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EDITORIAL

Unplanned pregnancies are a major problem worldwide as many end up in being terminated through unsafe abortion, which is responsible for the deaths of some 80,000 women every year and causes lifelong debilitating illness for tens of thousands more. In the European region there are approximately nine million abortions every year, and 25% of maternal mortality is related to abortion complications. A recent WHO/HRP study confirms that an existing, well-tested compound can be used easily and safely to prevent a great number of such unplanned pregnancies. Preventive family planning and a reorientation of reproductive health services to include emergency contraception can reduce these unnecessary deaths.

The Women’s and Reproductive Health programme of WHO-Euro is committed to promoting all efforts to reduce the incidence of reproductive health related mortality. Including reliable and effective emergency contraception in reproductive health services is one means of obtaining these results.

Emergency contraception is a recognised method to prevent pregnancy after unprotected sexual intercourse or a contraceptive failure. Around the world emergency contraception is not only increasingly being offered by doctors to women in need, but is simultaneously being requested by women who have become aware of the method. However, although studies show emergency contraception to be safe and largely effective, the public’s lack of knowledge about emergency contraception, coupled with provider misconceptions, continue to be the major hindrances to its use. In this issue of Entre Nous we present the emergency contraception debate as well as detailed information on all aspects of emergency contraception. Emergency contraception has met with broad-based support from healthcare professionals, NGOs, pharmaceutical companies, governments and international agencies, because it prevents pregnancy and unwanted abortion.

As Anna Glasier writes in her article on page 6, "As all marketed hormonal emergency contraceptives must be taken within 72 h of intercourse, they cannot possibly induce abortion since implantation will not have taken place within this period of time and pregnancy is not therefore established".

One of the major current debates concerning emergency contraception is whether or not it should be available over the counter. Dr Charlotte Ellertson et al. conclude that indeed emergency contraception should be available to women without a prescription. In fact, numerous experts recommend that emergency contraceptive pills should be available to women prior to the need arising.

Thanks to the Consortium for Emergency Contraception it has been possible to compile an extensive resource list including web sites, contacts, books, videos and articles on emergency contraception from around the world.

Moreover, in response to reader requests Entre Nous will now feature a “News” section on the back page of each issue. Recent studies and reports on the magazine’s main theme will be found here. One landmark news item is that in a paper published in the 8 August issue of the Journal The Lancet, researchers working with the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) confirm that the use of levonorgestrel alone for emergency contraception is more effective and produces side-effects in considerably fewer users than the Yuzpe regimen - currently the most widely used method for such contraception.

An abridged version of Dr Paul F. A. Van Look’s article “Emergency contraception: a brighter future”, presented at the emergency contraception roundtable workshop at the FIGO conference held in Copenhagen in 1997, is found on pages 4-5. Here, Dr Van Look discusses worldwide barriers to the use of emergency contraception.

In addition to featuring emergency contraception, there is a three-page insert from the “Safe Motherhood” journal, a report by Beverley Chalmers from a meeting in Sweden on female genital mutilation and a statement from a WHO technical meeting on prevention of HIV transmission from mother to child.

Future topics in Entre Nous will include “ICPD + 5” (Winter 1998), STDs (Spring 1999) and Social deprivation and poverty and RH (Summer 1999). As always, contributions from our readers are welcome.

Entre Nous welcomes Dr Gro Harlem Brundtland, the former Prime Minister of Norway, as Director-General of the World Health Organization. Dr Brundtland took office on 21 July 1998. She was nominated by WHO’s Executive Board on 27 January and elected to the post on 13 May by the Member States of WHO. Her term of office is five years.

Dr Brundtland announced in May during her speech to the World Health Assembly, that she would change the course of things and make a difference. She emphasized (addressing all WHO staff on 21 July) that serving WHO is a privilege, and went on to say, “We can help build healthy communities and populations. We can combat ill-health. We can do our part to combat poverty and suffering. Nothing in life as I see it has more meaning”.

Dr Brundtland said that she will focus on four areas of concern: “WHO will help monitor, roll back and where possible eradicate communicable diseases; WHO will help fight and reduce the burden of noncommunicable diseases; WHO will help countries build sustainable health systems that can help reach equity targets and render quality services to all, with a particular emphasis on the situation of women and mothers who are so critical for giving children a safe and healthy start in life; WHO will speak out for health, back its case with solid evidence and thereby be a better advocate for health towards a broader audience of decision-makers.”

Dr Gro Harlem Brundtland, the first woman to become Director-General of WHO, concluded her speech by saying: “My motivation will be this: Making a difference, being able to make an effort, being one of many dedicated people working together for what we believe in. I envisage a world where solidarity binds the fortunate with those less favoured. Where our collective efforts will help roll back all the diseases of the poor. Where our collective efforts ensure universal access to compassionate and competent health care. Bringing the world one step closer to that goal is our call for action.”
EMERGENCY CONTRACEPTION

a brighter future?

Introduction

For centuries women have adopted measures, or used devices or preparations, in their attempts to prevent pregnancy after intercourse has taken place. Violent physical exercise to try dislodging the ejaculated semen from the genital tract; potions, seeds or herbs taken orally or placed in the vagina; and postcoital douching are all known to have been used, some of them as long ago as 1500 BC.

