce that something can be done to help her prevent an unwanted pregnancy. Tell her how ECPs work, their effectiveness, characteristics of ECPs and possible side effects. If Joyce chooses to use ECPs, explain the correct use of the method, review the written instructions with her and give her a copy. If she wishes, you can also help Joyce choose a regular contraceptive method that is suitable for her. Remind her, however, that only condoms offer protection from STIs. Explain that if she and her boyfriend do not use condoms consistently, she may be vulnerable to STIs and HIV. Explain how she can protect herself.

If you provide IUD insertions at your health clinic, you may also tell Joyce about IUD use for EC – how it works, its effectiveness and possible side effects. If Joyce chooses to use the IUD, explain that the IUD may be kept in place for use as a regular contraceptive method; however it will not protect her from STIs, including HIV. If she does not wish to continue using the IUD, she should be advised to return during or soon after her next menstrual period for its removal.

Inform Joyce that she should return for follow-up if she has a delay in her menstruation, suspects she may be pregnant or has other concerns.



Resources

Tools:

- International Consortium for Emergency Contraception (CEC):
 - *Resources for Programs*. www.cecinfo.org/html/resources.htm. Includes:
 - Dedicated Products and their Availability
 - Materials for Program Planning
 - Adapting Resource Materials for Local Use
 - *Expanding Global Access to Emergency Contraception: A Collaborative Approach to Meeting Women's Needs*. October 2000.
- Family Health International (FHI):
 - *Checklist for clients who want to initiate COCs in community-based services*. www.fhi.org/en/RH/Pubs/servdelivery/checklists/cocchecklists/index.htm
 - *Quick reference chart for the medical eligibility criteria of the WHO to initiate the use of COCs, NET-EN, DMPA or copper IUDs*. www.fhi.org/en/rh/pubs/servdelivery/quickreferencechart.htm

Training Modules/Curricula:

- Family Health International. *Contraceptive Technology Update Series: Emergency Contraception Pills*. N.D. Also available in French and Spanish. www.fhi.org/en/ctu/ctu.html
- Pathfinder International. "Module 5: Emergency Contraceptive Pills." *Comprehensive Reproductive Health and Family Planning Training Curriculum*. Revised September 2000. www.pathfind.org/site/PageServer?pagename=Publications_Training_Modules

Medical and Service Delivery Guides:

- International Consortium for Emergency Contraception (CEC). *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines*. Second Edition, 2003. www.cecinfo.org/files/Guidelines%202nd%20editione.pdf
- Hatcher R, et al. *Contraceptive Technology*, 17th Revised Edition. New York: Ardent Media, Inc., 1998.
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Counseling Resources:

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- Population Reports. *Gather Guide to Counseling*, Volume XXVI, Number 4 December, 1998. www.infoforhealth.org/pr/j48/skills.shtml

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- World Health Organization. *The New Emergency Health Kit 98*. 1998. Order from: IDA Foundation, P.O. Box 37098, 1030 AB Amsterdam, The Netherlands. Tel: + (31 20) 403.30.51, Fax: + (31 20) 403.18.54, Email: info@ida.nl, Website: www.ida.nl/en-us/

IEC/Client Materials on EC:

- International Consortium for Emergency Contraception:
 - Adapting Resource Materials for Local Use. www.cecinfo.org/files/Adapting-materials.rtf
 - Materials for EC Advocacy – Questions and Answers for Decision Makers. www.cecinfo.org/files/QA-for-Decision-Makers.rtf
 - Materials for EC Clients. www.cecinfo.org/files/Sample-Mtrls-for-Clients.rtf
- The Emergency Contraception Website (Not-2-Late). Operated by Princeton University. EC-Related Material Search – hosts an extensive database of EC materials, searchable by type of material, language, target audience, target location and author/producer of material. <http://ec.princeton.edu/ecmaterials/default.asp>
- International Planned Parenthood Federation. Emergency Contraception Fact Card No. 7. Available in English, Spanish and French. www.ippf.org/resource/contracards/index.htm
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Websites:

International Consortium for Emergency Contraception
www.cecinfo.org

United Nations Population Fund (UNFPA)
www.unfpa.org

Reproductive Health Response in Conflict Consortium
www.rhrc.org

World Health Organization (WHO)
www.who.int/reproductive-health

United Nations High Commissioner for Refugees (UNHCR) www.unhcr.ch



ANSWERS FROM QUIZ P.23

1. b. False – EC acts before the implantation of a fertilized egg and therefore does not disrupt or damage an established pregnancy. EC is not a form of abortion.
2. a. True – ECPs will not harm an existing pregnancy.
3. b. False – EC is appropriate not only for rape victims, but a women who had sexual intercourse and: 1) is not currently using regular contraception; 2) did not use her regular contraceptive correctly or consistently; or 3) used a contraceptive method that failed.
4. d. 120 hours
5. a. 12 hours
6. b. False – ECPs are inappropriate for regular use, as periodic use of ECPs is less effective than correct use of regular contraceptive pills.
7. a. Nausea b. Vomiting
8. d. 7 days
9. a. Yes
10. b. False – According to WHO recommendations, an IUD insertion can be considered for a client at risk of STIs when ECPs are unavailable, unacceptable or if more than 120 hours have elapsed since the first episode of unprotected sex. The client, however, must be advised to have the IUD removed and to switch to another contraceptive method at the next menstrual period.
11. c. Cramping d. Spotting or heavier menstrual bleeding
12. d. 5-10 years
13. d. All of the above
14. d. All of the above
15. a. At the outset of an emergency response



Charts & Checklist For EC Service Delivery

Sample Screening Protocol for Emergency Contraception

The checklist provided below is a sample protocol that can be used or adapted when screening potential clients.

