MODULE 5: EMERGENCY CONTRACEPTIVE PILLS

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ACKNOWLEDGEMENTS

The development of the Comprehensive Family Planning and Reproductive Health Training Curriculum, including this module, is an ongoing process and the result of collaboration between many individuals and organizations. The development process of this curriculum began with the privately funded Reproductive Health Program (RHP) in Viet Nam. While most of the modules are adapted from the Family Planning Course Modules, produced by the Indian Medical Association in collaboration with Development Associates, Inc., Module 5: Emergency Contraceptive Pills is based on the Consortium for Emergency Contraception's Using Emergency Contraceptive Pills: A Prototype ECP Training Curriculum, the product of collaboration between: the Concept Foundation, the International Planned Parenthood Federation (IPPF), the Pacific Institute for Women's Health (PIWH), Pathfinder International, the Population Council, the Program for Appropriate Technology in Health (PATH), and the World Health Organization Program for Research of Human Reproduction (WHO/HRP). Other parts of this curriculum are adapted from the work of: IPAS, for Manual Vacuum Aspiration, Postpartum/Postabortion Contraception; JHPIEGO for Infection Prevention, Reproductive Tract Infections; FHI for Postpartum/Postabortion Contraception; Georgetown University for Lactational Amenorrhea Method; and AVSC for Client's Rights, Counseling, and Voluntary Surgical Contraception.

The entire comprehensive training curriculum was used to train service providers in 1995 under this cooperative project which included Pathfinder International, IPAS, AVSC International, and the Vietnamese Ministry of Health. Individual modules were used to train service providers in: Nigeria (DMPA); Azerbaijan, Ethiopia, Kenya, Peru, Tanzania, and Uganda (Infection Prevention); Azerbaijan, Kazakstan, and Peru (Counseling); and Jordan (POPs & COCs; IUD). Feedback from these trainings has been incorporated into the training curriculum to improve its content, training methodologies, and ease of use.

With the help of colleagues at Pathfinder International, this curriculum has been improved, expanded, and updated to its present form. Thanks are due to: Ellen Eiseman, who provided technical support and input; Penelope Riseborough, who provided technical editing and guidance on printing and publication; Tim Rollins, and Erin Majernik who designed, formatted, and edited the document, and coordinated the process; Anne Read, who designed the cover; and Elizabeth Peterson, who entered hundreds of corrections and reproduced numerous corrected pages. Thanks also go to Val Montanus and Gwyn Hainsworth, who edited and produced this revision, and to Michele Whigham-Brown, who formatted and entered edits. Participants in the Reproductive Health Project, and the development of this curriculum for its initial use in Viet Nam, include the following:

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Development Associates
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The Indian Medical Association

Institute for Reproductive Health
Kristin Cooney
Special thanks are due Mary Broderick, Michelle Burns, Sharon Camp, Charlotte Ellertson, Peter Faians, Peter Hall, Carlos Huezo, Douglas Huber, Karen Otsea, Herbert Peterson, Elizabeth Raymond, Jeff Spieler, James Trussell, Elisa Wells, Paul Van Look, and Helena Von Hertzen, who contributed to the original Consortium for Emergency Contraception's Emergency Contraceptive pills: Medical and Service Delivery Guidelines, August 1996 and July 2000 draft on which much of this module is based. Elisa Wells deserves additional thanks for developing many of the training exercises in this curriculum and her extensive hours working on developing the consortium's curriculum.

Members of the Consortium for Emergency Contraception

Asociacion Colombiana para el Estudio de la Poblacion • Asociacion Para la Prevencion de Embarazos No Deseados • AVSC International • British Pregnancy Advisory Service • Concept Foundation* • CONRAD Program • DKT International • Family Health International • Institute for Reproductive Health • International Planned Parenthood (IPPF)* • IPPF/Western Hemisphere Region • Ipas • Management Sciences for Health (MSH) • Marie Stopes International • Meridian Development Foundation • Pacific Institute for Women's Health* • PATH (Program for Appropriate Technology in Health) • Pathfinder International* • Population Council* • Population Services International (PSI) • SHILO Pregnancy Advisory Service • UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (WHO/HRP)*

* Founding Members
# Table of Contents

## Notes to the Trainer
- Purpose ........................................................................................................... i
- Design ............................................................................................................... i
- Suggestions for Use ....................................................................................... i
- Client's Rights During Clinical Training ...................................................... ii
- Demonstration Technique .......................................................................... iii

## Do's and Don'ts of Training ........................................................................ v

## TRAINER’S MANUAL ..................................................................................... 1
- ECPs as a Method .......................................................................................... 4
- Contraindication to ECPs ........................................................................... 12
- How ECPs are Used ..................................................................................... 13
- Managing Side Effects ................................................................................. 15
- Common Questions on ECPs ..................................................................... 18
- ECP Service Provision ............................................................................... 19
- ECP Knowledge Demonstration ............................................................... 32

## APPENDIX

### Participant Handouts
- 0: Pre-test .................................................................................................... 33
- 1: ECPs as a Method .................................................................................. 35
- 2: Precautions ............................................................................................. 40
- 3: Formulations and Dose Required for Emergency Contraception ........ 41
- 4: Side Effects and Management ............................................................... 42
- 4.1: Side Effects Case Studies ................................................................. 44
- 5: Common Questions asked about ECP (Grab Bag Exercise) .............. 45
- 5.1: Common Questions asked about ECP (Answer Key) ...................... 46
- 6: Providing ECP Services ....................................................................... 49
- 6.1: Sample ECP Screening Checklist .................................................... 56
- 6.2: Sample Screening Checklist for Clients Initiating or Continuing COCs 57
- 6.3: Sample Written Instructions for Using ECPs .................................. 58
- 6.4: ECP Counseling Skills Checklist ...................................................... 59
- 6.5: Role Play A ......................................................................................... 61
- 6.6: Role Play B ......................................................................................... 62
- 6.7: Role Play C ......................................................................................... 63
- 7: Situations for ECPs Provision ................................................................. 64
- 8: Use of Copper IUDs for Emergency Contraception .......................... 70
- 9: Post-test .................................................................................................. 71
- 10: Participant Evaluation Form ............................................................... 73
**Trainer's Tools**

1. Pre- and Post-test Answer Key ................................................................. 75
2. Side Effects Case Studies (Answer Key) ...................................................... 77
3. Role Plays A, B & C (Trainer's Notes) ......................................................... 78
4. Supplemental Notes on Mifepristone ............................................................ 79

**Transparencies**

1. Module Objectives ..................................................................................... 81
NOTES TO THE TRAINER

PURPOSE:

This training manual is designed for use as part of the comprehensive family planning and reproductive health training of service providers. It is designed to be used to train physicians, nurses, and midwives.

This manual is designed to actively involve participants in the learning process. Sessions include simulation skills practice, discussions, and clinical practice using objective knowledge, attitude, and skills checklists.

This particular module, Module 5: Emergency Contraceptive Pills, is based largely on the Consortium for Emergency Contraception’s Emergency Contraceptive Pills: Medical and Service Delivery Guidelines (July 2000 draft), which is an excellent resource on emergency contraception.

DESIGN:

The training manual consists of 16 modules:

1. Introduction/Overview
2. Infection Prevention
3. Counseling
4. Combined Oral Contraceptives and Progestin-only Pills
5. Emergency Contraceptive Pills
6. DMPA
7. Intrauterine Devices
8. Breastfeeding and Lactational Amenorrhea Method
9. Condoms and Spermicides
10. Voluntary Surgical Contraception
11. MVA for Treatment of Incomplete Abortion
12. Reproductive Tract Infections
13. Postpartum/Postabortion Contraception
14. Training of Trainers
15. Quality of Care
16. Reproductive Health Services for Adolescents

Included in each module is a set of knowledge assessment questions, skills checklists, trainer resources, participant materials, training evaluation tools, and a major references and training materials section.

SUGGESTIONS FOR USE:

- The modules are designed to provide flexibility in planning, conducting, and evaluating the training course.
Module 5

- The curriculum is designed to allow trainers to formulate their own training schedule, based on results from training needs assessments.
- The modules can be used independently of each other.
- The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
- In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, the overall objective, general, and specific objectives are presented in terms of achievable changes in these three areas.
- Training references and resource materials for trainers and participants are identified.
- Each module is divided into a Trainer's Manual and Appendix sections.
- The Trainer's Manual presents the information in two columns:
  1. Content: This section contains the necessary technical information.
  2. Training/Learning Methods: This section contains the training methodology (i.e., lecture, role play, discussion, etc.) used to convey the technical information most effectively.
- The Appendix section contains:
  - Participant handouts, including a pre- and post-test and participant evaluation form
  - Trainer's Tools, including answer keys and supplementary information
  - Transparencies
- The Participant Handouts are referred to in the Training/Learning Methods sections of the curriculum and include a number of different materials and exercises, ranging from recapitulations of the technical information from the Content of the module to role play descriptions, skills checklists, and case studies.
- The Participant Handouts should be photocopied for the trainees and distributed to them in a folder or binder to ensure that they are kept together as a technical resource after the training course has ended. The Participant Evaluation Form should also be copied to receive the trainees' feedback in order to improve future training courses.
- Transparencies have been prepared where called for in the text. These should be copied onto clear overheads for display during the training sessions.
- The methodologies section is a resource for trainers for the effective use of demonstration/return demonstration in training.

To ensure appropriate application of learning from the classroom setting to clinical practice, Clinical Practicum sessions are an important part of this training. For consistency in the philosophy of client's rights, the following should be shared with participants, in preparation for their clinical practicum experiences:

**Client's Rights During Clinical Training**

The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g., service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).
The client’s permission must be obtained before having a clinician-in-training/participant observe, assist with or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training/participant. Furthermore, a client’s care should not be rescheduled or denied if s/he does not permit a clinician-in-training/participant to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.

Clinical trainers must be discreet in how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and clinician-in-training.

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and be conducted without reference to the client by name (AVSC, "Tips for Trainers-8," September 1994; NSV Trainer's Manual).

**Demonstration Technique**

The Five-Step Method of Demonstration and Return Demonstration is a training technique useful in the transfer of skills. The technique is used to make sure that participants become proficient in certain skills. It can be used to develop skills in pill dispensing, IUD insertion, performing a general physical examination, performing a breast or pelvic examination, etc. In short, it can be used for any skill that requires a demonstration. The following are the "five steps:"

1. **Overall Picture:** Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed on models in the classroom according to the steps in the skills checklist and practiced until participants become proficient in each skill and before they perform them in a clinical situation.

2. **Trainer Demonstration:** The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role playing participant as s/he would to a real client.

3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while the participant verbally repeats the step-by-step procedure.

**Note:** The trainer does not demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.
Module 5

4. **Participant Talk-Through:** The participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.

5. **Guided Practice:** In this final step, participants are asked to form pairs. Each participant practices the demonstration with his or her partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.
DO'S AND DON'TS OF TRAINING

The following "do's and don'ts" should ALWAYS be kept in mind by the trainer during any learning session.

DO'S

- Do maintain good eye contact
- Do prepare in advance
- Do involve participants
- Do use visual aids
- Do speak clearly
- Do speak loud enough
- Do encourage questions
- Do recap at the end of each session
- Do bridge one topic to the next
- Do encourage participation
- Do write clearly and boldly
- Do summarize
- Do use logical sequencing of topics
- Do use good time management
- Do K.I.S. (Keep It Simple)
- Do give feedback
- Do position visuals so everyone can see them
- Do avoid distracting mannerisms and distractions in the room
- Do be aware of the participants' body language
- Do keep the group on focused on the task
- Do provide clear instructions
- Do check to see if your instructions are understood
- Do evaluate as you go
- Do be patient

DON'TS

- Don't talk to the flip chart
- Don't block the visual aids
- Don't stand in one spot--move around the room
- Don't ignore the participants' comments and feedback (verbal and non-verbal)
- Don't read from curriculum
- Don't shout at participants
TRAINER'S MANUAL
MODULE 5:
EMERGENCY CONTRACEPTIVE PILLS (ECPs)

INTRODUCTION:
Although well documented and safe, Emergency Contraceptive Pills (ECPs) have not received significant attention or use until recently. ECPs can play a crucial role in family planning programs, providing a safe method of avoiding unwanted pregnancy after unprotected intercourse, as well as a bridge to continuing contraception. This training module will prepare providers to offer ECP services to family planning clients.

MODULE TRAINING OBJECTIVE:
To prepare providers to safely provide Emergency Contraceptive Pills (ECPs) in appropriate situations, accompanied by clear and correct information and explanations.

SPECIFIC LEARNING OBJECTIVES:
By the end of the training, participants will be able to:

1. List at least three aspects of ECPs related to the following:
   - description.
   - effectiveness.
   - mechanism of action.
   - characteristics.
   - appropriate uses.
   - other methods of emergency contraception.

2. Discuss the precautions and considerations to the use of ECPs.

3. Explain how ECPs are used.

4. Demonstrate, through the use of case studies, how to manage ECP side effects.

5. Answer common questions related to ECPs in classroom exercise.

6. Demonstrate a non-judgmental attitude and respect for the client when providing ECP services.

7. Demonstrate knowledge of ECP use through classroom situations.

TRAINING/LEARNING METHODOLOGY:
- Lecturette
- Discussion
- Brainstorming
- Grab bag
- Case studies
- Role plays
MAJOR REFERENCES AND TRAINING MATERIALS:


RESOURCE REQUIREMENTS:

- Overhead projector
- Flipchart or whiteboard
- Marking pens

*Note to Trainer: These guidelines contain additional references and material related to the updated content in this revised version of Module 5.*
**EVALUATION METHODS:**

- Continuous assessment of objectives being learned
- Question/Answer during session
- Case studies
- Pre- & Post-tests

**TIME REQUIRED:** Approximately 8 hours

**MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:**

- Transparency 1.1: Module Objectives
- Copies of Participant Handouts for all participants.
- Flipchart with instruction for case studies.
- Grab bag.
Specific Objective #1: List at least three aspects of ECPs related to description, effectiveness, mechanism of action, characteristics, and appropriate uses.