The origin of today's hormonal methods of emergency contraception can be traced back to the mid-1920s when it was demonstrated for the first time that ovarian extracts with estrogenic activity had an antifertility effect in several species of lower mammals. This finding led to the veterinary use of estrogen for pregnancy prevention, but it was only in the 1960s that the first human trials of postcoitally administered high-dose estrogen were undertaken. The combined estrogen-progestogen regimen, often referred to as the Yuzpe regimen after its inventor, the Canadian gynecologist, Albert Yuzpe, was introduced in the early 1970s and has now largely replaced the high-dose estrogen approach, while postcoital insertion of an intrauterine device (IUD) for emergency contraception was first reported in 1976.

There is no doubt that greater use of emergency contraception could prevent a substantial proportion of the tens of millions of unplanned pregnancies which occur every year. Meta-analysis of trials conducted on the effectiveness of the Yuzpe regimen indicates that this method prevents, on average, about three-quarters of the unplanned pregnancies that would occur if no treatment is given. In the case of postcoital insertion of an IUD, effectiveness is even greater, in the order of 99% or more.

In spite of its proven efficacy and the fact that it employs contraceptive technologies that have been available for more than 30 years, emergency contraception has remained very much in the shadows of reproductive health-care, its use in most countries restricted to rape victims and university health centres. This abridged paper reviews some of the major barriers that exist in countries around the world to full utilisation of this important method of contraception. In the full-length version of the article published in New Insights in Gynecology and Obstetrics: Research and Practice; The Proceedings of the FIGO World Congress on Gynecology and Obstetrics, some encouraging developments that have taken place during the past two years are discussed, giving hope that emergency contraception may be poised to emerge from the relative obscurity it has suffered over the past 30 years. In the preparation of this review, use has been made of several of the present author’s recent reviews on the topic of emergency contraception. These are also available in the aforementioned publication.

Worldwide barriers to use of emergency contraception

In virtually every country, major barriers will exist to widespread use of emergency contraception. Reasons underlying this unfortunate state of affairs can be grouped into four main categories.

Product-related reasons

All methods currently available for emergency use have limitations. That they can only be administered within a few days after intercourse (3 days for hormonal methods; 5 days for postcoital IUD insertion) restricts their usefulness and disqualifies for treatment women who cannot meet these deadlines. Moreover, the methods, and the hormonal regimens in particular, may cause unpleasant side-effects such as nausea, vomiting, headaches, dizziness and breast tenderness. These side-effects can limit compliance and, in the case of vomiting, may affect the methods' efficacy.

Emergency methods are generally not as effective as other contraceptive methods.

As stated above, even when the Yuzpe regimen is administered within the recommended 72 h, it fails to prevent one-quarter of the pregnancies that would be expected without the therapy. Also, although insertion of an IUD after unprotected intercourse is more effective and can be initiated later than the hormonal regimens, its usefulness is limited because of the risk of infection, especially in victims of sexual assault or following intercourse with a new partner. Insertion of an IUD is also not usually recommended for nulliparous women, and such women constitute a sizable proportion of those requesting emergency contraception.

In addition to the drawbacks of the existing methods, their variety is very limited; a woman seeking emergency contraception has few choices at her disposal. Thus, there is a clear need for new and improved methods, particularly methods that can be easily administered and would be appropriate for over-the-counter provision.

A second product-related reason that is affecting the wider use of emergency contraception is the absence, in most countries of the world, of a dedicated preparation specifically marketed for emergency contraceptive use. Until September 1996 only one pharmaceutical company (Schering AG) had a propriory preparation of the estrogen-progestogen combination (Yuzpe regimen) for emergency contraceptive use and this product was registered in very few countries (UK, New Zealand, Germany, Switzerland, Norway, Finland, Sweden and South Africa). This preparation is relatively expensive and only four tablets are supplied. For these reasons, many doctors in these countries are making up their own supplies using packets of an appropriate oral contraceptive-pill preparation that contains the same hormones, i.e. ethinylestradiol and levonorgestrel (or dl-norgestrel) (Table 1). This is considerably cheaper and extra pills can be given should vomiting occur. In

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Table 1. Examples of formulations and doses required for Yuzpe regimen of emergency contraception

<table>
<thead>
<tr>
<th>Formulation</th>
<th>Common brand name</th>
<th>Tablets per dose</th>
<th>Doses required</th>
<th>Timing of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE 50 µg + LNG 250 µg</td>
<td>Duoluton, Eugynon 250, Monovar, Neogynon, Noral, Ovicon, Ovran, Stediril-d</td>
<td>2</td>
<td>2</td>
<td>First dose within 72 h of unprotected sex. Second dose 12 h later</td>
</tr>
<tr>
<td>EE 50 µg + NG 500 µg</td>
<td>Eugynon, Eugynon-50, Ovral, Primovlar, Stediril</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>EE 30 µg + LNG 150 µg</td>
<td>Levlen, Microgynon, Nordette, Ovranet, Rigevidon</td>
<td>4</td>
<td>2</td>
<td>First dose within 72 h of unprotected sex. Second dose 12 h later</td>
</tr>
<tr>
<td>EE 30 µg + NG 300 µg</td>
<td>Lo-Femenal, Lo-Ovral</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

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September 1996, the Hungarian pharmaceutical company, Gedeon Richter, acquired a license to market its Yuzpe-type preparation in Hungary. According to company sources applications for registration in other countries are planned.

