Emergency contraception

This statement has been developed and reviewed by the Women’s Health Committee and approved by the RANZCOG Board and Council.

A list of Women’s Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

Objective: To provide advice on emergency contraception.

Target audience: Health professionals providing gynaecological care, and patients.

Values: The evidence was reviewed by the Women’s Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women’s Health Committee in 1995 and most recently reviewed in July 2016.

Funding: The development and review of this statement was funded by RANZCOG.

First endorsed by RANZCOG: 1995
Current: July 2016
Review due: July 2019
1. Patient Summary

Emergency contraception (EC) can be used by a woman after unprotected sexual intercourse to prevent pregnancy. It can take different forms including tablet or pill (sometimes called the morning after pill or emergency pill) or the form of an intrauterine device (IUD). Prompt and easy access to emergency contraception is crucial for women, and there are a number of safe and effective options available in Australia and New Zealand. In addition, women accessing emergency contraception should be provided with advice that preserves confidentiality, privacy and dignity. Other important aspects of emergency contraception care include advice regarding ongoing contraception needs, assessment of risk for sexually transmitted infections, and what to do if the contraception does not work and pregnancy occurs.

2. Types of emergency contraception

The following methods are currently available for emergency contraception:

- Emergency contraceptive pills (ECPs): progestogen-only, combined oestrogen/progestogen pills and ulipristal acetate.
- Copper-releasing IUDs.

3. Emergency contraception pills

- Ulipristal acetate 30mg, a selective progesterone receptor modulator, is the most effective of the oral ECPs with data from a meta-analysis demonstrating greater efficacy compared to levonorgestrel especially if taken within the first 24 hours after UPSI. In addition, it is effective within 5 days (120 hours) of UPSI compared to 3 days (72 hours) for levonorgestrel whilst the adverse event profile is similar for both medications.\(^1\)\(^2\)
- Of the other hormonal ECPs, the levonorgestrel-only regimen is better tolerated and more effective (will prevent 85% of pregnancies) compared to the combined pill regimen - Yuzpe method which will prevent 75% of pregnancies.\(^3\)
- A single dose of levonorgestrel (1.5mg) is licensed for use up to 72 hours but has proven efficacy up to 4 days (96 hours). Liver enzyme inducing drugs reduce the efficacy of both UPA and LNG. The FSRH recommends that women on these medications should be advised that the Copper IUD is the only method of EC not affected. If this is not possible, or is declined, expert opinion recommends doubling of the dose of LNG (3mg).\(^4\)
- There is some evidence that the sooner emergency contraception pills are taken after sexual intercourse, the more likely they are to be effective.\(^4\)\(^3\)

The mechanism of action of both levonorgestrel and ulipristal acetate emergency contraception is inhibition or delay of ovulation.\(^4\)\(^5\)

The risk of oral levonorgestrel EC failure has been found to be greater in obese women compared to women of normal BMI. Use of ulipristal acetate (less significant reduction in efficacy compared to levonorgestrel) or a copper intrauterine device is a more effective EC option in these women.\(^6\)
4. Copper releasing IUDs

- Copper IUDs are highly effective as emergency contraception with a less than 1% failure rate and may be indicated if more than 72 hours have elapsed since unprotected sexual intercourse (UPSI) and/or the client is considering using an IUD for long-term contraception.\(^3\)
- Copper IUDs can be inserted for EC within 5 days of unprotected intercourse, or if the date of ovulation can be estimated, up to 5 days after ovulation, in women for whom they are suitable.
- Screening for STIs is indicated in women considered at higher risk of STIs (<25 years of age, recent change in sexual partner or more than one partner in last 12 months) but should not prevent use of an IUD for EC.\(^7\)

There is no evidence to support the use of the Mirena® levonorgestrel-releasing Intrauterine Contraceptive Device as emergency contraception and it is not approved for this indication.

5. Other options

- The antiprogestogen Mifepristone, previously known as RU486, is a very effective emergency contraceptive agent that in mid-range doses (25-50mg) is more effective and better tolerated than the levonorgestrel EC. It can be used up to 120 hours after unprotected sex but may delay the onset of the next menses.\(^7\) It is not available in Australia or New Zealand for this indication.
- Ulipristal acetate is currently not available in New Zealand.\(^2\)

6. Indications

RANZCOG considers that prompt and easy access to emergency contraception is crucial and that the provision of emergency contraception should be accompanied by:

- Advice on dosage and administration of the EC in a setting that preserves the patient’s confidentiality, privacy and dignity.
- The provision of advice and information about ongoing contraception, as required.
- The provision of information about, and access to, testing for sexually transmitted infections, as required. Arrangements for medical review to exclude ongoing pregnancy if the period is delayed following EC use.
- The provision of advice about what a woman should do if the emergency contraceptive is not successful and pregnancy occurs.

If the above requirements are met, emergency contraception can be promptly and safely supplied by suitably trained health professionals including pharmacists, as supported by the Faculty of Sexual and Reproductive Health Care Clinical Effectiveness Unit (FSRH).\(^4\)
7. References


8. Other suggested reading


9. Links to other College statements

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

10. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via: https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets
Appendices

Appendix A Women’s Health Committee Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position on Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Stephen Robson</td>
<td>Chair and Board Member</td>
</tr>
<tr>
<td>Dr James Harvey</td>
<td>Deputy Chair and Councillor</td>
</tr>
<tr>
<td>Associate Professor Anusch Yazdani</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Associate Professor Ian Pettigrew</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Dr Ian Page</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Professor Yee Leung</td>
<td>Member of EAC Committee</td>
</tr>
<tr>
<td>Professor Sue Walker</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Lisa Hui</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Joseph Sgroi</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Marilyn Clarke</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Donald Clark</td>
<td>General Member</td>
</tr>
<tr>
<td>Associate Professor Janet Vaughan</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Benjamin Bopp</td>
<td>General Member</td>
</tr>
<tr>
<td>Associate Professor Kirsten Black</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Jacqueline Boyle</td>
<td>Chair of the ATSIWHC</td>
</tr>
<tr>
<td>Dr Martin Byrne</td>
<td>GPOAC representative</td>
</tr>
<tr>
<td>Ms Catherine Whitby</td>
<td>Community representative</td>
</tr>
<tr>
<td>Ms Sherryn Elworthy</td>
<td>Midwifery representative</td>
</tr>
<tr>
<td>Dr Michelle Proud</td>
<td>Trainee representative</td>
</tr>
</tbody>
</table>

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in 1995 and was most recently reviewed in July 2016. The Women’s Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.

- Structured clinical questions were developed and agreed upon.

- An updated literature search to answer the clinical questions was undertaken.

- At the July 2015 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women’s Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women’s Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.
Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

**iii. Grading of recommendations**

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

<table>
<thead>
<tr>
<th>Recommendation category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Body of evidence can be trusted to guide practice</td>
</tr>
<tr>
<td>B</td>
<td>Body of evidence can be trusted to guide practice in most situations</td>
</tr>
<tr>
<td>C</td>
<td>Body of evidence provides some support for recommendation(s) but care should be taken in its application</td>
</tr>
<tr>
<td>D</td>
<td>The body of evidence is weak and the recommendation must be applied with caution</td>
</tr>
<tr>
<td>Consensus-based</td>
<td>Recommendation based on clinical opinion and expertise as insufficient evidence available</td>
</tr>
<tr>
<td>Good Practice Note</td>
<td>Practical advice and information based on clinical opinion and expertise</td>
</tr>
</tbody>
</table>
Appendix C Full Disclaimer
This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.