Emergency Contraception: The International Planned Parenthood Federation’s Experience

By Pramilla Senanayake

The first contraceptive revolution took place in the early 1960s with the introduction of the pill. During the ensuing three decades, oral contraceptives, IUDs, injectables, barrier methods, and improved forms of surgical contraception became widely available and acceptable. As a result, contraceptive prevalence worldwide rose from 10% in the 1960s to around 50% in the mid-1980s. Despite this dramatic escalation in contraceptive use, an estimated 500 million women throughout the world have an unmet need for contraception. These include not only women who do not have access to effective methods, but also those who are not satisfied with the method they are using and those who discontinue use even though they want no more children. According to data from the Demographic and Health Surveys in a variety of countries, among the reasons women give for discontinuing contraceptive use are their dissatisfaction with the methods available or worries about side effects, their partners’ disapproval of the methods, inconvenience of use, difficulties in obtaining the methods and cost.

Furthermore, since even an effective, available and acceptable method can fail or be used incorrectly, a different kind of contraceptive might also provide backup for these situations. The International Planned Parenthood Federation (IPPF) has been promoting and offering guidance on such a method—emergency contraception—for more than 10 years.

Background
IPPF, established in 1952, is a global nongovernmental organization comprising 136 autonomous member family planning associations. The organization’s policies on emergency contraception, as on any subject, are determined by its governing body, the Central Council. Expert panels provide programmatic guidance to IPPF affiliates. One such group, the International Medical Advisory Panel (IMAP), was created in 1980 to advise the Council on medical matters. Guidance offered by IMAP is followed not only within IPPF, but also by many governments and by other family planning agencies. Once IMAP statements are adopted by the Central Council, they are disseminated directly to the affiliates, as well as through publication in several languages in the Medical Bulletin, an IPPF publication with a readership of about 40,000.

One of IMAP’s earliest subjects, addressed in 1981, was emergency contraception. The panel reviewed the available literature and concluded that IPPF should recommend that all affiliates provide the method. In 1982 and 1985, the panel updated its research, and the conclusion remained unchanged.

Since 1985, a substantial body of research on emergency contraception has become available, causing IMAP to assess once more its policy in this area. To add depth to the review, in 1994, IPPF conducted a survey of its affiliates, to study their practices with regard to the provision of emergency contraceptive services, as well as the reasons women seek these services. On the basis of the results, IPPF developed a revised, broadened policy statement on emergency contraception. In addition, the results yield some lessons for those seeking to expand access to emergency contraception.

Affiliates Survey
Questionnaires addressing service-related factors and characteristics of women who obtain emergency contraception were mailed to all 136 IPPF affiliates; 72 affiliates (53%), representing every region of the world, responded.

Service Provision
Overall, 43% of participating family planning associations reported providing emergency contraception (see Table 1, page 70), including at least one affiliate in each region (except the Arab world) and all responding European affiliates. Some began offering emergency contraception as early as 1965. More typically, provision started in the mid-1980s. One affiliate began to offer the service in late 1994.

IPPF affiliates offer a wide variety of products for emergency contraception. These include combined oral contraceptives (such as Neoprimovar, Nordette, Ovral, Steridil and Tetragynon), pure estrogen (ethinyl estradiol), progestin-only pills (Ovrette and Postinor) and the TCu 380A IUD.

Affiliates that do not provide emergency contraception offered various explanations. The reasons given tend to fall into five categories: Clients have expressed no need for the service; the service is not legally recognized or is illegal; emergency contraception may be viewed as tantamount to abortion, and providing it may link the family planning association to abortion, which is illegal in some countries; no official product for emergency contraception is available, and staff have had no training or can find no protocol to guide them; and the agency has never considered offering the service.

Respondents were asked to describe any promotional efforts their agency makes to inform women about emergency contraception. Although family planning associations that provide the method also typically advertise the service, there are exceptions. One-third of participating affiliates that offer the service are reluctant to advertise it. In some cases, since the promotion of emergency contraception is not explicitly authorized by law, the agency’s protocols and policy documents do not cover it. In others, the agency is not yet ready to advertise the service.
family planning associations that both offer and promote emergency contraception, each has a protocol for its provision.

**User Profile**

In all, the affiliates responding to the survey reported that they had provided emergency contraceptive services to about 40,000 women in 1993. The bulk of these women were in Australia, France, Hong Kong and New Zealand. They ranged in age from 14 to 45, but most were aged 15–30. According to the affiliates, women offered several kinds of reasons for needing emergency contraception. First, many women had had difficulties using their regular method. Condom users had experienced breakage or slippage of a condom. Pill users had not remembered to take the pill every day. While even imperfect use of the pill might offer some protection, women relying on rhythm or withdrawal had no protection if they used their method inconsistently or incorrectly. Second, affiliates reported that in several cases, women requiring emergency contraception had had no regular method. Some of these women had refused to accept the side effects inherent in the available methods; others had been unsure of where to obtain a method. Third, some women had simply not used a contraceptive before the act of intercourse that led them to seek treatment with emergency contraception. Finally, the affiliates reported, many women obtaining emergency contraception had been forced or coerced into having unplanned intercourse with an abusive partner.

**Conclusion**

The IPPF experience demonstrates several important points for expanding access to emergency contraception. First, despite the IPPF leadership’s strong endorsement of the method for more than a decade, many affiliates still do not offer it. Advocates for the method will need to understand the obstacles faced by these affiliates and providers in general.

Second, although provision of emergency contraception is not universal, at least one affiliate in every region except the Arab world offers it. This finding suggests that in principle, the method is suitable for both developed- and developing-country settings.

Third, the lack of an approved product designed and marketed specifically for emergency contraception hinders at least some family planning associations that are willing to offer the service. IPPF has resolved to include specifically marketed products on its commodities list. Furthermore, the organization will ensure that affiliates know that certain brands of oral contraceptives, hormone replacement therapies and IUDs are effective for emergencies as well as for their other indicated uses.

Fourth, the lack of a perceived need reported by several family planning associations may actually reflect ignorance about the therapy. If women are unaware of emergency contraception, they cannot request it. Providers should view women’s regular visits as an opportunity to educate them about emergency contraception, to ensure that they know about the method if the need for it arises. Better still, providers should make the therapy available to women before they need it.

Fifth, the information the affiliates provided on the characteristics of women seeking emergency contraception demonstrates that women may need this method at any age during their reproductive years, and for a variety of reasons. Promotional efforts should recognize that, for instance, advertising emergency contraception only for rape victims could do a disservice to women who need the medication because they forgot to use another method. Providers should offer emergency contraception to any woman who needs it, regardless of her reasons.

Sixth, whether or not the family planning association can currently offer emergency contraception, staff at all affiliates should be trained in providing the method and should be familiar with the protocols for its use. With such knowledge, they can be prepared to advocate for the introduction of the method and to implement its distribution if they are successful. Similarly, providers should develop the capacity to counsel patients about the method and to record patients’ reasons for needing it. Such steps might enable providers to sense latent demand for the method, and to prepare to fulfill that demand.

Finally, emergency contraception needs to be positioned as an option distinct from abortion. The difference between the two is difficult for many people to comprehend, and this confusion has been exploited by abortion opponents. Family planning organizations need to be clear that emergency contraception is a way to prevent the need for abortion.

**References**