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<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods</th>
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<tr>
<td>Knowledge/Attitudes/Skills</td>
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**Introduction**

Despite the availability of highly effective methods of contraception, many pregnancies are unplanned and unwanted. These pregnancies carry a higher risk of morbidity and mortality, often due to unsafe abortion. Many of these unplanned pregnancies can be avoided using emergency contraception.

**Definition of ECPs**

Emergency contraceptive pills (ECPs) are hormonal methods of contraception that can be used to prevent pregnancy following an unprotected act of sexual intercourse.

ECPs sometimes are referred to as "morning-after" or "post-coital" pills. The term "emergency contraceptive pills" is preferred because it conveys the important message that the treatment should not be used as an ongoing contraceptive method, and it avoids giving the mistaken impression that the pills must be taken on the morning after sex.

This training course includes information on two types of emergency contraceptive pills:

- Pills containing a progestin only levonorgestrel (LNG-only pills).
- Pills containing a combination of a progestin (levonorgestrel or norgestrel) and an estrogen (ethinyl estradiol), i.e. combined oral contraceptives (COCs).

**Introduction of Participants (Px) (30 min.)**

The trainer should:

- Divide the Px into pairs.
- Ask each Px to interview her/his partner for five minutes. S/he may ask any questions that will help her/him get to know her/his partner.
- After the interviews, have the Px regroup. Ask each Px to tell the group about her/his partner.
- Distribute and administer the Pre-test (Px Handout 0) to determine areas needing particular attention. See Trainer's Tool 1: Answer Key.
- Allow Px as much time as needed to complete the test.

**Lecturette (10 min.)**

The trainer should:

- Introduce the concept of ECPs, give a description, and review its effectiveness.
- Allow for Px questions and provide clarification.
<table>
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<th>CONTENT Knowledge/Attitudes/Skills</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td><strong>ECP Regimens</strong></td>
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<tr>
<td>Two ECP regimens are discussed in this curriculum:</td>
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<tr>
<td>• <strong>Levonorgestrel (LNG)-only regimen.</strong></td>
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<tr>
<td>0.75 mg LNG (or 1.5 mg norgestrel) taken as soon as possible after unprotected sex but optimally within 72 hours. This dose should be taken a second time, 12 hours after the first dose.</td>
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</tr>
<tr>
<td>• <strong>Yuzpe COC regimen (combined oral contraceptives).</strong></td>
<td></td>
</tr>
<tr>
<td>100 mcg ethinyl estradiol plus 0.5 mg of LNG (or 1.0 mg norgestrel) taken as soon as possible after unprotected sex but optimally within 72 hours. This same dose should be taken a second time, 12 hours after the first dose.</td>
<td></td>
</tr>
<tr>
<td>Both regimens maybe available in many locations and some products are specifically indicated for use as ECPs. However, they also can be made up from a variety of regular combined oral contraceptive (COC) pills.</td>
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</tr>
<tr>
<td>Treatment should begin as soon as possible after unprotected sex because the efficacy of both methods declines substantially with time.</td>
<td>(See <em>Px Handout 3.</em>)</td>
</tr>
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</table>

**Effectiveness of ECPs**

Although both regimens are effective, the LNG-only regimen is preferred because it is more effective and is associated with a lower risk of nausea and vomiting than the Yuzpe regimen.

**Lecturette (10 min.)**

The trainer should:

- Highlight the content that gives the rationale for not using ECPs as a regular contraceptive method.
## Knowledge/Attitudes/Skills

- The **LNG-only** regimen reduces the risk of pregnancy by about 85 percent after a single act of intercourse. This means that if 100 women had unprotected sex about 8% would become pregnant compared to only 1% if LNG-only ECPs were taken.

- The **Yuzpe** regimen using COCs reduces the risk of pregnancy by about 74 percent.

Both regimens are significantly and substantially more effective the sooner after sex that they are used.

Overall, ECPs are less effective than most regular contraceptive methods. Because the ECP pregnancy rate is based on a one-time use, it cannot be directly compared to pregnancy rates of regular contraceptives, which represent the risk of pregnancy during a full year of use. Theoretically, if ECP were to be used during a full year, the pregnancy rate would be much higher than that of regular hormonal contraceptives. Therefore, ECPs are inappropriate for regular use.

### Mechanism of Action

The exact mode of action of ECPs is not known. In some studies, ECPs have been shown to prevent or delay ovulation. The precise mechanism of action may depend on the time during the menstrual cycle when the woman had unprotected sex and when ECPs are taken. Pregnancy may be prevented through the following additional mechanisms, although these have not been proven:

- By affecting the movement of sperm through the cervical mucus.

## Training/Learning Methods (Time Required)

- Ask Px how ECPs prevent pregnancy. Confirm or correct PX responses.
- Provide additional information from the content column if it is not covered through the question and answers.
- Note on a flip chart the content of Px responses related to ECPs' mechanism of action.
<table>
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<th>CONTENT</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
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</table>
| • By altering transport of sperm, ovum, or embryo.  
• By interfering with corpus luteum function.  
• By preventing fertilization.  
• By inhibiting implantation.  
The two ECP regimens (the LNG-only and Yuzpe regimens) act as true contraceptives and do not disrupt established (implanted) pregnancies. **ECPs will not cause an abortion.** |  |
| Trainers note:  See the Consortium for Emergency Contraception's *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines* (July 2000 draft) for additional information on mechanism of action. |  |
| **Safety**  
**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; the short exposure to estrogens and/or progestins does not appear to alter blood-clotting mechanisms, as can occur with longer use of combined oral contraceptives (COCs).  
• The COCs used as ECPs have not been associated with fetal malformations or congenital defects.  
• Available data suggest that ECPs do not increase the possibility that a pregnancy following use of ECPs will be ectopic. |  |
| Lecturette (10 min.)  
The trainer should:  
• Highlight the points on safety, since these points are different from safety concerns of long-term COC use.  
• Allow for questions from Px. |  |
| Brainstorming (10 min.)  
The trainer should:  
• Ask Px, based on content just covered, what would be the characteristics (advantages and disadvantages) of ECPs.  
• Record Px comments on flipchart and ask for clarification as required.  
• Note the accuracy/appropriateness of Px contributions to brainstorming ECP characteristics. |  |
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<td>Brainstorming (10 min.)</td>
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<tr>
<td>Characteristics</td>
<td></td>
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<tr>
<td>• Documented safety.</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• Readily available (both COCs and LNG-only pills).</td>
<td>• Ask Px, based on content just covered, what would be the appropriate uses for ECPs.`</td>
</tr>
<tr>
<td>• Acts to prevent ovulation, fertilization, or implantation.</td>
<td>• Record Px comments on flip chart and ask for clarification as required.</td>
</tr>
<tr>
<td>• Reduces the need for abortions.</td>
<td>• Confirm or correct answers as necessary.</td>
</tr>
<tr>
<td>• Reduces the risk of unwanted pregnancy.</td>
<td>• Note the accuracy/appropriateness of Px contributions to brainstorming uses of ECPs.</td>
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<tr>
<td>• Appropriate for use after unprotected intercourse (including rape or contraceptive failure).</td>
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<tr>
<td>• Can be used by young adults who may be less likely to prepare for a first sexual encounter.</td>
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<tr>
<td>• Provides a bridge to the practice of regular contraception.</td>
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<tr>
<td>• Drug exposure and side effects are of short duration.</td>
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<tr>
<td>• Does not protect against the transmission of sexually transmitted infections (STIs) and HIV/AIDS.</td>
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<tr>
<td>• Does not provide ongoing protection against pregnancy.</td>
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<tr>
<td>• Should be used as soon as possible within three days of unprotected intercourse.</td>
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<tr>
<td>• May cause nausea and sometimes vomiting, especially with COC regimens.</td>
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<tr>
<td>• May change the time the woman's next menstrual period begins.</td>
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<tr>
<td>• Not appropriate for regular use due to high cumulative failure rate.</td>
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**Indications for the Use of ECPs**

- Documented safety.
- Readily available (both COCs and LNG-only pills).
- Acts to prevent ovulation, fertilization, or implantation.
- 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 young adults who may be less likely to prepare for a first sexual encounter.
- Provides a bridge to the practice of regular contraception.
- Drug exposure and side effects 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 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.
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ECPs are used to prevent pregnancy after unprotected sexual intercourse, including:

- When no contraceptive 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 (depot medroxy progesterone acetate [DMPA] or norethisterone acetate [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 dislodgment, 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) explosion.
- In cases of sexual assault when the woman was not protected by a reliable contraceptive method.

**Who can provide ECPs?**
ECPs can be distributed safely 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 counselors may be able to provide ECPs, depending on local regulations and practice. All ECP providers should receive training before distributing ECPs.

- Appropriate distribution mechanisms can include family planning and reproductive health care clinics, general practitioners and family doctors, community-based services, pharmacies, social marketing programs, and health service programs for youth, among others. 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 services for those cases where it may be required (for instance, if more than 72 hours have passed since the act of unprotected sex occurred and ECPs may not be appropriate.)

- 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 family planning visit and may be particularly appropriate for women who select methods that are highly dependent

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>Lecturette (10 min.)</td>
</tr>
<tr>
<td></td>
<td>The trainer should:</td>
</tr>
<tr>
<td></td>
<td>• Emphasize that ECPs can be provided by a broad range of personnel, not just physicians.</td>
</tr>
<tr>
<td></td>
<td>• Stress that advance counseling about ECPs and or distribution of advance supplies can greatly improve access to ECPs.</td>
</tr>
<tr>
<td></td>
<td>Discussion (10 min.)</td>
</tr>
<tr>
<td></td>
<td>The trainer should:</td>
</tr>
<tr>
<td></td>
<td>• Ask Px how ECPs will be provided through their services (which personnel are authorized to provide, what types of distribution mechanisms will be used, whether ECPs will be given as advance supplies).</td>
</tr>
<tr>
<td></td>
<td>• If appropriate, ask PX to brainstorm ways that access to ECPs could be increased in their community, especially for high-risk groups such as adolescents or displaced populations.</td>
</tr>
<tr>
<td></td>
<td>• Distribute Px Handout 1.</td>
</tr>
<tr>
<td>CONTENT</td>
<td>Training/Learning Methods (Time Required)</td>
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<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Knowledge/Attitudes/Skills</td>
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<tr>
<td>upon correct use at the time of intercourse (for instance, condoms or the diaphragm). Advanced supplies can greatly improve the convenience 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.</td>
<td></td>
</tr>
<tr>
<td>• Regardless of whether ECPs are distributed in advance, providers should inform women about their availability at the time of regular family planning or reproductive health service visits.</td>
<td></td>
</tr>
</tbody>
</table>
Specific Objective #2: Discuss the precautions and considerations to the use of ECPs.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td><strong>Precautions</strong></td>
<td><strong>Lecturette (10 min.)</strong></td>
</tr>
<tr>
<td>• 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.</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• 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.¹</td>
<td>• Present the precautions.</td>
</tr>
<tr>
<td>• 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 COCs and LNG-only pills do not apply to ECPs.²</td>
<td>• Assess Px understanding by asking the following questions:</td>
</tr>
<tr>
<td></td>
<td>– Should ECPs be offered to a woman whose period is 5 days late? Answer: No.</td>
</tr>
<tr>
<td></td>
<td>– Can ECPs be provided to a woman with a history of severe headaches? Answer: Yes.</td>
</tr>
<tr>
<td></td>
<td>– Can ECPs be provided to a woman who has diabetes? Answer: Yes.</td>
</tr>
<tr>
<td></td>
<td>– Can ECPs be provided to a woman with high blood pressure? Answer: Yes.</td>
</tr>
<tr>
<td></td>
<td>– Can ECPs be provided to a woman with varicose veins? Answer: Yes.</td>
</tr>
<tr>
<td></td>
<td>• Note on a flipchart the accuracy of Px answers to questions related to the precautions and considerations.</td>
</tr>
<tr>
<td></td>
<td>• Distribute <em>Px Handout 2</em>.</td>
</tr>
</tbody>
</table>


Specific Objective #3: Explain how ECPs are used.