In countries where a dedicated Yuzpe-type product is not available, use of tablets from an appropriate oral contraceptive-pill preparation is the only available option and this approach is certainly followed in several countries. However, since the practice involves the use of oral contraceptive pills for a non-approved indication, practitioners are reluctant to employ pills for this purpose, thus hampering wider availability and use.

**Client-related reasons**

Knowledge of emergency contraception among women takes a long time to disseminate, even in countries where a dedicated product is on the market. For example, in the UK, where the Schering product has been registered since 1984, a survey of a general practice-based population 10 years later, in 1994, showed that 21% of 878 women aged 16-50 years had not heard of emergency contraception and only 15% knew the correct time limit for using it. The main reason underlying this ignorance is, of course, the failure of family planning services and providers of the education system to give information about emergency contraceptives to potential users, particularly those at risk of unprotected intercourse and unplanned pregnancy such as adolescents, women not using contraception, users of a barrier method and those requesting pregnancy termination.

The impact of well-designed and intensive information, education and communication campaigns cannot be underestimated. For instance, in the UK, significant efforts have been made in the past two years to make emergency contraception better known in an attempt to lower the rates of unplanned pregnancy and abortion among teenagers. These efforts appear to have paid off as illustrated by recent findings from Scotland. Using a confidential questionnaire survey of fourth-year pupils, aged 14-16 years, in 20 secondary schools and around Edinburgh, it was found that 93% of the pupils had heard of emergency contraception. A total of 194 girls (33%) and 168 boys (28%) had experienced sexual intercourse and, nearly one-third (31%) of these 194 girls had used emergency contraception. Asked where they had learnt about emergency contraception, pupils gave school (437 pupils; 39%) and magazines (425 pupils; 38%) as the most common sources (Table 2). Similarly, in a postal survey of a stratified random sample of 2000 Grampian women aged 18-47 years, 94% of respondents were aware of emergency contraception although far fewer (39%) know the correct timing for its use.

These figures were generally higher among younger, single women. The popular media represented the most common source of information, whereas general practitioners and family-planning clinics were cited rarely.

Failure to use emergency contraception is not always a matter of ignorance, however. In a recent study, also from the UK, among 167 teenagers (aged 13-19 years) requesting pregnancy termination (n = 95; 57%) or having their first antenatal visit (n = 72; 43%), 135 girls (81%) had heard of emergency contraception but 119 did not obtain it. In just over two-thirds of these 19 teenagers, the girl was aware that she was at risk of pregnancy but "took a chance" rather than obtain emergency contraception. Clearly, counseling about the risk of unplanned pregnancy following unprotected intercourse must be given greater emphasis in sex education, family-planning counseling, etc.

**Provider-related reasons**

The role that service providers and other types of health-care personnel play in ensuring availability and use of emergency contraception cannot be underestimated, but few data have been reported in the literature on knowledge, attitudes and practices (KAP) of these professional groups in respect of this method of contraception. In a recently published KAP study from Australia less than one-third of general practitioners included information about emergency contraception in routine contraceptive counseling. In addition, the survey results suggested that some doctors never provided information or prescribed emergency contraception, probably because of moral or religious objections.

**Service-related reasons**

Data from a survey conducted by the International Planned Parenthood Federation among its affiliate members indicate that several family-planning programs do not provide emergency contraception because of the mistaken belief that its mode of action is an abortifacient one. Where such misconception does not exist and emergency contraception is available, a number of service-related factors frequently hamper accessibility and wider use.

Hormonal emergency contraception must be started within 72 hours of intercourse and, in the few countries where a dedicated product is licensed, it can only be prescribed by a doctor. The greatest need for emergency contraception is often at weekends, when clinics and doctors' offices are closed, and on Monday mornings, when they are at their busiest. Many people, particularly the young, often find it difficult to obtain emergency contraception from their family doctor and not all hospital accident and emergency departments will supply it. For people living at a distance from a doctor or clinic where emergency contraception can be obtained, accessibility is an even greater problem. For these reasons, and in view of the potential of emergency contraception for reducing unwanted pregnancies, the possibility of making it available over the counter from pharmacists has been discussed in the UK, New Zealand and Norway. Another approach, taken in China, is to give barrier-method users emergency contraceptive pills prophylactically, for back-up use in case of mishap with the barrier method.

The full text of this article with references is available in New Insights in Gynecology and Obstetrics: Research and Practice; The Proceedings of the FIGO World Congress on Gynecology and Obstetrics, Copenhagen, August 1997, published by Parthenon Publishing.

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**Table 2. Sources of knowledge about emergency contraception**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage of pupils*</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>39.0</td>
</tr>
<tr>
<td>Magazines</td>
<td>37.9</td>
</tr>
<tr>
<td>Friend</td>
<td>22.6</td>
</tr>
<tr>
<td>Family member</td>
<td>17.8</td>
</tr>
<tr>
<td>Leaflet or poster</td>
<td>16.6</td>
</tr>
<tr>
<td>General practitioner, family planning clinics, etc.</td>
<td>9.2</td>
</tr>
<tr>
<td>TV and radio</td>
<td>4.6</td>
</tr>
<tr>
<td>Cannot recall</td>
<td>21.8</td>
</tr>
</tbody>
</table>

*Since more than one source could be recorded, percentages add up to more than 100%
EMERGENCY CONTRACEPTION: the users and the services

Introduction
Emergency contraception is for use by women who are at risk of pregnancy usually as a result of either unprotected intercourse or the failure of a barrier method, e.g. burst condom. While condom failures are not always recognised, in a recent study of condom breakage and slippage, between 4 and 7% of couples in the USA experienced a recognised condom failure over a study period of up to 3 months. In all such cases, emergency contraception might prevent pregnancy.