If a woman requests emergency contraception, ask the following questions:

1. What was the first day of your last menstrual period?

Date: _____ - Is this less than 4 weeks ago? Yes No

2. Was this period normal in both its length and timing? Yes No

3. Have you had unprotected sex during the last 5 days?

Yes Date: _____ Time: _____

No If the answer is No, go to question 4.

If the response is yes to all 3 questions, you may offer ECPs to the woman.

4. Have you had unprotected sex during the last 7 days?

Yes Date: _____ Time: _____

If you are sure the woman is not pregnant, you may also offer to insert a copper-bearing IUD for emergency contraception, provided that there is a clinician with the appropriate skills available and that hygienic conditions can be ensured.

No If the answer is No, it has been more than 7 days, she may already be pregnant. Provide counseling and support.



ECP Regimen charts

Each type of contraceptive has different regimens, with both high and low doses. The charts and descriptions below detail the regimens for each type of ECP. For all regimens, ECPs should be taken as soon as possible after intercourse but optimally within 120 hours.

Progestin-only Emergency Contraceptive Pills	First Dose = no later than 120 hours after unprotected sex	Second Dose = 12 hours after the first dose
HIGH DOSE: * pills with 750 µg (0.75 mg) levonorgestrel	2 pills only	--
HIGH DOSE: pills with 750 µg (0.75 mg) levonorgestrel	1 pill	1 pill
LOW DOSE (mini): pills with 30 µg levonorgestrel	25 pills	25 pills

Progestin-only Emergency Contraceptive Pills

HIGH DOSE: When progestin-only EC is available in pills containing 750 µg levonorgestrel, two pills can be taken in one dose no later than 120 hours (5 days) after unprotected sex. Alternatively, the first dose of one pill should be taken no later than 120 hours after unprotected sex. The second dose of one pill must be taken 12 hours after the first dose.

LOW DOSE (mini): When the progestin-only contraceptive is only available in mini-pills containing 30 µg levonorgestrel, the first dose of 25 pills should be taken no later than 120 hours after unprotected sex. The second dose of another 25 pills must be followed 12 hours after the first dose. *Note: This refers to standard contraceptive progestin-only mini-pills*

Combined Oral Contraceptive Pills	First Dose = no later than 120 hours after unprotected sex	Second Dose = 12 hours after the first dose
HIGH DOSE: pills with 50 µg ethinylestradiol and 250 µg levonorgestrel (or 500 µg norgestrel)	2 pills	2 pills
LOW DOSE: pills with 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg norgestrel)	4 pills	4 pills
LOW DOSE: pills with 20 µg ethinylestradiol and 100 µg levonorgestrel	5 pills	5 pills

Combined Oral Contraceptive (COC)

HIGH DOSE: When COCs are available in specially packed pills or as high dose pills containing 50 µg of ethinylestradiol and 250 µg levonorgestrel (or 500 µg norgestrel), the first dose of two pills should be taken no later than 120 hours after unprotected sex. The second dose of two pills must be taken 12 hours after the first dose.

LOW DOSE: When only low-dose COC pills containing 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg norgestrel) are available, the first dose of four pills should be taken no later than 120 hours after unprotected sex. The second dose of four pills must be taken 12 hours after the first dose. Alternatively, when only low-dose COC pills containing 20 µg ethinylestradiol and 100 µg levonorgestrel are available, the first dose of five pills should be taken no later than 120 hours after unprotected sex. The second dose of five pills must be taken 12 hours after the first dose. *Note: This refers to standard combined oral contraceptive pills. Use 4 or 5 of the 21 hormone-containing pills for each dose of EC. The last 7 pills from a 28-pill pack cannot be used for EC as these pills do not contain hormones.*

For updated information on ECP formulations, please refer to the International Consortium for Emergency Contraception website at www.cecinfo.org/html/fea-ecpformulations.htm.

* A recent study found that a 1.5 mg single levonorgestrel dose can substitute two 0.75 mg doses taken 12 hours apart. See Von Hertzen H, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. *The Lancet* 2002 Dec 7; 360:1803-1810.





Photos:

Cover, P. 5:
S. Colvey, IDRC

P. 4
R. Charbonneau, IDRC

P. 6, 25, 31
D. Marchand, IDRC

P. 21
C. Mayo, IDRC

Contact Us

RHRC Consortium contact

For more information about the Reproductive Health Response in Conflict Consortium, please visit our website at www.rhrc.org.

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