<table>
<thead>
<tr>
<th>CONTENT Knowledge/Attitudes/Skills</th>
<th>Training/Learning Methods (Time Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECP Regimens</strong></td>
<td><strong>Lecturette (10 min.)</strong></td>
</tr>
<tr>
<td>Although two ECP regimens are described in this training, a variety of different types or dosages of oral contraceptive pills may be available:</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>1. The Yuzpe or Combined Oral Contraceptive (COC) regimen consists of &quot;combined&quot; pills containing ethinyl estradiol (EE) and levonorgestrel (LNG) or comparable formulations (for instance, those containing norgestrel). This regimen has been studied and widely used since the mid-1970s.</td>
<td>• Present the ECP regimens.</td>
</tr>
<tr>
<td><strong>When pills containing 50 mcg EE and 0.25 mg LNG (or 0.50 mg norgestrel) are available:</strong></td>
<td>• Distribute and review <em>Px Handout 3: Formulations and Dose Required for Emergency Contraception</em>, which presents the content information in table form.</td>
</tr>
<tr>
<td>• Two pills should be taken as the first dose as soon as possible but optimally within 72 hours after unprotected sex. These should be followed by another two pills 12 hours later.</td>
<td>• Assist the Px in listing what types of COCs and LNGs regimens are usually available in their worksites and in determining how those contraceptives fit in to the 2 regimens.</td>
</tr>
<tr>
<td><strong>When only pills containing 30 mcg EE and 0.15 LNG (or 0.30 mg norgestrel) are available:</strong></td>
<td></td>
</tr>
<tr>
<td>• Four pills should be taken within 72 hours after unprotected sex. These should be followed by another four pills 12 hours later.</td>
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</tr>
<tr>
<td>2. The levonorgestrel (LNG-only) regimen consists of progestin-only pills. It is more effective than the Yuzpe regimen and has a significantly lower incidence of nausea and vomiting.</td>
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</tr>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>Training/Learning Methods (Time Required)</td>
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<tr>
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</tr>
<tr>
<td>When LNG-only pills containing 0.75 mg LNG are available:</td>
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<tr>
<td>- One pill should be taken as the first dose as soon as possible but optimally within 72 hours after unprotected sex. This should be followed by another pill 12 hours later</td>
<td></td>
</tr>
<tr>
<td>When only pills containing 0.03 mg LNG (or 0.0375 mg LNG or 0.075 mg norgestrel) are available:</td>
<td></td>
</tr>
<tr>
<td>- 20 or 25 pills should be taken as the first dose as soon as possible but optimally within 72 hours after unprotected sex. These should be followed by another 20 or 25 pills 12 hours later. 25 of the 0.003 mg LNG or 20 of the 0.0375 mg LNG pills are used for each dose. This large number of pills may not be practical or acceptable for some women.</td>
<td></td>
</tr>
<tr>
<td>Treatment using either regimen should begin as soon as possible after unprotected sex because effectiveness of ECP in preventing pregnancy declines substantially over time.</td>
<td></td>
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</tbody>
</table>
Specific Objective #4: Demonstrate, through the use of case studies, how to manage ECP side effects.

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<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>Lecturette (10 min.)</td>
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<tr>
<td></td>
<td>The trainer should:</td>
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<tr>
<td></td>
<td>• Present the common side effects and the frequency of their occurrence.</td>
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<tr>
<td></td>
<td>• List the five other possible side effects.</td>
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<tr>
<td></td>
<td>Reading (20 min.)</td>
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<td></td>
<td>The trainer should:</td>
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<tr>
<td></td>
<td>• Distribute Px Handout 4: Side Effects and Management.</td>
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<tr>
<td></td>
<td>• Ask volunteer Px to take turns reading each side effect and its management.</td>
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<td></td>
<td>• Stop after each reading and allow for questions to clarify management.</td>
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<td></td>
<td>• Encourage Px to use handouts as a reference when providing services.</td>
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<tr>
<td></td>
<td>Case Studies (Total 45 min., 15 min. for group work, 30 min. for plenary.)</td>
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<tr>
<td></td>
<td>The trainer should:</td>
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<tr>
<td></td>
<td>• Divide group into 3 smaller groups.</td>
</tr>
<tr>
<td></td>
<td>• Distribute Px Handout 4.1: ECP Side Effects Case Studies.</td>
</tr>
<tr>
<td></td>
<td>• Display flipchart with group task and read instructions:</td>
</tr>
<tr>
<td></td>
<td>1. Read through the case thoroughly.</td>
</tr>
<tr>
<td></td>
<td>2. Select a recorder and reporter to present group's work.</td>
</tr>
</tbody>
</table>

### Common Side Effects of ECPs

#### 1. Nausea

About 43% of women using the Yuzpe COC regimen will experience nausea. Nausea is significantly lower (23%) with the LNG-only regimen. Symptoms are usually limited to the first three days after treatment.

**Management**

The best way to minimize nausea and vomiting is to use the LNG-only regimen whenever possible, instead of the COC regimen. With the LNG-only regimen, nausea and vomiting are uncommon, such that it is not routinely warranted to use an antiemetic (anti-vomiting) drug. If a COC regimen is used, you may consider pretreatment with an antiemetic, depending on program and client resources. Meclizine (also known as Ancolan, Antivert, Postafen, or Bonamine) is the only drug proven to be effective, although other antiemetics may be helpful. A single 50 mg oral dose taken one hour before the first ECP dose reduces the chance of nausea and vomiting by about 30 percent. Women should be warned that Meclizine may cause drowsiness.

It is difficult to predict which women will have nausea or 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, decrease her
<table>
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<tbody>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
<td><strong>(Time Required)</strong></td>
</tr>
<tr>
<td>stress, help her to withstand any nausea that may occur, and avoid vomiting.</td>
<td>3. Answer or perform tasks that relate to managing the assigned case.</td>
</tr>
<tr>
<td>2. <strong>Vomiting</strong></td>
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</table>
Occurs in about 6 percent of women using the LNG-only regimen and in 16 percent of those using COC regimen. |  
- Invite each group to present their work in 5 minutes; lead feedback and discussion for 5 minutes per case study. |
| **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. |  
- Note accuracy of group work; supplement or correct as necessary using *Trainer's Tool 2: Answer Key to Case Studies*. |
| 3. **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 women that ECPs do not bring on menses immediately (a common misperception 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 you cannot provide the test, advise her to seek pregnancy testing and appropriate care. |
## 4. 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.
Specific Objective #5: Answer common questions related to ECPs in classroom exercise.

<table>
<thead>
<tr>
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<th>Training/Learning Methods (Time Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>Grab Bag (30 min.)</td>
</tr>
<tr>
<td>Common Questions Asked About ECPs</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• Can COCs that contain progestin other than levonorgestrel (LNG) also be used for ECPs?</td>
<td>• Cut up a copy of <em>Px Handout 5</em> so that each question is on a separate strip of paper.</td>
</tr>
<tr>
<td>• Why is pregnancy the only precaution for using ECPs when there are several contraindications for the routine use of the same COCs?</td>
<td>• Place folded questions in a bag and shake to distribute them within the bag.</td>
</tr>
<tr>
<td>• May breastfeeding women use ECPs?</td>
<td>• Invite one Px at a time to pick from the bag, read the question aloud, and answer it.</td>
</tr>
<tr>
<td>• Can triphasic pills be used for ECPs?</td>
<td>• If the Px is unable to answer the question, it can be passed once, to another Px.</td>
</tr>
<tr>
<td>• Can progestin-only pills be used as ECPs?</td>
<td>• If the question cannot be answered at the second pass, answer the question and assist Px to understand the content.</td>
</tr>
<tr>
<td>• What should a woman do if vomiting is severe after the first dose of ECPs and she cannot take her second dose?</td>
<td>• Confirm or correct answers.</td>
</tr>
<tr>
<td>• Should we provide ECPs if the woman had unprotected sex on a day when her risk of pregnancy was not very high?</td>
<td>• Correct answers may be found on <em>Px Handout 5.1: Common Questions Asked about ECPs (Answer Key)</em> or in specific objectives throughout the module.</td>
</tr>
<tr>
<td>• Can ECPs be used with more than one act of unprotected sex?</td>
<td>• Continue until all nine questions are answered.</td>
</tr>
<tr>
<td>• Should ECP use be repeated?</td>
<td>• At the end of the exercise, distribute <em>Px Handout 5.1</em>.</td>
</tr>
<tr>
<td>• Can ECPs be taken before intercourse?</td>
<td>• Note the degree and frequency of accuracy in answering ECP questions.</td>
</tr>
<tr>
<td>• If knowledge of ECPs becomes widespread, could incorrect use or overuse of ECPs become a problem?</td>
<td></td>
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</tbody>
</table>
Specific Objective #6: Demonstrate non-judgmental attitude and respect for the client in providing ECP services.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td><strong>Counseling</strong></td>
<td></td>
</tr>
<tr>
<td>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 counseling.</td>
<td><strong>Brainstorming (5-10 min.)</strong></td>
</tr>
<tr>
<td>During counseling providers should:</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• Reassure all clients, regardless of age or marital status, that all information will be kept confidential.</td>
<td>1. Remind Px that as with other contraceptive methods, counseling is an important part of ECP service delivery.</td>
</tr>
<tr>
<td>• 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 counseling about regular contraceptive use and sexually transmitted infection (STI) prevention.</td>
<td>2. Ask Px to brainstorm some of the key principles of good counseling (many Px may be familiar with these principles from previous training).</td>
</tr>
<tr>
<td>• Actively involving the client in the counseling process may be more effective in ensuring compliance rather than simply providing her with information. This active involvement may include:</td>
<td>Possible responses include:</td>
</tr>
<tr>
<td>– Asking her what she has heard about ECPs.</td>
<td>• Greet clients warmly.</td>
</tr>
<tr>
<td>– Discussing her experience with other contraceptive methods (particularly the incident that led to ECP use).</td>
<td>• Be respectful.</td>
</tr>
<tr>
<td>– Validating or correcting her ideas as appropriate.</td>
<td>• Ensure privacy and confidentiality.</td>
</tr>
<tr>
<td></td>
<td>• Respect client's choices.</td>
</tr>
<tr>
<td></td>
<td>• Avoid making judgements.</td>
</tr>
<tr>
<td></td>
<td>• Ask if client has questions.</td>
</tr>
<tr>
<td></td>
<td>• Listen to client's concerns.</td>
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<tr>
<td></td>
<td><strong>Lecturette (10 min.)</strong></td>
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<tr>
<td></td>
<td>The trainer should:</td>
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<tr>
<td></td>
<td>• Emphasize the special counseling and information needs of ECP clients as described in the content column.</td>
</tr>
<tr>
<td></td>
<td>(See Px Handout 6.)</td>
</tr>
<tr>
<td></td>
<td><strong>Brainstorming (10-15 min.)</strong></td>
</tr>
</tbody>
</table>
Whenever possible, ensure that counseling 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 counseling about regular contraceptive methods. Reassure the woman that all information will be kept confidential, including the fact that she has received ECP treatment.

There are a number of special issues related to counseling clients for use of ECPs.

### Stress

Clients may feel particularly anxious after unprotected intercourse due to fear of becoming pregnant, worry about missing the 72-hour window of opportunity for emergency contraception, embarrassment at failing to contracept 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 counseling is especially important.

### Frequent use

Emphasize that ECPs are for emergency use 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.

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<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• Whenever possible, ensure that counseling 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 counseling about regular contraceptive methods. Reassure the woman that all information will be kept confidential, including the fact that she has received ECP treatment.</td>
<td>• Ask Px to brainstorm some of the medical and legal issues associated with cases of sexual violence.</td>
</tr>
<tr>
<td>• Stress</td>
<td>• Ask Px to list what social services or support systems they could use to help a survivor of sexual violence.</td>
</tr>
<tr>
<td>Clients may feel particularly anxious after unprotected intercourse due to fear of becoming pregnant, worry about missing the 72-hour window of opportunity for emergency contraception, embarrassment at failing to contracept 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 counseling is especially important.</td>
<td>• Ask Px if these services vary from rural to urban areas.</td>
</tr>
<tr>
<td>Frequent use</td>
<td>Lecturette (20 min.)</td>
</tr>
<tr>
<td>Emphasize that ECPs are for emergency use 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.</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• Write the steps in providing ECP services on flip chart:</td>
<td></td>
</tr>
<tr>
<td>– Greet client, introduce yourself, and ask what she needs.</td>
<td>• Using the information in the content column, review each step with Px, allowing time for questions.</td>
</tr>
<tr>
<td>– Screen client.</td>
<td>• Recap steps of the information giving</td>
</tr>
<tr>
<td>– Tell client about ECPs.</td>
<td></td>
</tr>
<tr>
<td><strong>CONTENT</strong></td>
<td><strong>Training/Learning Methods</strong></td>
</tr>
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</tr>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
<td><strong>(Time Required)</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td>process.</td>
</tr>
<tr>
<td><strong>HIV and STIs</strong></td>
<td>• Distribute and review <em>Px Handout 6: Providing ECP Services</em>.</td>
</tr>
<tr>
<td>Clients may be very concerned about possible infection, especially in cases of rape. Counseling on this topic should be provided along with STI diagnostic services (or referrals) and information about STI/HIV preventive measures. Clients must understand that ECPs offer no protection against STIs, including HIV/AIDS.</td>
<td><strong>Discussion (20 min.)</strong></td>
</tr>
<tr>
<td><strong>Counseling about other contraceptive methods</strong></td>
<td>The trainer should:</td>
</tr>
<tr>
<td>Whenever possible, clients requesting ECPs should also be offered information and services for regular contraceptives. However, not all clients want contraceptive counseling at the time of ECP treatment. Thus, while counseling related to the use of regular contraceptives is recommended for 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 counseling at the time of the ECP visit, at a follow-up appointment scheduled at a more convenient time, or should be referred to a FP clinic if other FP methods are not available (i.e., pharmacies, etc.). If the reason for requesting emergency contraception is that a regular contraceptive method was not used, or was used incorrectly, discuss how it can be used consistently and correctly in the process.</td>
<td>• Ask Px what medical history information is necessary to provide ECPs.</td>
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<tr>
<td></td>
<td>• Answers should include information under <em>Screening</em> in the <strong>Content</strong> column.</td>
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<tr>
<td></td>
<td>• Confirm or correct answers as needed. Fill in any missing information from the <strong>Content</strong> column.</td>
</tr>
<tr>
<td></td>
<td>• Distribute and discuss <em>Px Handouts 6.1 and 6.2</em>, which contain screening checklists for ECPs and for ECP clients wishing to continue with COCs.</td>
</tr>
<tr>
<td><strong>Learning Exercise (30 min.)</strong></td>
<td>The trainer should:</td>
</tr>
<tr>
<td>The trainer should:</td>
<td>• Divide the Px into small groups.</td>
</tr>
<tr>
<td></td>
<td>• Ask Px to use <em>Px Handout 6: Providing ECP Services</em> and <em>Px Handout 3: Formulations and Dose Required for Emergency Contraception</em> to create simple written client instructions for both regimens.</td>
</tr>
<tr>
<td></td>
<td>• Encourage Px to brainstorm how these messages could be illustrated with examples or made into pictorial instructions.</td>
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<td></td>
<td>• Review the groups’ output and</td>
</tr>
<tr>
<td>CONTENT</td>
<td>Training/Learning Methods</td>
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<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>compare with <em>Px Handout 6.3</em>, sample written instructions for using ECPs. Distribute <em>Px Handout 6.3</em>. This may be photocopied for clinic use.</td>
</tr>
<tr>
<td>future.</td>
<td></td>
</tr>
<tr>
<td>Women should be provided at least a temporary method, such as condoms, whenever possible, to use in the immediate future.</td>
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</tr>
<tr>
<td><strong>Client Screening</strong></td>
<td></td>
</tr>
<tr>
<td>Screen the client for ECP use by:</td>
<td></td>
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<tr>
<td>• Assessing the date of her 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 <strong>ECPs may be administered, as long as the client understands that pregnancy has not been ruled out.</strong></td>
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<tr>
<td>• Establishing how long ago the episode of unprotected sex occurred. If it occurred within the past 72 hours then treatment may be given, but the woman should be warned that effectiveness gradually decreases the closer she begins treatment to the 72-hour limit.</td>
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<tr>
<td>Other health assessments (e.g. pregnancy test, pelvic exam, etc.) are not required, but could be offered if medically indicated for other reasons and desired by the client</td>
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<tr>
<td>• With appropriate screening and unless contraindicated, the provider may offer</td>
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<td>Knowledge/Attitudes/Skills</td>
<td>Training/Learning Methods (Time Required)</td>
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<tr>
<td>to insert a Copper IUD if more than 72 hours have passed since the episode of unprotected sex. This would be a more effective method to prevent pregnancy than ECP. (See Px Handout 8.)</td>
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<tr>
<td><strong>Providers also should ask if the client is currently using a regular method of contraception;</strong> this question can be a good starting point for a discussion of regular contraceptive use and how to use methods correctly.</td>
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<tr>
<td>If the woman wishes to continue with COCs as her contraceptive method immediately after ECPs, patient history needs to be considered (cardiovascular disorders, smoking, breastfeeding, breast cancer, or high blood pressure).</td>
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<tr>
<td><strong>Information for the Client</strong></td>
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<tr>
<td>Women should be provided with basic information about ECPs before receiving emergency contraceptive pills. ECP information for the client should include:</td>
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<tr>
<td>• How and when to take the pills.</td>
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<tr>
<td>• What to expect once the pills are taken.</td>
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<tr>
<td>• Possible side effects and what the woman should do.</td>
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<tr>
<td>• Failure rates.</td>
<td></td>
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<tr>
<td>• Importance of using ongoing contraception.</td>
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<tr>
<td>Information regarding services for regular contraceptive use should also be provided if desired by the client.</td>
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</table>
Key Points