It is not usually appropriate to prescribe emergency contraception for missed oral contraceptive pills since effective rules involving secondary use of a barrier method make physiological sense and are easy to follow.

The users
In the UK, women seeking emergency method contraception are often young and nulliparous. The characteristics of users in other countries have not been described.

Knowledge among providers and potential users
Emergency contraception is not universally available. In countries where a marketed product has existed for some considerable time, such as the UK and the Netherlands, most doctors and nurses (the usual providers) and probably the majority of potential users know of the existence of emergency contraception. Even in these countries, knowledge of the practical details (among both providers and users) is often surprisingly poor. A survey of mainly 14- and 15-year-old schoolchildren undertaken in Scotland in 1996 demonstrated that, while over 90% of the teenagers had heard of emergency contraception, less than one-half of them knew the correct time limits. In a random sample of 2,000 women aged between 18 and 47 and living in the north of Scotland, only 39% of women knew the correct timing for emergency contraception use. Among professionals, a small survey of general practitioners (family doctors) in London (A. Graham, unpublished data) revealed gaps in their knowledge and prejudices about how often it was safe to use the combined estrogen-progestogen regimen (Yuzpe, Tetragynon®) of emergency contraception. In countries where no marketed product exists (such as the USA) or where licensing of emergency contraception has only recently been discussed (such as South Africa), ignorance abounds among both the public and professionals. In such countries, service providers are often reluctant to provide emergency contraception because they confuse the method with abortion. As all marketed hormonal emergency contraceptives must be taken within 72 h of intercourse, they cannot possibly induce abortion since implantation will not have taken place within this period of time and pregnancy is not therefore established.

Myths and misunderstandings about the safety of emergency contraception are also common. Scottish teenagers not uncommonly believe that repeated use can cause infertility. In their as yet unpublished survey of general practitioners, Graham and colleagues reported that 4% of doctors thought of the Yuzpe regimen as a "harmful drug" while a further 10% appeared to have reservations about safety aspects. These concerns about safety together with a not uncommon tendency to moralising about emergency contraceptive use leads to frequent refusals to prescribe hormonal emergency contraception more than once, certainly in the same cycle and quite often in the same year. Misconceptions among providers only add to those of potential users, so that it is not only lack of knowledge of the methods among the general public which limits the use of emergency contraception.

It is interesting to note that almost one-half of the women surveyed in the north of Scotland thought that emergency contraception should not be made available over the counter. The most common reason for disapproval was the fear that emergency contraception would become too easy to use or would be used inappropriately. Almost 20% of respondents felt that the move would encourage casual or unsafe sex. Moralisining on the issue is not only limited to providers!

Provision of services
In the UK, as in many other countries, emergency contraception must be prescribed by a doctor. For this reason it is only widely and reliably available from general practitioners and community family planning clinics. Recently, attempts have been made to improve provision, and many genitourinary medicine clinics now provide emergency contraception. It is still not available from all hospital accident and emergency departments, but in many hospitals arrangements for provision through gynaecological wards are in place. In reality, hormonal emergency contraception is not available 24 h per day in most places, but then it does not need to be because potential users have 72 h to act.

The recently established Consortium for Emergency Contraception, which is committed to making emergency contraception a standard part of reproductive health-care worldwide, has produced a resource packet for health-care providers and programme managers which gives advice about possible service delivery systems. For widespread use of emergency contraception to be possible, supplies must be available from a source which is accessible in terms of geography and time of day and in a manner which is regarded by potential users as approachable.

There has recently been widespread discussion about making hormonal emergency contraception available over the counter. The marketed product equivalent to the Yuzpe regimen (PC4) has been licensed in the UK since 1984 and prescribed to well over 4 million women. Recognising its potential role in preventing unwanted pregnancy, the Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners and Royal Pharmaceutical Society all approved the over-the-counter availability in 1995, but the manufacturers are reluctant to seek the appropriate change in the product license. This is perhaps not surprising in view of an increasing tendency of the public in the UK to sue pharmaceutical companies.

Conclusion
In summary, anyone who has had unprotected intercourse or an accident with a barrier method, and yet who wishes to avoid pregnancy, is eligible to use emergency contraception. Widespread use is limited by lack of knowledge and misinformation among both potential users and providers. Widespread use is only possible if methods of emergency contraception are available and genuinely accessible from an approachable source of provision.

The full text of this article with references is available in New Insights in Gynecology and Obstetrics: Research and Practice: The Proceedings of the FIGO World Congress on Gynecology and Obstetrics, Copenhagen, August 1997, Parthenon Publishing.

