Maternal and Family Health Services, Inc.
Family Planning Protocols
Section V – Contraceptive Methods

TITLE:
Emergency Contraception
(Postcoital Oral Contraception)

Policy

Maternal and Family Health Services, Inc. shall make available either directly or through referral, all of the DHHS approved methods of contraception including the dedicated emergency contraception products. ACOG and manufacturer's guidelines are utilized as a resource for providing contraceptive methods.

Standards

1. Routine method counseling for enrolled Family Planning clients will include information on the availability and use of emergency contraception. To facilitate access, MFHS clinicians may provide an advance supply of or prescription for emergency contraception pills to clients at the time of a routine family planning visit.

2. Emergency contraception will be offered or made available to women who request it (enrolled client or initial visit request) at any time according to manufacturer's guidelines prior to or up to 72 to 120 hours (3-5 days) after unprotected or inadequately protected sexual intercourse. No clinician examination or pregnancy testing is necessary before provision or prescription of emergency contraception. Treatment should be initiated as soon as possible after unprotected or inadequately protected intercourse to maximize efficacy.
    - No evidence demonstrates that emergency contraception is unsafe for women with specific contraindications to oral contraceptives or for those with any particular medical condition.
    - Although existing pregnancy is not a contraindication for emergency contraception in terms of risk of adverse effects, *emergency contraception is not indicated in women with confirmed pregnancy* because it will have no effect.

3. Providers who prescribe emergency contraception must be working within their scope of practice as specified in the state clinical practice acts.

4. Initial visit emergency contraception request service process must include signed Universal Consent.

   Clients who present to the clinic for emergency contraception as an initial visit must also be counseled about STD/HIV risks. Clients who have been assessed to be at risk for STD/HIV, screening is offered.

5. Progestin-only pills and combination pills may be used if the woman has used it before, even within the same menstrual cycle. Ulipristal should be taken only once during a menstrual cycle.

6. Method counseling will include instruction that:

   Progestin-only pills:
   - The 1.5mg levonorgestrel-only regimen can be taken as a single dose.
   - Levonorgestrel-only EC is less effective for women with a BMI ≥ 26.
   - Because the incidence of nausea and vomiting is low with the levonergestrel-only regimen, prophylactic antiemetics are not necessary, but that the dose of emergency contraception should be repeated if vomiting does occur within two hours of taking a dose.

- There is pregnancy risk later in the same menstrual cycle with subsequent coital acts, and effective contraceptive methods for immediate and long term use should be used post emergency contraception (i.e. emergency contraception should not be used as long-term contraception).
  - All women should begin using barrier contraception to prevent pregnancy (e.g. condoms, diaphragm, or spermicides) immediately after taking emergency contraception for the next 7 days or not have sexual intercourse during that time.
  - Short term hormonal contraceptives (e.g. pills, patches and rings) may be started either immediately (with a backup barrier method) or after the next menstrual period.
  - Long term hormonal methods should be started after the next menstrual period when it is clear that the client is not pregnant.

Ulipristal pills:

- Requires prescription written by the provider.
- A single dose of ella (30 mg Ulipristal pill).
- Most effective method of oral emergency contraceptive for clients within BMI of ≥ 26.
- Advise the client that using ella and hormonal contraceptives together can affect the effectiveness of each, therefore a non-hormonal method (condom) should be used until the next menstrual period starts.
  - The client needs to wait 5 days to resume using their hormonal birth control method (pill, patch, ring, implant, shot or hormonal IUD).
  - A barrier method (condom, diaphragm, and spermicide) must also be used or not have sexual intercourse until the next period.
  - Ella should not be used if the client is breastfeeding because ella enters the breast milk.

The Copper IUD

- Insertion of a Copper IUD is the most effective method of EC.
- The Copper IUD is appropriate for use as EC in women who meet standard criteria for an IUD and who desire long-acting contraception.
- The efficacy of the Copper IUD for contraception is not affected by BMI.

BMI / EC effectiveness:

- Clinical trials have shown that any EC pill loses its effectiveness in women with a BMI > 30.
- However, oral emergency contraception should not be withheld from women who are overweight or obese because no research to date has been powered adequately to evaluate a threshold weight at which it would be ineffective.

7. No scheduled follow up is required after use of emergency contraception, however, clinical evaluation is indicated for women who have used emergency contraception if:
   - Menses are delayed by a week or more after the expected time, or
   - Lower abdominal pain develops, or
   - Persistent irregular bleeding develops

Procedure

1. Obtain client's BMI for FP enrolled clients and for initial visit EC clients**.**

2. Include information on emergency contraception (ECs) – indications, availability, and use –when counseling enrolled clients about birth control methods.

3. For initial visit EC requests, obtain client universal consent and obtain client history information; prescribe or provide the method per eligibility determination with method counsel as outlined in standards (#5); counsel about STD/HIV risks; provide condoms for immediate post ECP method use/STD protection. Provide and review instructions for emergency contraceptive use according to manufacturer's guidelines.

4. Review client's RLP and discuss client's current contraceptive method and/or their desire to change contraceptive method. Provide contraceptive method as appropriate and reschedule follow up appointment as indicated. Provide counseling/education on client's chosen contraceptive method; effectiveness, contraindications, risks, and side effects. Document and verify client's understanding.

5. For enrolled clients with ECP request at any visit, provide/prescribe ECPs to those who request it at any time according to manufacturer's guidelines prior to or up to 72 to 120 hours (3-5 days) after unprotected or inadequately protected sexual intercourse, provide counseling regarding use, side effects, resuming contraceptive method of choice, and reasons for follow up evaluation after ECP use if indicated, verify and document client understanding.

6. Offer STD/HIV screening/testing for clients who have been assessed at risk for STD/HIV.

7. For initial visit emergency contraception clients and enrolled clients; provide counseling/education information for the emergency contraception, verify and document client understanding.

Resources

- ACOG FAQ #114
- Contraceptive Technology (Hatcher et al…) 21st Edition
- ACOG Practice Bulletin, Number 152, September 2015, Emergency Contraception
- Program Requirements for Title X Family Planning, OPA, April 2014
- Providing Quality Family Planning Services (Recommendations of CDC and the U.S. Office of Population Affairs). April 25, 2014

Document History

- Revised December 2019
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