The following list covers key points to include when giving information to ECP clients.

- 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.
  - The woman should swallow the first dose as soon as possible after unprotected sex, and the second dose 12 hours after the first dose.

- Advise clients not to take any extra ECPs, as these will likely increase the possibility of nausea or vomiting, but will not increase effectiveness.

- 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
<table>
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<tr>
<th>CONTENT</th>
<th>Knowledge/Attitudes/Skills</th>
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<tr>
<td>for the remainder of her cycle. A different contraceptive method may be initiated at the beginning of her next cycle if desired. For some women, initiating or continuing COCs the day after using ECPs may be an option.</td>
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<tr>
<td>a barrier method, such as the condom,</td>
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<tr>
<td>• Explain that ECPs typically do not cause the client's menses to come immediately. <strong>This is another common misperception.</strong> The client should understand that her period might come a few days earlier or later than normal.</td>
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<tr>
<td>• Explain that if her period is more than a week late, she may be pregnant. She should seek evaluation and care for possible pregnancy.</td>
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<tr>
<td>• Advise the client to come back or visit a referral clinic (as appropriate):</td>
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<tr>
<td>− If there is a delay in her menstruation of more than one week past the expected date.</td>
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<tr>
<td>− If she has any reason for concern.</td>
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<tr>
<td>− As soon as possible after the onset of the menstrual period for contraceptive counseling, if desired.</td>
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<tr>
<td>• Use simple written or pictorial instructions to help reinforce important messages about correct use of ECPs.</td>
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<tr>
<td>Programs also should attempt to make ECP services available to high-risk audiences, such as youth and victims of sexual assault.</td>
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<tr>
<td>• <strong>Youth.</strong> Reaching adolescents with emergency contraceptive information and services poses special challenges to programs. Young women may find it difficult to access relevant information</td>
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<td>Training/Learning Methods</td>
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<td>Knowledge/Attitudes/Skills</td>
<td>Training/Learning Methods (Time Required)</td>
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<tr>
<td>and/or service on emergency contraception because they:</td>
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<tr>
<td>− Are unaware of the availability of ECPs.</td>
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<tr>
<td>− Lack confidence or are embarrassed to visit a family planning clinic.</td>
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<tr>
<td>− Do not know of the existence of the clinic.</td>
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<tr>
<td>− Find the clinic hours inconvenient.</td>
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<tr>
<td>− Fear a pelvic examination.</td>
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<tr>
<td>− Are anxious about judgmental attitudes of the providers.</td>
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<tr>
<td>Programs should work to ensure that clinics serving adolescents are youth-friendly (for example, ensuring privacy and confidentiality, accessible facilities, reasonably priced services, and flexible hours-particularly during evenings and weekends).</td>
<td></td>
</tr>
<tr>
<td>• <em>Sexual assault victims.</em> Reaching women who have been forced to have sex also poses special challenges. ECP providers should be attentive to the possibility that these women may be:</td>
<td></td>
</tr>
<tr>
<td>− Unaware that something can be done to prevent pregnancy after sexual assault.</td>
<td></td>
</tr>
<tr>
<td>− Unwilling to report the assault and therefore unwilling to seek services.</td>
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<tr>
<td>− Concerned they will be blamed for the assault by the medical provider.</td>
<td></td>
</tr>
<tr>
<td>− In need of diagnosis and treatment for STIs including an HIV test in the future.</td>
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<tr>
<td>Program managers and providers should ensure that police stations, emergency health care centers, and other facilities where women may seek help after an assault can provide clients with ECPs, if appropriate, or at least with information about where to obtain ECPs as promptly as possible.</td>
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</table>

| Written Instructions for the Client |
| The following written instructions should also be provided: |

**How to take ECP:**

- Swallow the first dose as soon as possible and no later than 72 hours (3 days) after unprotected sex.
- Swallow the second dose 12 hours after the first dose.
- **DO NOT** take an extra dose unless you vomit within one hour after taking either dose. Taking more will not work better, and may make you sick to your stomach.

**What to Expect**

- Many women feel sick to their stomach when they take ECPs. A few may vomit.
- Some women may feel dizzy or have headaches, cramping, abdominal pain, or breast tenderness. These side effects are not serious and they usually stop in a day or two.
- Your next period may come on time, or it may start a week early or late. If it... |
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<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tr>
<td>Knowledge/Attitudes/Skills</td>
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</table>

more than one week later than you expect it, you may be pregnant. You should have a pregnancy test and appropriate care.

- If you become pregnant before or after using ECPs, the pregnancy will not be harmed in any way. ECPs will not cause an abortion or birth defects.

### Preventing Pregnancy

- Do not have unprotected sex after using ECPs. Be sure to use a contraceptive method.

- ECPs are for emergency protection. They are not effective for use as a long-term contraceptive. To prevent pregnancy after taking ECPs, you need to use another method of contraception.

- ECPs do not protect against HIV/AIDS or other sexually transmitted infections (STI). If the episode of unprotected sex also put you at risk of an STI, you should be evaluated and possibly treated for an STI. You may want to consider having a test for HIV in the future.

- Return to the clinic if you have a question or concern.

- Your next menstrual period is your sign that ECPs have worked and you are not pregnant. Most contraceptives for on-going use may be started within 5 days after your menstrual period begins.

Discussion (15 min.)
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<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>Provider Information</td>
<td>• Ask Px what the goals of an ECP follow-up visit should be.</td>
</tr>
<tr>
<td>• Name of Facility or Provider</td>
<td>• Answers should be consistent with material in the content column.</td>
</tr>
<tr>
<td>• Location/Telephone number</td>
<td>• Confirm or correct Px answers.</td>
</tr>
<tr>
<td>• Open on these days and hours</td>
<td>• Allow time for questions and clarifications.</td>
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</tbody>
</table>

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:

• 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 birth defects following ECP use.
• Available information suggests no increased likelihood that a pregnancy

Role Play (60 min.)

The trainer should:

• Divide Px into three-person groups after completing presentation of Specific Objective #6.
• Explain that each Px will have a chance to role play as a service provider, as a client, and as an observer.
• Ask Px to spend five minutes looking over Px Handouts 6.1, 6.2, and 6.4: ECP Counseling Skills Checklist before they begin the role plays.
• Px Handouts 6.5-6.7 describe client roles. Give a copy of Px Handout 6.5 to one member of each of the groups; repeat with Px Handouts 6.6 and 6.7.
• Tell the group they have ten minutes to conduct each role play and 30 minutes for a large group discussion of the exercise.
• During the first role play, the Px with Px Handout 6.5 will be the client, one of the other group members will play the provider, and the other will observe.
### Knowledge/Attitudes/Skills

Knowledge/Attitudes/Skills

- will be ectopic as a result of ECP failure.

### Training/Learning Methods

Training/Learning Methods (Time Required)

- In the second role play, the Px with *Px Handout 6.6* will play the client, etc.

- The client should play the role described on the handout.

- The service provider should counsel the client, going through all the steps on the *ECP Counseling Skills Checklist (Px Handout 6.4)*.

- The observer checks off the steps on the checklist and writes observations.

- Rotate the roles and repeat the role play.

- After the role plays, return the checklists to the person being monitored and discuss in small groups ways to improve counseling services.

- Reassemble the full group and ask Px to talk about their experiences as service providers, clients, and observers.

- Use *Trainer's Tool 3* as a guide for your discussion.

### Initiation or Resuming Regular Contraception

Initiating or Resuming Regular Contraception

A barrier contraceptive or abstinence from sex should be used until initiating regular contraception during or after the next menstrual period. Whenever possible, clients receiving ECPs should be given a contraceptive method or methods:

- **Condoms, diaphragms, 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, *Px Handout 6.2*.)

- **Progestin-only injectables** should be initiated within seven days of the beginning of the next menstrual cycle.

- **Combined injectables** should be initiated within five days of the beginning of the next menstrual cycle.

- **Implants** should be inserted within seven days after the beginning of the next menstrual cycle.

- **IUDs** should be initiated during the next menstrual cycle.

- Natural family planning will require abstinence from sexual intercourse or use of a back-up method such as condoms until the first normal...
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<th>CONTENT</th>
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<td>Knowledge/Attitudes/Skills</td>
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<tr>
<td>menstrual cycle.</td>
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<tr>
<td>• Voluntary Sterilization should only be performed when informed free</td>
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<tr>
<td>choice can be ensured. It is not recommended that clients make this</td>
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<tr>
<td>decision under the stressful conditions that often surround ECP use.</td>
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<tr>
<td>If the woman wants no more children and desires contraceptive</td>
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<tr>
<td>sterilization, the decision may be considered after the next</td>
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<td>menses. Interim contraception should be provided.</td>
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**Specific Objective #7: Demonstrate knowledge of ECP use through classroom situations.**

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<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tr>
<td>Knowledge/Attitudes/Skills</td>
<td><strong>Synthesis</strong></td>
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<td>This part of the session provides an opportunity for participants to practice applying their new knowledge of ECP service provision.</td>
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<td><strong>Trainer Presentation and Group Discussion (45 min.)</strong></td>
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<td>The trainer should:</td>
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<td>• Present each of the ten situations for ECP provision found in <em>Px Handout 7: Situations for ECP Provision</em>.</td>
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<td>• Ask Px the questions that follow each situation.</td>
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<td>• Discuss and supplement their responses as necessary.</td>
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<td>• At the end of the exercise, distribute <em>Px Handout 7</em>.</td>
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<td><strong>Closure (45 min.)</strong></td>
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<td>The trainer should:</td>
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<td>• Review session objectives and allow for Px questions.</td>
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<td>• Distribute and administer the <em>Post-test (Px Handout 9)</em>.</td>
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<td>• Distribute <em>Participant Evaluation Forms (Px Handout 10)</em>.</td>
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<td>• Allow Px as much time as needed to complete the evaluation.</td>
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<td></td>
<td>• Collect the <em>Participant Evaluation Forms</em>.</td>
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</table>
Participant Name: ________________________________________________________________

**Instructions:** Circle the letter(s) of the answer(s) you consider best. There may be more than one correct answer.

3. ECPs may be used:
   
   a. up to 24 hours after unprotected sex  
   b. up to 48 hours after unprotected sex  
   c. up to 72 hours after unprotected sex  
   d. up to one week after unprotected sex  

The **most common** side effect of ECPs is:
   
   b. nausea  
   c. vomiting  
   d. blurry vision  
   e. weight gain  
   f. none of the above  

If using **low-dose combined oral contraceptives**, the correct formulation for emergency contraception would be:

   a. Two pills immediately followed by two pills 12 hours later  
   b. Four pills immediately followed by four pills 12 hours later  
   c. Twenty pills immediately followed by twenty pills 12 hours later  
   d. One pill immediately  

The following methods may be started immediately following ECP use:

- Voluntary Surgical Contraception  
- Injectables  
- Combined Oral Contraceptives  
- Condoms  
- Norplant implants  

Following ECP use, the percentage of women who become pregnant is approximately:

   e. 20 percent  
   f. 10 percent  
   g. 5 percent  
   h. 1-2 percent  

ECPs are appropriate for use in the following situations:

   i. In cases of contraceptive failure  
   j. In cases of sexual assault  
   k. In cases of contraceptive non-use  
   l. All of the above  

Following ECPs using combined oral contraceptives, vomiting will occur:
- m. In approximately 1 out of every 10 women
- n. In approximately 2 out of every 10 women
- o. In approximately 5 out of every 10 women
- p. all women

If a woman develops severe vomiting Progestin-only (levonorgestrel-only) eight hours following her first dose of ECPs, the appropriate treatment is to:
- q. skip the second dose
- r. repeat the first dose
- s. suggest vaginal administration of the second dose
- t. have the client drink milk

Instructions: Mark "True" or "False" in the blank provided for each statement.