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The Consortium for Emergency Contraception is an international collaboration among eight organisations committed to making a dedicated product for emergency contraception a standard part of reproductive health care around the world. Member organisations are: The Concept Foundation (Bangkok); International Planned Parenthood Federation (London); Pacific Institute for Women’s Health (Los Angeles); Pathfinder International (Boston); Population Council (New York); Population Services International (Washington, DC); Program for Appropriate Technology in Health (PATH); and UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (Geneva). The Consortium will fulfill its original mandate by mid-1999. At that time, given the enthusiastic response to emergency contraception around the world, an increase in the number of organisations engaged in introducing this method, the Consortium will welcome new members interested in working together to ensure a coordinated introduction of emergency contraception worldwide.

Questions and Answers for Decision-Makers

What is emergency contraception?
The term emergency contraception covers a number of methods used by women within a few hours or a few days following unprotected intercourse to prevent pregnancy. Most of these methods have been known to the medical community for many years and involve the use of standard contraceptive products.

Does emergency contraception cause an early abortion?
Medical science considers that a pregnancy has begun once implantation of a fertilized egg in the lining of a woman’s uterus is complete. The process of implantation begins about five days after fertilization and is completed about one week later, around the time of the expected menses. Emergency contraceptives are ineffective once implantation has begun; they cannot cause an abortion if the woman is already pregnant.

What happens in cases of failure if a fetus is carried to term?
Over the years, many women have accidentally taken birth control pills (including older, high-dose pills) after they were already pregnant. Studies show no increased risk of birth defects or other problems when the pregnancies were carried to term. Thus, there is no reason to suspect that one time emergency use of the pills would be associated with birth defects if the pills fail to prevent pregnancy or if they are taken after a woman is already pregnant.

What is the need for emergency contraception? Who uses the method now?
All current methods of contraception sometimes fail. Emergency contraception is an important backup when routine contraception fails to work properly, as when a condom breaks or a diaphragm or IUD becomes dislodged.

Worldwide, one of the most critical uses for emergency contraception has been in cases of sexual assault. Rape crisis centres routinely provide emergency contraception, even in countries where the method is not generally in use.

Could emergency contraception reduce the number of abortions?
By preventing unintended pregnancies, emergency contraception can reduce the need for abortion. In the Netherlands, which has the lowest abortion rate of any industrialised country, contraceptive use is high among young people and emergency contraception has been widely available as a backup for decades. In Finland, early evidence suggests that abortion rates among teenagers have dropped following the spread of information about emergency contraception.

In many developing countries, where abortion remains illegal, unsafe abortions are a leading cause of death among women of reproductive age. Abortions are also a major drain on scarce medical resources. In these settings, the availability of emergency contraception could prevent much needless death and suffering. It could also reduce the growing pressure on hospital beds, nursing staff, blood supplies, and medications needed to treat the life threatening medical complications of abortions performed by untrained practitioners under unsanitary conditions.

Will access to emergency contraception encourage promiscuity and sexual irresponsibility among young people?
There is no evidence to suggest that knowledge of emergency contraception increases sexual activity among young people. What is clear is that the need for emergency contraception often brings sexually active young people into family planning clinics, where they can receive other services and counselling, including help in learning how to say “no” when they choose to be abstinent. For adolescents who are already sexually active, emergency contraception provides a bridge to effective birth control and disease prevention.

Will women stop using other forms of contraception if emergency contraception becomes too easily available?
Emergency contraceptives can have unpleasant side effects, including nausea and sometimes vomiting. A few women also experience headaches, breast tenderness, or fluid retention. These side effects, although not serious from a medical standpoint, do discourage reliance on emergency contraception for routine birth control. Emergency contraception is less effective in preventing pregnancy and more expensive than most forms of regular contraception, two additional disincentives against routine use of the method.

Technical Assistance for EC Programs

The Consortium maintains a database of individuals and organisations with expertise in emergency contraception programming. They are available to provide technical assistance in a variety of areas related to EC, including:

- Introducing emergency contraceptive pills;
- Quality assurance;
- Service delivery;
- Training and educational materials development;
- Public awareness and community mobilisation;
- Social marketing; and
- Evaluation.
Emergency Contraceptive Pills: What You Need To Know

What is Emergency Contraception?
Emergency contraception is a way of preventing pregnancy if you have had sex without using contraception or if you had a contraceptive accident (such as a broken condom).

The most common method is Emergency Contraceptive Pills (ECPs). In some cases, a copper intrauterine device (IUD) also can be used as emergency contraception. All emergency contraceptive methods must be used within several days of unprotected sex. They are effective and safe for most women. Your health care service provider can help you choose the method that is best for you.

What are Emergency Contraceptive Pills (ECPs)?
ECPs contain the same hormones used in some birth control pills, but ECPs are used differently.

How do ECPs work?
Depending on when you use ECPs during your monthly cycle, the pills will either stop the release of an egg, prevent fertilisation of an egg, or stop a fertilised egg from becoming attached in your uterus. Pregnancy occurs only after the egg has become attached in your uterus. Once this has happened, ECPs are no longer effective.

When can I use ECPs?
The first ECP dose must be taken within 72 hours (3 days) after unprotected sex. A second dose is taken 12 hours after the first dose.

How effective are ECPs?
ECPs prevent most pregnancies but they are not 100 percent effective. The treatment fails in approximately 2 percent of women using ECPs correctly. If a woman uses ECPs frequently, her chance of becoming pregnant is much higher than if she uses regular contraceptives. This is why ECPs are not a substitute for regular contraceptives.

Are ECPs safe?
Most women can use ECPs safely. Health care providers have safely prescribed ECPs since the mid-1970s. Talk to your health care provider about ECPs to learn whether there is any reason you cannot use them.