___ Only pills containing estrogen and a progestin may be used for emergency contraception.

___ Progestin-only (levonorgestrel-only) ECPs cause nausea in approximately 20% of users.

___ ECPs provide contraceptive protection for the duration of the menstrual cycle in which they are used.

___ ECPs cannot cause an abortion.

___ Condoms and other barrier methods may be started immediately following ECPs use.

___ The only contraindication to ECP use is a current pregnancy.

___ ECPs provide protection against HIV/AIDS and other STDs.

___ Depending on local regulations, ECPs can be provided by properly trained doctors, nurses, or pharmacists.

___ ECPs can be effective when used as a regular contraceptive method.

___ All clients should undergo a full pelvic exam before receiving ECPs.
Participant Handout 1: ECPs as a Method

Introduction

Despite the availability of highly effective methods of contraception, many pregnancies are unplanned and unwanted. These pregnancies carry a higher risk of morbidity and mortality, often due to unsafe abortion. Many of these unplanned pregnancies can be avoided using emergency contraception.

Definition of ECPs

Emergency contraceptive pills (ECPs) are hormonal methods of contraception that can be used to prevent pregnancy following an unprotected act of sexual intercourse.

ECPs sometimes are referred to as "morning-after" or "post-coital" pills. The term "emergency contraceptive pills" is preferred because it conveys the important message that the treatment should not be used as an ongoing contraceptive method, and it avoids giving the mistaken impression that the pills must be taken on the morning after sex.

This training course includes information on two types of emergency contraceptive pills:

- Pills containing a progestin only levonorgestrel (LNG-only pills).
- Pills containing a combination of a progestin (levonorgestrel or norgestrel) and an estrogen (ethinyl estradiol), i.e. combined oral contraceptives (COCs).

ECP Regimens

Two ECP regimens are discussed in this curriculum:

- **Levonorgestrel (LNG)-only regimen.**
  0.75 mg LNG (or 1.5 mg norgestrel) taken as soon as possible after unprotected sex but optimally within 72 hours. This dose should be taken a second time, 12 hours after the first dose.

- **Yuzpe COC regimen (combined oral contraceptives).**
  100 mcg ethinyl estradiol plus 0.5 mg of LNG (or 1.0 mg norgestrel) taken as soon as possible after unprotected sex but optimally within 72 hours. This same dose should be taken a second time, 12 hours after the first dose.

Both regimens maybe available in many locations and some products are specifically indicated for use as ECPs. However, they also can be made up from a variety of regular combined oral contraceptive (COC) pills.

Treatment should begin as soon as possible after unprotected sex because the efficacy of both methods declines substantially with time.
Effectiveness of ECPs

Although both regimens are effective, the **LNG-only regimen is preferred because it is more effective and is associated with a lower risk of nausea and vomiting** than the Yuzpe regimen.

- The **LNG-only** regimen reduces the risk of pregnancy by about 85 percent after a single act of intercourse. This means that if 100 women had unprotected sex about 8% would become pregnant compared to only 1% if LNG-only ECPs were taken.

- The **Yuzpe** regimen using COCs reduces the risk of pregnancy by about 74 percent.

Both regimens are significantly and substantially more effective the sooner after sex that they are used.

Overall, ECPs are less effective than most regular contraceptive methods. Because the ECP pregnancy rate is based on a one-time use, it cannot be directly compared to pregnancy rates of regular contraceptives, which represent the risk of pregnancy during a full year of use. Theoretically, if ECP were to be used during a full year, the pregnancy rate would be much higher than that of regular hormonal contraceptives. Therefore, ECPs are inadequate for regular use.

Mechanism of Action

The exact mode of action of ECPs is not known. In some studies, ECPs have been shown to prevent or delay ovulation. The precise mechanism of action may depend on the time during the menstrual cycle when the woman had unprotected sex and when ECPs are taken. Pregnancy may be prevented through the following additional mechanisms, although these have not been proven:

- By affecting the movement of sperm through the cervical mucus.
- By altering transport of sperm, ovum, or embryo.
- By interfering with corpus luteum function.
- By preventing fertilization.
- By inhibiting implantation.

The two ECP regimens (the LNG-only and Yuzpe regimens) act as true contraceptives and do not disrupt established (implanted) pregnancies. **ECPs will not cause an abortion.**

**Trainers note:** See the Consortium for Emergency Contraception’s *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines* (July 2000 draft) for additional information on mechanism of action.
Participant Handout 1: ECPs as a Method (cont.)

Safety

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; the short exposure to estrogens and/or progestins does not appear to alter blood-clotting mechanisms, as can occur with longer use of combined oral contraceptives (COCs).
- The COCs used as ECPs have not been associated with fetal malformations or congenital defects.
- Available data suggest that ECPs do not increase the possibility that a pregnancy following use of ECPs will be ectopic.

Characteristics

- Documented safety.
- Readily available (both COCs and LNG-only pills).
- Acts to prevent ovulation, fertilization, or implantation.
- 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 young adults who may be less likely to prepare for a first sexual encounter.
- Provides a bridge to the practice of regular contraception.
- Drug exposure and side effects 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 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 due to high cumulative failure rate.
Participant Handout 1: ECPs as a Method (cont.)

Indications for the Use of ECPs

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

- When no contraceptive 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 (depo medroxy progesterone acetate [DMPA] or norethisterone acetate [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 dislodgment, 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) explosion.
- In cases of sexual assault when the woman was not protected by a reliable contraceptive method.

Who can provide ECPs?

ECPs can be distributed safely 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 counselors may be able to provide ECPs, depending on local regulations and practice. All ECP providers should receive training before distributing ECPs.
- Appropriate distribution mechanisms can include family planning and reproductive health care clinics, general practitioners and family doctors, community-based services, pharmacies, social marketing programs, and health service programs for youth, among others. Mass media informational campaigns and advertising can improve access to all sources of ECPs.
Participant Handout 1: ECPs as a Method (cont.)

- When ECPs are provided through non-clinic outlets, the providers must have access to referral services for those cases where it may be required (for instance, if more than 72 hours have passed since the act of unprotected sex occurred and ECPs may not be appropriate.)

- 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 family planning 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). Advanced supplies can greatly improve the convenience 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.

- Regardless of whether ECPs are distributed in advance, providers should inform women about their availability at the time of regular family planning or reproductive health service visits.
Participant Handout 2: Precautions

- ECPs should not be given to a woman who has a confirmed pregnancy, primarily because ECPs will not be effective if pregnancy is already established.

- ECPs may be given when pregnancy status is unclear and pregnancy testing is not available, as there is no evidence that suggests harm to the woman or to an existing pregnancy.3

- There are no other known medical conditions 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 COCs and LNG-only pills do not apply to ECPs.4 Women with a history of previous ectopic pregnancy may use ECPs.

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Participant Handout 3: Formulations and Dose Required for Emergency Contraception

For all regimens the first dose should be taken as soon as possible after intercourse, but optimally within 72 hours. The second dose should then be taken 12 hours after the first.

<table>
<thead>
<tr>
<th></th>
<th>Formulation (per pill)</th>
<th>Common Brand Names</th>
<th>Pills per Dose</th>
<th>Doses Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Levonorgestrel-only</strong></td>
<td>LNG 0.75 mg</td>
<td>Levonelle-2, Norlevo, Plan B, Postinor, Postinor-2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>LNG 0.03 mg</td>
<td>Microlut, Microval, Norgeston</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>LNG 0.0375 mg</td>
<td>Ovrette</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td><strong>Yuzpe Regimen</strong></td>
<td>EE 50 mcg + LNG 0.25 mg</td>
<td>Neogynon, Noral, Nordiol, Ovidon, Eugynon 50, Ovral, Ovran, PC-4, Preven</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EE 50 mcg + NG 0.50 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EE 30 mcg + LNG 0.15 mg</td>
<td>Microgynon 30, Nordette, Rigievidon, Lo/Femenal, Ovral L</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EE 30 mcg + NG 0.30mg</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations
EE ethinyl estradiol
LNG levonorgestrel
NG norgestrel
# Participant Handout 4: Side Effects and Management

<table>
<thead>
<tr>
<th>Side Effect/Explanation</th>
<th>Management of Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nausea</strong></td>
<td>The best way to minimize nausea and vomiting is to use the LNG-only regimen whenever possible, instead of the COC regimen. With the LNG-only regimen, nausea and vomiting are uncommon, such that it is not routinely warranted to use an antiemetic (anti-vomiting) drug. If a COC regimen is used, you may consider pretreatment with an antiemetic, depending on program and client resources. Meclizine (also known as Ancolan, Antivert, Postafen, or Bonamine) is the only drug proven to be effective, although other antiemetics may be helpful. A single 50mg oral dose taken one hour before the first ECP dose reduces the chance of nausea by about 30 percent and the frequency of vomiting by about 60 percent. Women should be warned that Meclizine may cause drowsiness. It is difficult to predict which women will have nausea or 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 ECPs with some culturally appropriate food (boiled potatoes, rice, dry crackers, or bread) may reassure her, decrease her stress, help her to withstand any nausea that may occur, and avoid vomiting.</td>
</tr>
<tr>
<td><strong>Vomiting</strong></td>
<td>If vomiting occurs within one hour of taking ECPs, the dose should be repeated. In cases of severe vomiting, vaginal administration of the pills may be effective.</td>
</tr>
</tbody>
</table>

Occurs in about 23 percent, or in about 2 out of every 10, women using the COC regimen. Nausea is significantly lower with the LNG-only regimen. Symptoms are usually limited to the first three days after treatment.

Occurs in about 6 percent of women using the LNG-only regimen and in 16 percent of those using COC regimens.
### Participant Handout 4: Side Effects and Management (cont.)

<table>
<thead>
<tr>
<th>Side Effect/Explanation</th>
<th>Management of Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Irregular vaginal bleeding or spotting</strong></td>
<td>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. Inform women that ECPs do not bring on menses immediately (a common misperception 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 you cannot provide the test, advise her to seek pregnancy testing and appropriate care.</td>
</tr>
<tr>
<td><strong>Other side effects of ECPs</strong></td>
<td>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. Aspirin, ibuprofen, acetaminophen, or another non-prescription pain reliever can be used to reduce discomfort due to headaches or breast tenderness.</td>
</tr>
</tbody>
</table>
Participant Handout 4.1: ECP Side Effects Case Studies

**Case 1:** Ms. K. is an 18-year-old who took her first dose of ECPs six hours ago. She has returned to you because she is nauseous and is afraid that she will vomit with the second dose. How would you handle this client's complaint?

**Case 2:** Mrs. Z. is a 32-year-old who has just taken her second ECP dose. She is complaining of a very strong headache. How would you handle this client's complaint?

**Case 3:** Ms. N. is a 22-year-old who vomited eight hours after her first dose of ECPs. She is afraid of taking the second dose and has come to you for advice. How would you handle this client's situation?
Participant Handout 5: Common Questions Asked about ECPs

(Grab Bag Exercise)

1. Can COCs that contain progestins other than levonorgestrel (LNG) also be used for ECPs?

2. Why is pregnancy the only precaution for using ECPs when there are several contraindications for the routine use of the same COCs?

3. May women who breastfeed use ECPs?

4. Can triphasic pills be used for ECPs?

5. Can progestin-only pills be used as ECPs?

6. Can the DMPA injection be given instead of ECPs?

7. What should a woman do if vomiting is severe after the first dose of ECPs and she cannot take her second dose?

8. Should we provide ECPs if the woman had unprotected sex on a day when her risk of pregnancy was not very high?

9. Can ECPs be used with more than one act of unprotected sex?

10. Should ECP use be repeated?

11. Can ECPs be taken before intercourse?

12. If knowledge of ECPs becomes widespread, could incorrect use or overuse of ECPs become a problem?

13. Is it a problem if a woman uses ECPs as her standard contraceptive?

14. Do ECPs interact with other drugs?

15. Can a woman receive ECPs if she presents later than three days (72 hours) after unprotected sex?
Participant Handout 5.1: Common Questions Asked about ECPs

Answer Key

1. Can COCs containing progestins other than levonorgestrel (LNG) also be used for ECPs?

**Answer:** COCs containing norgestrel also can be used. Because norgestrel contains only half the amount of active substance compared to levonorgestrel, twice as much norgestrel is needed. Other progestins (such as norethindrone) have not been studied; it is not known if they are effective.

2. Why is pregnancy the only precaution for using ECPs when there are several precautions and considerations for the routine use of the same COCs?

**Answer:** The duration of use of ECPs is short; a recent study has shown that blood clotting does not change with this short exposure. Therefore, the risk of complications related to blood clotting, such as heart attack or blood clots in the legs is probably very low.

3. May women who breastfeed use ECPs?

**Answer:** Yes. A woman who is exclusively breastfeeding and who has not had a menstrual period since delivery is unlikely to be at risk of pregnancy and therefore may not need ECPs. However, a woman who is providing supplemental feeding to her infant or who has had menses since delivery may be at risk for pregnancy. A single treatment with ECPs is unlikely to have an important effect on milk quantity or quality. Some hormones may pass into the breast milk, but they are unlikely to affect the infant adversely.

4. Can triphasic pills be used for ECPs?

**Answer:** Some triphasic oral contraceptives contain levonorgestrel (LNG) as the progestin. However, since the hormone doses vary within the pack, selecting the right pills may be more complicated (only the pills containing 0.125mg levonorgestrel can be used). It is better to keep the instructions for ECPs as simple as possible; therefore, triphasic COCs are suitable only as a substitute, when standard COCs with LNG are not available.

5. Can progestin-only pills be used for ECPs?

**Answer:** Yes. In some countries, a special high-dose progestin-only pill, Postinor, containing 0.75mg levonorgestrel, is sold specifically for emergency (post-coital) contraception. Where available, Postinor should be included as an ECP option. Mini-pills could be used, but there is little experience because the number of pills is large and may appear excessive to some women. (See Participant Handout 3.)

6. Can the DMPA injection be given instead of ECPs?

**Answer:** No. The DMPA injection’s effectiveness as a contraceptive is too slow to prevent a pregnancy because it is absorbed by the woman’s body over a long period of time.
Participant Handout 5.1: Common Questions Asked about ECPs

Answer Key (cont.)

7. What should a woman do if vomiting is severe after the first dose of ECPs and she cannot take her second dose?

Answer: Non-prescription, anti-nausea medication generally is not effective once nausea is present. If vomiting is severe, one option is for her to place the second dose of pills high into the vagina. Although studies are not complete about how effective this is, EE and LNG are absorbed through the vaginal wall and she will get some benefit. If the woman has no other options, (vomiting being severe) vaginal placement seems more reasonable than not taking the second dose. Inform the woman that the treatment may be less effective if the second dose is not taken.

8. Should we provide ECPs if the woman had unprotected sex on a day when her risk of pregnancy was not very high?

Answer: Yes, often a woman cannot be sure she is infertile at any one time during her cycle. Therefore ECPs should be provided any time unprotected sex occurs and the woman is concerned that she is at risk of pregnancy.

16. Can ECPs be used with more than one act of unprotected sex?

Answer: Yes. ECPs should not be withheld if the client has had more than one unprotected act of sex, unless she is known to already be pregnant. However, women should be informed that as the interval between the earliest unprotected act and the use of the ECPs lengthens the effectiveness of the ECPs will be lower. Women should be encouraged to use ECPs as promptly as possible after unprotected sex, and not to wait until they have had a series of unprotected acts. Only one ECP regimen should be given at a time, regardless of the number of prior unprotected acts.

17. Should ECP use be repeated?

Answer: Yes. ECPs are not intended for repeated use however, given the low likelihood of harm from limited repeat use, ECPs should not be denied just because the woman has used them before, even within the same menstrual cycle. Women who use ECPs repeatedly should be given information about other forms of contraception and counseling about how to avoid future contraceptive failure.

18. Can ECPs be taken before intercourse?

Answer: Yes. No data is available about how long the contraceptive effect of ECPs persists after the pills have been taken. Presumably ECPs taken immediately before intercourse are as effective as ECPs taken immediately afterwards. However, if a woman has the opportunity to plan to use a contraceptive method before intercourse, a method other than ECPs, such as condoms or another barrier method, it is recommended.
19. If knowledge of ECPs becomes widespread, could incorrect use or overuse of ECPs become a problem?

**Answer:** Misuse is not likely. In countries where ECPs have been publicized and made readily available, misuse has not been a problem. Making ECPs readily available with accurate instructions through established family planning services, whether clinic, pharmacy or community based, will help reduce any risk of incorrect or frequent use and will ensure appropriate follow-up counseling and contraceptive services.

20. Is it a problem if a woman uses ECPs as her standard contraceptive?

**Answer:** Yes. Contraceptive protection will be low. The 1-2 percent failure rate of ECPs is for one menstrual cycle. Most women will have 13 menstrual cycles in a year; therefore the cumulative failure rate for one year would be high among sexually active women. Use of ECPs on a frequent basis also may result in disrupted menstrual cycles and erratic intermenstrual bleeding (spotting). Providers must inform women that ECPs are not as effective, nor as suitable, as a regular method of contraception.

21. Do ECPs interact with other drugs?

**Answer:** No specific data is available about the interaction of ECPs 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, Rifampin, certain anticonvulsant drugs, and Saint John's Wort) should be advised that the effectiveness of ECPs may be reduced. In this case you may increase the amount of hormone in the ECPs, either by increasing the amount of hormone in one or both doses, or by giving an extra dose.

22. Can a woman receive ECPs if it is later than three days (72 hours) after unprotected sex?

**Answer:** Experts believe that ECPs may still have some effect in preventing pregnancy for up to five days after unprotected intercourse, when the process of implantation begins. The benefit of treatment within five days may outweigh any disadvantages. Studies of effectiveness within 72 hours show an increasing risk of pregnancy as the 72 hours progresses, but suggest ECPs probably have some limited effectiveness even after 72 hours. However, the woman must understand that her chances of pregnancy may be increased, compared with a woman who takes ECPs within three days (72 hours). A more effective option would be to insert a copper IUD (see Participant Handout # 11: use of Copper Intrauterine Devices (IUDs) for Emergency Contraception) if the woman is otherwise a candidate for emergency IUD insertion.
Participant Handout 6: Providing ECP Services

Counseling

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 counseling. During counseling, providers should reassure all clients, regardless of age or marital status, that all information will be kept confidential. Providers also should 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 counseling about regular contraceptive use and sexually transmitted infection (STI) prevention.

Actively involving the client in the counseling 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 the ECP use), and then validating or correcting her ideas as appropriate.

Whenever possible, ensure that counseling is conducted in a private and supportive environment. In situations where it is difficult to maintain privacy (for instance, 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 counseling about regular contraceptive methods. Reassure the woman that all information will be kept confidential, including the fact that she received ECP treatment.

There are a number of special issues related to counseling clients for use of ECPs.

Stress

Clients may feel particularly anxious after unprotected intercourse due to fear of becoming pregnant, worry about missing the 72-hour window of opportunity for emergency contraception, embarrassment at failing to contracept 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 counseling is especially important.

Frequent use

Emphasize that ECPs are for emergency use 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. Counseling on this topic should be provided along with STI diagnostic services (or referrals) and information about STI/HIV preventive measures, particularly condoms. Clients must understand that ECPs offer no protection against STIs, including HIV/AIDS.

Counseling 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 counseling at the time of ECP treatment. Thus, while counseling related to the use of regular contraceptives is recommended for 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 counseling about appropriate methods at the time of the ECP visit, at a follow-up appointment scheduled at a more convenient time, or referred to a FP clinic if other FP methods are not available (i.e., at pharmacies, etc.). If the reason for requesting emergency contraception is because the regular contraceptive method was not used, or was used incorrectly, discuss with the client 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.

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 hours then treatment should be given, but the woman must be warned that effectiveness gradually decreases as the time of beginning treatment approaches the 72-hour mark. If more than 72 hours have passed since the episode of unprotected sex, the provider may, with appropriate screening and unless contraindicated, offer to insert a Copper IUD. This would be a more effective method to prevent pregnancy than ECP. (See Participant Handout 8.)

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 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).

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 first dose as soon as possible after unprotected sex, and the second dose 12 hours after the first dose.
- 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. Advise clients not to take any extra ECPs, as these will likely increase the level of side effects but will not increase effectiveness.
- 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 the day after 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.
Participant Handout 6: Providing ECP Services (cont.)

- 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.

Programs also should attempt to make ECP services available to high-risk audiences, such as youth and victims of sexual assault.

- **Youth.** Reaching adolescents with emergency contraceptive information and services poses special challenges to programs. Young women may find it difficult to access relevant information and/or service on emergency contraception because they:
  - Are unaware of the availability of ECPs.
  - Lack confidence or are embarrassed to visit a family planning clinic.
  - Do not know of the existence of the clinic.
  - Find the clinic hours inconvenient.
  - Fear a pelvic examination.
  - Are anxious about judgmental attitudes of the providers.

Programs should work to ensure that clinics serving adolescents are youth-friendly (for example, ensuring privacy and confidentially, accessible facilities, reasonably priced services, and flexible hours-particularly during evenings and weekends).

- **Sexual assault victims.** Reaching women who have been forced to have sex also poses special challenges. ECP providers should be attentive to the possibility that these women may be:
  - Unaware that something can be done to prevent pregnancy after sexual assault.
  - Unwilling to report the assault and therefore unwilling to seek services.
  - Concerned they will be blamed for the assault by the medical provider.
  - In need of diagnosis and treatment for STIs, including an HIV test in the future.

Program managers and providers should ensure that police stations, emergency health care centers, and other facilities where women may seek help after an assault can provide clients with ECPs, if appropriate, or at least with information about where to obtain ECPs as promptly as possible.

**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.
Participant Handout 6: Providing ECP Services (cont.)

During the follow-up appointment:

- 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.

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, diaphragms, 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 (*Participant Handout 6.2*).
- Progestin-only injectables should be initiated within seven days of the beginning of the next menstrual cycle.
Module 5/Participant Handouts

• Combined injectibles should be initiated within five days of the beginning of the next menstrual cycle.
Participant Handout 6: Providing ECP Services (cont.)

- IUDs should be initiated during the next menstrual cycle.
- Natural family planning will require abstinence from sexual intercourse or use of a back up method such as condoms until the first normal menstrual cycle.
- Implants should be initiated within seven days of the beginning of the next menstrual cycle.
- Sterilization should only be performed when informed free choice can be ensured. It is not recommended that clients make this decision under the stressful conditions that often surround ECP use. If the woman wants no more children and desires contraceptive sterilization, the decision may be considered after the next menses. Interim contraception should be provided.
- A barrier contraceptive or abstinence from sex should be used until initiating regular contraception during or after the next menstrual period.
## 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>Diaphragm</td>
<td>Can be used immediately.</td>
</tr>
<tr>
<td>Spermicide</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 this 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. (See Participant Handout 6.2 for appropriate screening checklist.)</td>
</tr>
<tr>
<td>Injectables</td>
<td>Initiate progestin-only injectables within seven days of the beginning of the next menstrual cycle. Initiate combined injectables within five days after the beginning of the next menstrual cycle</td>
</tr>
<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. (See Participant Handout 8.)</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.</td>
</tr>
<tr>
<td>Implants (e.g. Norplant)</td>
<td>Initiate within seven days of the beginning of next menstrual cycle.</td>
</tr>
<tr>
<td>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>
### Participant Handout 6.1: Sample ECP Screening Checklist

<table>
<thead>
<tr>
<th>Ask the potential client the following questions:</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Has the first instance of unprotected sex during this menstrual cycle been within the last 72 hours?</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.

<table>
<thead>
<tr>
<th>9. Have you had your last menstrual period within the last month? Write in the date of the first day of the last menstrual period. (_______________)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Was this period normal in both its length and timing?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

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 exam 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.
### Participant Handout 6.2: Sample Screening Checklist for ECP Clients to Initiate or Continue COCs

<table>
<thead>
<tr>
<th>Ask the potential COC user the following questions:</th>
<th>Response</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>YES  NO</td>
</tr>
<tr>
<td>6. Are you currently breastfeeding a baby under 6 months of age and plan to continue?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>7. Do you smoke cigarettes AND are you over 35 years of age?</td>
<td>YES  NO</td>
</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>YES  NO</td>
</tr>
<tr>
<td>9. Do you have high blood pressure?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>10. Have you ever had a stroke, blood clot in your legs or lungs, or a heart attack?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>11. Do you have diabetes (sugar in your blood)?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>12. Do you have or have had breast cancer?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>13. Do you have a serious liver disease or jaundice (yellow skin or eyes)?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>14. Do you regularly take any pills for tuberculosis (TB), fungal infections, or seizures (fits)?</td>
<td>YES  NO</td>
</tr>
</tbody>
</table>

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.

If the client answers **NO** to all the above questions, continue with the question below.

| 11. Do you have bleeding after intercourse (sex) or bleeding between menstrual periods which is unusual for you? | YES  NO |

If the client answers **YES**, she can use COCs, but refer her to the clinic/physician for further evaluation of bleeding.
Participant Handout 6.3: Sample Instructions for Using Emergency Contraceptive Pills (ECP)

How to Take ECP

- Swallow the first dose as soon as possible and no later than 72 hours (3 days) after unprotected sex.
- Swallow the second dose 12 hours after the first dose.
- **DO NOT** take an extra dose unless you vomit within one hour after taking either dose. Taking more ECPs than prescribed will **NOT** work better, and may make you sick to your stomach.

What to Expect

- Many women feel sick to their stomach when they take ECPs. A few may vomit.
- Some women may feel dizzy or have headaches, cramping, abdominal pain, or breast tenderness. These side effects are not serious and they usually stop in a day or two.
- Your next period may come on time, or it may start up to a week early or late. If it is more than one week later than you expect it, you may be pregnant. You should have a pregnancy test and appropriate care.
- If you become pregnant before or after using ECPs, the pregnancy will not be harmed in any way. ECPs will not cause an abortion or birth defects.