Do ECPs cause side-effects?
ECPs often cause temporary side-effects such as nausea and vomiting. Sometimes they can cause headaches, dizziness, cramping, or breast tenderness. These side-effects generally do not last more than 24 hours.

What should I do after using ECPs?
You will not see any immediate signs showing whether or not the ECPs worked. Your menstrual period should come on time (or a few days early or late). If your period is more than a week later than expected or if you have any cause for concern, see your health care provider.

If the ECPs do not work, and I become pregnant, will the pregnancy be normal? Based on available information, there is no reason to believe that the pregnancy would be abnormal or the baby hurt in any way.

Important: If you have unprotected sex after using ECPs, they will not protect you. Use a regular contraceptive method to prevent pregnancy in the future.

For Emergency Use Only
Emergency Contraceptives should not be used routinely to prevent pregnancy. Regular contraceptives (condoms, pills, injectables, IUDs, sterilisation, etc.) are more effective and have fewer side-effects. If you want more information about regular contraceptives or if you are having trouble using a method, ask your health care provider for help choosing a method that works for you.

How do I use ECPs?
- Take 2 tablets with milk or water as soon as possible after unprotected sex. Make sure to take the first dose at a time when it will be convenient to take the second dose 12 hours later. Take the tablets after eating a meal or snack. This may reduce nausea.
- Important: If more than 72 hours (3 days) have passed since you had unprotected sex, do not start using ECPs. See your health care provider as soon as possible to discuss other options.
- Take the remaining 2 tablets with milk or water 12 hours after taking the first 2 tablets. Take the tablets after eating if you can.
- If you vomit within 2 hours of taking a dose, take another 2 tablets as soon as possible. If the vomiting occurred after the first dose, you will still need to take the second dose 12 hours later. (You provider can give you extra pills.) To reduce the nausea, take the tablets after eating.
- If you vomit more than 2 hours after taking the pills, do not worry. The medication is already in your system.

Emergency Contraception and Sexually Transmitted Disease (STD)
ECPs do not protect against AIDS and other sexually transmitted diseases (STDs or VD) like syphilis, gonorrhea, chlamydia, and herpes. If you are worried about whether you may have been infected with AIDS or other sexually transmitted diseases, talk to your health care provider about your concerns and ask how you can protect yourself in the future.

Other Emergency Contraceptive Methods
Several other methods of emergency contraception may be available from your health care provider. Your provider can advise you about which method is best for you.

Copper T IUD
A copper T IUD can be inserted by a trained health care provider within 5 days of unprotected sex to prevent pregnancy. This method is very effective: the treatment fails in less than one percent of women. Because an “emergency” IUD can be used for many years as a regular contraceptive, it may be an option for women seeking emergency contraception who want long-lasting contraceptive protection. The IUD is not appropriate for all women, however, particularly those who have reproductive tract infections or who may be at risk of sexually transmitted diseases.

Progestin-only pills
Certain pills containing only a progestin (and no estrogen) also can be used for emergency contraception. The first dose of these progestin-only ECPs must be taken within 72 hours (3 days) of unprotected sex, followed by a second dose 12 hours later. The effectiveness of progestin-only ECPs is similar to ECPs that contain estrogen, but progestin-only ECPs generally cause less nausea and vomiting.

This brochure is available from the Consortium for Emergency Contraception and may be freely reproduced.
PREGNANCY IS SPECIAL
let's make it safe

The Safe Motherhood Initiative is now in its 11th year. This year WHO is marking its annual World Health Day to put the spotlight on efforts to make motherhood safer and on problems that still need to be overcome. After weighing the progress of the past decade, the original sponsors of the Safe Motherhood Initiative have come up with 10 action messages (see Box) that they hope will guide safe motherhood programmes as they enter the next century.

The 10 action messages were the focus of a technical consultation that was held in Colombo, Sri Lanka in October 1997 to mark Safe Motherhood's 10th anniversary. The consultation brought together 250 participants from all over the world and was organized by the Inter-Agency Group - the same group of organizations and agencies that cosponsored the launch of the Safe Motherhood Initiative in Nairobi, Kenya, in 1987.

The consensus that emerged in Colombo is summarized in a set of fact sheets that are available from WHO. This summary of the actions needed - and the reasons for them - is based on those fact sheets.

**10 messages on safe motherhood**

These 10 messages were the focus of the technical consultation on safe motherhood that took place in Colombo, Sri Lanka, in October 1997.

1. Establish safe motherhood as a human right.
2. Safe motherhood is a vital economic and social investment.
3. Empower women: ensure choices.
4. Delay marriage and first birth.
5. Every pregnancy faces risks.
6. Ensure skilled attendance at delivery.
7. Improve access to quality maternal and health services.
8. Address unwanted pregnancy and unsafe abortion.
9. Measure progress.
10. Use the power of partnership.

**Maternal death and disability**

Every day at least 1600 women die from the complications of pregnancy and child-birth. In addition to these 585,000 maternal deaths each year, a further 50 million women suffer acute complications. For 18 million of these women the result is long-term disability.

Most maternal deaths happen during or soon after delivery. Yet research shows that this is the very time when women are least likely to have the health care they need. Every year 60 million deliveries take place with only a relative or an untrained birth attendant present. Far too many women give birth completely alone.