Preventing Pregnancy

- Do not have unprotected sex after using ECPs. Be sure to use a contraceptive to protect yourself.
- ECPs are for emergency protection. They are not effective for use as a long-term contraceptive. To prevent pregnancy after taking ECPs, you need to use another method of contraception.
- ECPs do not protect against HIV/AIDS or other sexually transmitted infections (STI). If the episode of unprotected sex also put you at risk of an STI, you should be evaluated and possibly treated for an STI. You may want to have a test for HIV in the future.
- Return to or contact the clinic if you have a question, concern, or vomiting.
- Your next menstrual period is your sign that the ECPs have worked and you are not pregnant. Most contraceptives for on-going use may be started within 5 days after your menstrual period begins.

Name of Facility or Provider ____________________________________________
Location/Telephone Number ____________________________________________
Open on these days and hours __________________________________________
### Participant Handout 6.4: ECP Counseling Skills Checklist

<table>
<thead>
<tr>
<th>TASK</th>
<th>YES/NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Greets the client in a friendly, respectful, and helpful way.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Introduces him/herself if the client doesn’t know him/her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Asks client why she has come to the clinic or what makes her think that she needs ECPs. Ensures confidentiality.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Takes a brief medical history, which includes information on dates of unprotected sex and last menstrual period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Tells the client about ECPs, including how they work, their effectiveness, and the possible side effects.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Allows client to ask questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Explains the correct use of ECPs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Shows client the ECP tablets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Asks the client to summarize the instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Gives clients correct number of ECP tablets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Explains how to manage possible ECPs side-effects.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1 Nausea. Reminds client that it is a common side-effect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.2 Vomiting: Reassures client that this side-effect can occur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.3 Nausea. Reminds client that it is a common side-effect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.4 Vomiting: Reassures client that this side-effect can occur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.5 Nausea. Reminds client that it is a common side-effect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.6 Vomiting: Reassures client that this side-effect can occur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TASK</td>
<td>YES/NO</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>--------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Side effects continued</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.3 <em>Breast tenderness, headaches, or dizziness.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reminds client the side-effects are common and will not last long. Offers aspirin or ibuprofen for discomfort.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.4 <em>Irregular bleeding or spotting.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reassures client that this is a common side-effect and should not last long.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Tells client to return or report to a clinic or hospital if she has any concerns or questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Tells client her menstrual period is likely to be within one week before or after her expected date. Reminds client to return for a pregnancy test if her menses are more than a week late.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Reminds client that ECPs are not suitable as a regular method of contraception. Asks client if she would like to discuss other methods she can use in the future.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Provides contraceptive information and services or schedules an appointment for another visit to discuss ongoing contraceptive use. Provides referral services and/or STD/HIV prevention information as needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Demonstrates a non-judgmental attitude and respect for client throughout ECP service provision.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 6.5: Role Play A

Today you will play the role of Miss M., a 20-year-old woman. Tell the provider that you have heard about emergency contraception from friends and think you might need it, but you are scared to try it because you think that it might make you infertile and that it might not be safe because you smoke.

Background information that you may need to answer questions your provider asks you:

- You had unprotected sex last night (you were not expecting to have sex with your new boyfriend and did not have any contraceptive protection nearby).
- Your last menstrual period ended five days ago and was normal.
- You are a heavy smoker and have herpes but have no other health problems.
- You have been pregnant twice before and had abortions both times and are scared of having another one.
- You have not been sexually active for awhile but are starting a new relationship.
- You are interested in learning more about the pill for ongoing contraception.
Participant Handout 6.6: Role Play B

Today you will play the role of Mrs. R., a 31-year-old woman. Tell the provider that you had sex on Friday night and the condom broke. Now it's Tuesday and you are very worried you might have gotten pregnant. You would have come to the clinic earlier, but you couldn't find transportation and child care. You want to know if there is anything you can do now to prevent pregnancy and if there is a more reliable method you can use in the future.

Background information that you may need to answer questions your provider asks you:

- Your last menstrual period started three weeks ago and was normal.
- You are married and have two children.
- Your doctor told you that you couldn't use the pill because of your severe migraine headaches, so you and your husband use condoms.
- You have diabetes and had a severe case of hepatitis a year ago.
- You and your husband are considering sterilization, but you want to wait a few years until your youngest child is a little older.
Participant Handout 6.7: Role Play C

Today you will play the role of Mrs. Q., a 25-year-old woman. Tell the provider that you have heard there is a pill you can take after having sex to prevent pregnancy and that you want to get some to use for birth control. You have used regular birth control pills on and off for the past few years, but often forget to take them. In fact, you got pregnant with your third child while you were using the pill. You were really excited to hear about this new pill from friends, because you have heard it is very effective and you know it will be a lot easier to remember to take than the daily pill. You need the new kind of pills right away because you just had sex last night and you have not yet started your new pill pack so you are not protected.

Background information that you may need to answer questions your provider asks you:

- Your last menstrual period started five weeks ago.
- You have been using pills, but think you forgot to take quite a few of them this month; you haven't yet started your new pack because you are waiting for your period to start.
- You and your husband have been having sex regularly; you most recently had sex last night.
- You have asthma.
- You really want to use a method that is easy to remember.
Participant Handout 7: Situations for ECPs Provision

26. Miss M. is a 21-year-old coming to you today for ECP. Her last menstrual period (LMP) was five days ago, she has had two pregnancies, both aborted. The client also admits to smoking five cigarettes per day. There is no history of blood clots in the veins, high blood pressure, migraines, or cancer of the reproductive organs. She had unprotected intercourse this morning at 1:00 a.m. Miss M. has not been using contraceptives since she has not been sexually active and this is a new relationship but she is interested in using pills.

a. Can this client use ECPs? Yes.

b. If you give her ECPs and Lo/Femenal is in stock, what dosage would you give her? Four tablets within 72 hours + four tablets 12 hours after the first dose.

c. What instructions and information would you give her? Tell the client about how ECPs work, their effectiveness, characteristics of ECP, and possible side effects. Explain the correct use of the method. Review the written instructions and give her a copy. Explain the risk of sexually transmitted diseases, including HIV infection, and how to protect herself. Discuss future contraceptive needs if the client wishes. Inform client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns. Encourage client to stop smoking.

27. Pretend that today is February 5, 2000 and Miss S. is a 16-year-old coming to you with a last menstrual period (LMP) that started on January 8, 2000, which was normal. She has never been pregnant, does not smoke, and has no history of medical conditions. She had unprotected intercourse on February 3, 2000. She has been using condoms for contraception. Upon further history taking you find that she used ECPs September 1999 and January 3, 2000.

a. Can this client use ECPs? Yes.

b. If you give her ECPs and the LNG-only product for EC is in stock, what dosage would you give her? One tablet within 72 hours + one tablet 12 hours after the first dose.

c. What instructions and information would you give her? Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, possible side effects, and their management. Explain the correct use of the method. Review the written instructions with her and give her a copy. Stress that ECPs is not a method for regular contraception, it is for emergency use. Discuss the client’s needs for continuing contraception. Explain the risk of STDs, including HIV infection, and how to protect herself. Inform the client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns.
Participant Handout 7: Situations for ECPs Provision (cont.)

28. Mrs. R. is a 33-year-old seeing you today, LMP was two weeks ago. She has a history of asthma, herpes, and smokes one pack of cigarettes per day. There is no other history of medical conditions. Date of unprotected intercourse was yesterday morning; she usually uses condoms for contraception.

d. Can this client use ECPs?  Yes.

e. If you give her ECPs and Ovral is in stock, what dosage would you give?  Two tablets within 72 hours + two tablets 12 hours after the first dose.

f. What instructions and information would you give her?  Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, and possible side effects. If she wishes, help the client choose a contraceptive method that is suitable to her lifestyle and health for use after ECPs. Explain the correct use of the method. Review the written instructions with her and give her a copy. Explain the risk of STDs, including HIV infection, and how to protect herself. Inform client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns. Encourage client to stop smoking.

29. Miss P. is 17 years old, has never been pregnant, and has a negative medical history. Her LMP was three weeks ago. The act of unprotected intercourse was three days ago, she was using condoms and states that the condom "broke."

g. Can this client use ECPs?  Yes.

h. If you give her ECPs and the LNG-only product is in stock, what dosage would you give her?  One tablet within 72 hours + one tablet 12 hours after the first dose.

i. What information and instructions would you give her?  Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, and possible side effects. If the client wishes, help her choose a contraceptive method that is suitable to her lifestyle and health for use after ECPs. Explain the correct use of the method. Explain the risk of STDs, including HIV infection, and how to protect herself. Inform client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns.
Participant Handout 7: Situations for ECPs Provision (cont.)

30. Mrs. B. is 37 years old, has one living child, and had one spontaneous abortion at six weeks of pregnancy. She comes to you today for help because it has been two weeks since she aborted and she had unprotected sex yesterday morning. She wants to use a contraceptive method that she does not have to "worry about doing something" when she has sex.

j. Can this client use ECPs? Yes.

k. If you give her ECPs and Nordette is in stock, what dosage would you give her?
   *Four tablets within 72 hours + four tablets 12 hours after the first dose.*

l. What information and instructions would you give her? *Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, and possible side effects. Explain the correct use of the method. Review the written instruction with her and give her a copy. Since she requests it, help the client choose a contraceptive method that is suitable to her lifestyle and health for use after ECPs. Give information about oral contraceptives, IUDs, implants, injectable hormones, and voluntary surgical contraception (VSC). Refer for injectable, IUD, implant, or VSC services. Explain the risk of STDs, including HIV infection, and how to protect herself. Inform client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns. A copper IUD for emergency contraceptive may be an effective option for her if she is otherwise a good candidate for an IUD and a pregnancy test is negative before IUD insertion.*

31. Ms. T. is 28 years old with one child and had a normal LMP two weeks ago. Medical history is negative. She comes to you today for ECPs. She had unprotected sex four days ago when her husband forced her to have sex. She does not want any more children, but her husband will not agree. She is willing to use a contraceptive without his knowledge.

m. Can this client use ECPs? Yes, although treatment may not be effective when used beyond 72 hours after unprotected sex.

n. If you give her ECPs and Neogynon is in stock, what dosage would you give her?
   *Two tablets within 72 hours + two tablets 12 hours after the first dose.*

o. What information and instructions would you give her? *Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, 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 the client choose a contraceptive method that is suitable to her lifestyle and health for use after ECPs. Explain the risk of STDs, including HIV infection. Her history of forced sex may also indicate that she is at risk of STDs. Explain how she can protect herself. Tell the client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns. Explore with client the need for social services referral.*
32. Mrs. J. is a 24-year-old with three children. She found her diaphragm dislodged this morning. Her LMP was one week ago. She has a history of high blood pressure during pregnancy and migraine headaches. She is satisfied with her diaphragm, but is not ready for another pregnancy.

p. Can this client use ECPs? Yes.

q. If you give her ECPs and Ovrette is in stock, what dosage would you give her? Twenty tablets within 72 hours + twenty tablets 12 hours after the first dose.

r. What information and instructions would you give her? Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, and possible side effects. Explain the correct use of the method. Review the written instructions with her and give her a copy. Explain the risk of STDs, including HIV infections, and how to protect herself. Inform client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns. Check the client's diaphragm size and help her practice correct insertion and placement.
33. Mrs. F. is a 30-year-old with four children, who comes to you for ECPs because her friend told her that she could prevent a pregnancy by taking pills after sex. Mrs. F. had stopped using pills three months ago because she kept forgetting to take them. Her LMP was five weeks ago and she fears that she is pregnant. The last act of unprotected sex was two days ago.

s. Can this client use ECPs? No.

t. What instructions and information would you give her? Tell the client that she may already be pregnant; advise her about her options and counsel as appropriate. If she wants to continue the pregnancy, refer the client for antenatal services. Provide a pregnancy test. If the client is not pregnant, give information about the contraceptives available at your pharmacy and long-term/permanent methods available at clinics/hospitals in the area. Refer client for long-term/permanent methods if that is her choice.

34. Ms. Q. brings her 17-year-old sister to you because the sister was raped last night on her way home from after-school work. The family filed a complaint with the police and the sister was "treated" at the hospital with a tranquilizer. A neighbor suggested that they get ECPs for the sister to prevent a pregnancy. The sister has never had sex before and thinks her LMP was three weeks ago. There is only a history of an appendectomy at age 12.

u. Can this client use ECPs? Yes.

v. With Microgynon 30 in stock, what dosage would you give her? Four tablets within 72 hours + four tablets 12 hours after the first dose.

w. What information and instruction would you give her? Tell the client about how ECPs work, their effectiveness, characteristics of ECPs, 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 the client choose a contraceptive method that is suitable to her lifestyle and health for use after ECPs. Explain that because she was raped, she is at a high risk of STDs including HIV infection. Explain how she can protect herself. Inform the client to return for follow-up if she has a delay in her menstruation, suspects she may be pregnant, or has other concerns. Ask if the client or her sister want a social services referral.