Only 53% of deliveries in developing countries take place with the help of a doctor or midwife, and fewer than one-third of women receive postpartum care. Antenatal care is more likely, but still only 65% of women in developing countries receive it.

Most maternal deaths - and millions of cases of disease and disability - could be prevented through basic maternal care for all pregnancies. It would also save the lives of around 1.5 million babies each year.

Providing quality health care during and after labour and delivery (by having a skilled health professional present) is the single most important way of saving the lives and preserving the health of mothers and babies. Care during the post-partum period, when most maternal deaths occur, offers a chance to check that mother and baby are doing well, and to give them the support they need. And antenatal care helps because it is an opportunity to spot complications early and to give women advice about what to do if they occur.

**A social and economic investment**

Safe motherhood is more than just a matter of health. Saved lives and healthier women and children mean a more productive society.

When a woman dies, her family is often much less well off economically and socially. They lose her contribution to household management and the care she gave to other family members, as well as any income she may have had. Children suffer most. If their mother dies, surviving children are 3-10 times more likely to die within two years than children who live with both parents. Motherless children get less health care and less education.

When a woman dies, the economy loses her contribution to the workforce and the community loses her unpaid contribution. Even if she survives, her poor health - and the poor health care she receives - may mean the death or disablement of her child. At least 30-40% of infant deaths could be avoided if the mother received proper care. Poor maternal health and nutrition lead to babies born with low birth weight who are at greater risk of infection and impairment.

Research shows that women who are in good health are less likely to be poor. They are more productive and make a greater contribution to the welfare of others. They help their households and communities to break out of the poverty trap. Reducing unwanted pregnancies and improving maternal health benefits everyone.

**Social justice and human rights**

Stopping women from dying and becoming disabled is also a matter of social justice and human rights. Many women the world over simply do not have the same chance to be healthy that men have. They usually eat last and eat least. Some are less well nourished than men, they often do harder work than men, and decisions that affect their health (such as going to an antenatal clinic or seeking medical treatment) are often made for them.

**Women's human rights**

The following human rights directly apply to safe motherhood:

- Rights relating to life, liberty and the security of the person
- Rights relating to the foundations of families and of family life
- Rights relating to health care and the benefits of scientific progress, including to health information and education
- Rights relating to equality and nondiscrimination

Greater illiteracy and limited exposure to information means that women often do not know how to recognize danger signs during pregnancy. Women's social role means they frequently cannot decide for themselves to seek health care (and would not have the money to do so if they could). And the status society attributes to them means that their health concerns are often not listened to.

Several international conventions and covenants deal with the promotion and protection of the human rights of women, including their right to health. Governments have signed those treaties and have legally bound themselves to take the action necessary to make sure that women suffer no health disadvantage whatsoever as a result of their sex. That means more than just giving women the same access to health care as men have. It means protecting women from health problems that are specific to women and providing whatever health care is needed in order to do this.

Denying women access to a minimum of well proven interventions to make motherhood safer is discrimination against half of humanity.

**Delay childbearing**

Adolescent women are more vulnerable than older women to pregnancy-related complications, sexually transmitted diseases and unsafe abortion. Although adolescents are physiologically mature enough to get pregnant, their bodies are often not sufficiently developed to have a safe pregnancy and birth. Not only do young mothers have a greater risk of dying, but so do their babies. And even the infants who survive are more likely to die during the first five years of life than are babies born to older mothers.
Young women often lack knowledge of sexually transmitted diseases, lack the skills to say no to sex (or demand that it be "safe sex"), and are susceptible to sexual abuse and rape. In addition, women aged 15-19 have at least five million abortions - many of them unsafe - every year. Women need access to and information about reproductive health and family planning. Early pregnancy and childbirth limit a young woman's educational opportunities, compromise her ability to support herself and her family, and limit her self-determination and quality of life. Not only governments, but communities and family members have a role in helping young women delay marriage and childbirth. They can help expand girls' access to education and training and expand income-earning opportunities for young women. They can also help adolescent girls and boys to take responsibility for their sexual and reproductive health, and show them how to protect it.

Every pregnancy faces risk

Most pregnancies will follow their course without health-threatening complications but for each one there is of course a chance that something will go wrong. Risks cannot be totally eliminated once pregnancy has started, but they can be reduced through antenatal care. Some pregnant women are at higher risk of complications than others. However, it is not possible to identify which women these are with a great deal of accuracy. Rather than trying to sort out the high-risk women from the low-risk ones, it would be better to make sure that all women have access to antenatal care that is effective, affordable, accessible and acceptable to them. That way, all women would receive preventive care and those in need of extra help would get it promptly.

Health services should be as near as possible to where women live, should offer continuity of care with prompt referral to better equipped facilities if necessary. Children should aim to improve women's overall health, should help women and their families understand the risk of complications, and should identify symptoms early.

This means clean deliveries by personnel trained in midwifery and able to recognize possible problems, stabilization of women with complications and referral to the next level of care, and arrangements for rapid and safe transport both from the village to the health centre and from there to the next level of care.

Ensure skilled attendance at delivery

Only just over half (53%) of births in developing countries take place with a skilled attendant present. WHO defines skilled birth attendants as trained midwives, nurses, nurse-midwives or doctors who have completed a set course of study and are registered or licensed to practise. Traditional birth attendants, including those who have been trained, are not included in this definition.