35. Ms. W. is a first-time family planning client. After discussing various contraceptive options, she has selected condoms as her preferred method. She has never used them before, but paid close attention to your demonstration of how to use condoms.

a. Would you tell this client about ECPs? Yes. Clients need to know that ECPs are available and that the method she has selected (condoms) is a more reliable form of contraception for regular use. available and the correct time period for their use. Providing this information to your client will help her act responsibly and quickly in the event she fails to use a condom or experiences condom breakage.
Participant Handout 7: Situations for ECPs Provision (cont.)

b. Would you provide advance supplies of ECPs to this client? Yes. If your program’s protocols include advance provision of ECPs. Having an advance supply of the method will make it easier for your client to take ECPs as soon after unprotected sex as possible in the event she needs it.

c. What information and instruction would you give her? Tell the client how ECPs work, their effectiveness, and possible side effects. Explain the correct use of the method. Review written instructions with her and give her a copy. Emphasize that ECPs are for "emergency" use only.
Copper-bearing IUDs can be used as a method of emergency contraception and are most appropriate for women in stable relationships who wish to retain the IUD for long-term contraception and who meet the screening requirements for regular IUD use. When inserted within five days of unprotected intercourse, copper-bearing IUDs are the most effective method of emergency contraception; they reduce the risk of pregnancy by more than 99 percent.

However, emergency IUD insertion requires a much higher degree of training and clinical oversight than administration of ECPs, including screening to eliminate clients who are already pregnant (e.g., a pregnancy test, if the woman is not menstruating), who have pelvic inflammatory disease or another reproductive tract infection, or who are at high risk for STIs. In many instances, the act of unprotected intercourse that led to the request for emergency contraception might put the woman at increased risk of STIs, in which case the IUD is not an optimal contraceptive choice.

For further information about use of IUDs for emergency contraception, consult the IPPF Medical and Service Delivery Guidelines (the most recent edition, which contains information about emergency contraception, is available from IPPF, Regent's College, Inner Circle, Regent's Park, London NQW1 4NS, England), or the World Health Organization publication Emergency Contraception-A Guide for Service Delivery (1998).

Participant Handout 9: Emergency Contraceptive Pills
Post-Test

Participant Name: ____________________________________________________________

Instructions: Circle the letter(s) of the answer(s) you consider best. There may be more than one correct answer.

36. ECPs may be used:
   a. up to 24 hours after unprotected sex
   b. up to 48 hours after unprotected sex
   c. up to 72 hours after unprotected sex
   d. up to one week after unprotected sex

The most common side effect of ECPs is:
   g. nausea
   h. vomiting
   i. blurry vision
   j. weight gain
   k. none of the above

If using low-dose combined oral contraceptives, the correct formulation for emergency contraception would be:
   u. Two pills immediately followed by two pills 12 hours later
   v. Four pills immediately followed by four pills 12 hours later
   w. Twenty pills immediately followed by twenty pills 12 hours later
   x. One pill immediately

The following methods may be started immediately following ECP use:
   Voluntary Surgical Contraception
   Injectables
   Combined Oral Contraceptives
   Condoms
   Norplant implants

Following ECP use, the percentage of women who become pregnant is approximately:
   y. 20 percent
   z. 10 percent
   aa. 5 percent
   bb. 1-2 percent

ECPs are appropriate for use in the following situations:
   cc. In cases of contraceptive failure
   dd. In cases of sexual assault
   ee. In cases of contraceptive non-use
   ff. All of the above
Following ECPs using combined oral contraceptives, vomiting will occur:
  gg. In approximately 1 out of every 10 women
  hh. In approximately 2 out of every 10 women
  ii. In approximately 5 out of every 10 women
  jj. all women

If a woman develops severe vomiting Progestin-only (levonorgestrel-only) eight hours following her first dose of ECPs, the appropriate treatment is to:
  kk. skip the second dose
  ll. repeat the first dose
  mm. suggest vaginal administration of the second dose
  nn. have the client drink milk

Instructions: Mark "True" or "False" in the blank provided for each statement.

___ Only pills containing estrogen and a progestin may be used for emergency contraception.

___ Progestin-only (levonorgestrel-only) ECPs cause nausea in approximately 20% of users.

___ ECPs provide contraceptive protection for the duration of the menstrual cycle in which they are used.

___ ECPs cannot cause an abortion.

___ Condoms and other barrier methods may be started immediately following ECPs use.

___ The only contraindication to ECP use is a current pregnancy.

___ ECPs provide protection against HIV/AIDS and other STDs.

___ Depending on local regulations, ECPs can be provided by properly trained doctors, nurses, or pharmacists.

___ ECPs can be effective when used as a regular contraceptive method.

___ All clients should undergo a full pelvic exam before receiving ECPs.
Participant Handout 10: Comprehensive RH/FP Curriculum
Participant Evaluation

Module 5: Emergency Contraceptive Pills

Rate each of the following statements as to whether or not you agree with them, using the following key and circling the corresponding number next to each statement:

5 — Strongly agree
4 — Somewhat agree
3 — Neither agree nor disagree
2 — Somewhat disagree
1 — Strongly disagree

Course Materials

I feel that:

- The objectives of the module were clearly defined. 5 4 3 2 1
- The material was presented clearly and in an organized fashion. 5 4 3 2 1
- The pre-/post-test accurately assessed my in-course learning. 5 4 3 2 1
- The counseling skills checklist was useful. 5 4 3 2 1

Technical Information

I learned new information in this course. 5 4 3 2 1

I will now be able to:

- explain the role of Emergency Contraceptive Pills 5 4 3 2 1
  In FP programs.
- counsel and provide services to clients seeking ECPs. 5 4 3 2 1
- counsel ECP clients on continuing contraception and 5 4 3 2 1
  provide follow-up services to ECP clients.

Training Methodology

The trainers' presentations were clear and organized. 5 4 3 2 1
Class discussion contributed to my learning. 5 4 3 2 1
I learned practical skills in the role plays and case studies. 5 4 3 2 1
The required reading was informative. 5 4 3 2 1
The trainers encouraged my questions and input. 5 4 3 2 1
Training Location & Schedule

The training site and schedule were convenient. 5 4 3 2 1
The necessary materials were available. 5 4 3 2 1

Suggestions

1. What was the most useful part of this training? ________________________________
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______

2. What was the least useful part of this training? ________________________________
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______

3. What suggestions do you have to improve the module? Please feel free to reference any of the topics above. ________________________________ ________________________________ ________________________________ ________________________________
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ _______
   ________________________________ ________________________________ ______
   ________________________________ ________________________________ ______
Participant Name: ____________________________________________________________

**Instructions:** Circle the letter(s) of the answer(s) you consider correct. There may be more than one correct answer.

37. ECPs may be used:

   oo. up to 24 hours after unprotected sex  
   pp. up to 48 hours after unprotected sex  
   qq. up to 72 hours after unprotected sex  
   rr. up to one week after unprotected sex

The **most common** side effect of ECPs is:

   ss. nausea  
   tt. blurry vision  
   uu. weight gain  
   vv. one of the above

If using **low-dose combined oral contraceptives**, the correct formulation for emergency contraception would be:

   ww. Two pills immediately followed by two pills 12 hours later  
   xx. **Four pills immediately followed by four pills 12 hours later**  
   yy. Twenty pills immediately followed by twenty pills 12 hours later  
   zz. One pill immediately

The following methods may be started immediately following ECP use:

   aaa. Voluntary Surgical Contraception  
   bbb. Injectables  
   ccc. **Combined Oral Contraceptives**  
   ddd. Condoms  
   eee. Norplant implants

Following ECP use, the percentage of women who become pregnant is approximately:

   fff. 20 percent  
   ggg. 10 percent  
   hhh. 5 percent  
   iii. **1-2 percent**

ECPs are appropriate for use in the following situations:

   jji. In cases of contraceptive failure  
   kkk. In cases of sexual assault  
   lll. In cases of contraceptive non-use  
   mmm. **All of the above**
Following ECPs using combined oral contraceptives, vomiting will occur:

- **nnn.** In approximately 1 out of every 10 women
- **ooo.** **In approximately 2 out of every 10 women**
- **ppp.** In approximately 5 out of every 10 women
- **qqq.** All women

If a woman develops severe vomiting eight hours following her first dose of ECPs, the appropriate treatment is to:

- **rrr.** Skip the second dose
- **sss.** Repeat the first dose
- **ttt.** **Suggest vaginal administration of the second dose**
- **uuu.** Have the client drink milk

**Instructions:** Mark "True" or "False" in the blank provided for each statement.

- **F** Only pills containing estrogen and a progestin may be used for emergency contraception.
- **T** Progestin-only (levonorgestrel-only) ECPs cause nausea in approximately 20% of users.
- **F** ECPs provide contraceptive protection for the duration of the menstrual cycle in which they are used.
- **T** ECPs **cannot** cause an abortion.
- **T** Condoms and other barrier methods may be started immediately following ECPs use.
- **T** The only contraindication to ECP use is a current pregnancy.
- **F** ECPs provide protection against HIV/AIDS and other STDs.
- **T** Depending on local regulations, ECPs can be provided by properly trained doctors, nurses, or pharmacists.
- **F** ECPs can be effective when used as a regular contraceptive method.
- **F** All clients should undergo a full pelvic exam before receiving ECPs.
Trainer's Tool 2: Answer Key to Case Studies

Answer Key

Case 1: Ms. K. is an 18-year-old who took her first dose of ECPs six hours ago. She has returned to you because she is nauseous and is afraid that she will vomit with the second dose. How would you handle this client's complaint?

Answer: Remind Ms. K. that nausea is to be expected. Tell Ms. K. that anti-nausea medication is not likely to relieve her nausea. Encourage Ms. K. to take the second dose with a bland food such as boiled potatoes, rice, crackers, or bread. Alternatively, tell the client that she can place the tablets in her vagina; it may not reduce the nausea but it will ensure the medicine gets into her blood to prevent pregnancy.

Case 2: Mrs. Z. is a 32-year-old who has just taken her second ECP dose. She is complaining of a very strong headache. How would you handle this client's complaint?

Answer: Remind Mrs. Z. that headaches are a possible side effect of using ECPs and that it will not last long. For pain relief, offer the client aspirin, ibuprofen, or acetaminophen.

Case 3: Ms. N. is a 22-year-old who vomited eight hours after her first dose of ECPs. She is afraid of taking the second dose and has come to you for advice. How would you handle this client's situation?

Answer: Reassure Ms. N. that vomiting can occur with ECP use and that since she vomited long after taking the pills, the ECP is in her blood to prevent pregnancy. Tell Ms. N. that taking the second dose with food may help (see above). Remind her that if she vomits within two hours, she should repeat this dose. Alternatively, she can place the second dose of ECP in her vagina; it may not reduce the nausea but it will ensure that the medicine gets into her blood to prevent pregnancy. Vaginal administration may be a better option for a woman having repeated vomiting. You may give her a second packet of ECPs in case she needs to repeat the second dose and, if available, an anti-emetic to take 1 hour before the second dose.
Trainer's Tool 3: Notes for Counseling Role Play Processing: Role Plays A, B and C

After the small groups have completed all three role plays, process the exercise in a plenary session. Process the content of each role play separately, following the outline below:

vvv. Ask someone who played the part of the "provider" to describe the client visit, including what information and/or services he/she provided to the client.

www. Ask others who played the role of provider in this role play if they discovered any additional information about their client that led them to provide different treatment or advice. Discuss any differences or deficiencies in the treatment provided.

xxx. Using the Counseling Skills Checklist (Participant Handout 6.4) as a guide, ask participants if the "providers" they observed demonstrated any areas of particular strength or weakness. Ask participants to suggest ways "providers" could improve their counseling and service delivery skills.

Key points to discuss in Role Play A:

- Client is suitable for ECPs (within 72 hours of unprotected sex, normal last menstrual period).
- Client is concerned about safety of ECPs (fears infertility and concern about smoking) and should have been given special counseling on these topics.
- Client is motivated to practice contraception (fear of having another abortion) and has a desire for more information on the pill; provider should have given contraceptive information and services.
- Client’s relationship is new and she has a history of herpes; provider should have emphasized STD protection with client.

Key points to discuss in Role Play B:

- Client is just beyond the 72-hour window of opportunity for ECPs; provider may give ECPs, but should counsel client that effectiveness is lower but that there is no known harm to the fetus if the treatment fails. A copper IUD may be an effective option for her if she meets all screening criteria for the IUD and her pregnancy test is negative.
- Even though the client has been told she should not use oral contraceptives, she has no medical contraindications to ECP use.

Key points to discuss in Role Play C:

- Client may be pregnant already (based on LMP). If a pregnancy test is negative, she can receive ECPs. If a pregnancy test is positive, refer for appropriate services. Provider should have corrected client's misperception that ECPs can be used as a routine method and discussed which of the regular contraceptives might meet her needs for future contraception.
Trainer's Tool 4: Supplemental Notes on Mifepristone

Note to Trainer: This information on mifepristone is included only to assist the trainer in answering questions about mifepristone, if a question arises during training. Mifepristone is not part of the training content of this curriculum.

Trainer's Supplemental Notes on Mifepristone

Recent research has shown that Mifepristone, also known as RU486, is effective for emergency contraception. Doses of 10, 50, and 600 mg given orally once within 120 hours (5 days) after intercourse have been shown to be effective. In a comparative study, the 600 mg dose was found to be at least as effective as the Yuzpe regimen and was associated with fewer side effects. The 10 mg dose was associated with less menstrual disturbance than the higher doses. When given within 5 days of unprotected intercourse the mechanism of action of Mifepristone is not known. Mifepristone is not registered for emergency contraception in any country.

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Transparency 1: Module Objectives

Specific Learning Objectives:

1. List at least three aspects of ECPs related to the following:
   - description
   - effectiveness
   - mechanism of action
   - characteristics
   - appropriate uses
   - other methods of emergency contraception

2. Discuss the contraindications of ECP use.

3. Explain how ECPs are used.

4. Demonstrate, through the use of case studies, how to manage ECP side effects.

5. Answer common questions related to ECPs in classroom exercise.

6. Demonstrate non-judgmental attitude and respect for the client in providing ECP services.

7. Demonstrate knowledge of ECP use through classroom situations.