In developing countries, and particularly in rural areas, there is a shortage of persons with midwifery skills. The content of training courses that teach these skills is often out of date and does not reflect new knowledge and techniques. In-service refresher training is often insufficient, and many health workers who know how to deal with routine deliveries are not trained in handling obstetric emergencies.

Obviously there is a widespread need to train more personnel in midwifery skills and to define just what interventions midwives, nurses and doctors are authorized to carry out. In some countries this may mean that laws and regulations may need to be changed. The training should be standardized to make sure that all staff are competent to carry out effectively the tasks that may be required of them. And there needs to be much greater deployment of health workers with midwifery skills in poor and rural areas, not just in the big cities.

Improve access to maternal health services

Access means that women can reach maternal health care easily and are not deterred by cost or poor treatment by staff.

In most rural areas, one woman in three lives more than five kilometres from the nearest health facility and four out of five live more than five kilo-metres from the nearest hospital. Lack of transport makes it difficult for pregnant women or women in labour to reach help quickly.

Fees charged for health care often put women off having their babies in hospital, or even seeking help when complications arise. Many women also say they prefer to rely on traditional birth attendants because

Reducing maternal mortality is a matter of social justice

- extract from the 1998 World Health Day message of WHO's Director-General Dr Hiroshi Nakajima

"Pregnancy and childbirth are special events in women's lives and, indeed, in the lives of their families. This can be a time of great hope and joyful anticipation. It can also be a time of fear, suffering and even death. Although pregnancy is not a disease, it is a normal physiological process. It is associated with certain risks to health and survival both for the woman and for the infant she bears. These risks are present in every society and in every setting. In developed countries they have been largely overcome because every pregnant woman has access to special care during pregnancy and childbirth. Such is not the case in many developing countries where each pregnancy represents a journey into the unknown from which all too many women never return."

"This situation cannot be allowed to continue. The interventions that make motherhood safe are known and the resources needed are obtainable. The necessary services are neither sophisticated nor very expensive, and reducing maternal mortality is one of the most cost-effective strategies available in the area of public health. Access to family planning information and services can help reduce unwanted pregnancies and their adverse consequences. Access to health care, particularly at the critical time of birth, can help ensure that childbirth is a joyful event. It must be recognized that the reduction of maternal mortality is not only a matter of effective health care but also one of social justice. The risks that women face in bringing life into the world are not mere misfortunes or unavoidable natural disadvantages but injustices that societies have a duty to remedy through their political, health and legal systems."
health workers are rude and unsympathetic. And in many cases decisions about seeking care are made by mothers-in-law, husbands or other family members.

The problems of distance and lack of transport can be overcome by assigning health workers trained in midwifery to village health posts, by upgrading local health facilities so they offer more services, by organizing emergency transport systems, and by setting up maternity waiting homes near health facilities. The problem of cost can be tackled by providing maternal and infant health services free of charge, by adjusting fees to make essential services affordable, promoting insurance schemes or, when fees are charged, by retaining some of the funds locally to improve services.

Health workers should be encouraged to show more empathy for women. To facilitate this, health workers need to be shown and offered appropriate support by the health care system. Women and their families must learn the need for special care during pregnancy and childbirth. And, of course, women’s status and authority must be increased so that they are able to take decisions about their own health.

**Improve the quality of maternal health services**

Every year, more than 200 million women become pregnant. Around 15% of them are likely to develop complications that will need skilled obstetric care to avoid death or serious ill-health. All women, whether their pregnancies are complicated or not, need good quality maternal health services during pregnancy, delivery and the postpartum period.

Good quality maternal health services fulfill a number of criteria, according to WHO. They are accessible and available as close as possible to where women live; they are acceptable to users; they have the necessary supplies and equipment; they provide comprehensive care with links to other reproductive health services; and they provide for continuity of care and follow-up. Good quality maternal health services have technically competent staff who are respectful, respond to women’s needs without being judgemental, provide information and counselling, and involve the client in decisions. These services also offer economic and social support to health workers so they can do their job to the best of their ability.

**Prevent unwanted pregnancy**

Every year, women around the world have 75 million unwanted pregnancies. Some are due to contraceptive failure, others to rape, but most are due to lack of access to family planning. Some 350 million couples lack information about contraceptives and have no access to contraceptive services. Between 120 and 150 million married women who want to limit or space future pregnancies are not using a contraceptive method.

WHO recommends that action should be taken to ensure that everyone has access to “client-oriented and confidential family planning information and services that offer a wide choice of modern contraceptive methods, including emergency contraception”. Women and their families should be informed what is available and should be told not only about the prevention of pregnancy but also about the prevention of sexually transmitted diseases. Adolescents should receive a comprehensive sexual and reproductive health education. Confidential counselling and services should be accessible to everyone, including adolescents and unmarried women. In addition, women who have had an abortion should be given guidance on family planning.

**Address unsafe abortion**

Many women with an unwanted pregnancy seek to terminate it by recourse to abortion. Where safe abortion is not available, women may risk their lives and health by having unsafe abortions. Some 20 million unsafe abortions take place each year, killing approximately 200 women a day. Around 95% of unsafe abortions take place in developing countries. Globally, one unsafe abortion happens for every seven births. Apart from the women who die, millions more suffer long-term health problems, including chronic pelvic pain, pelvic inflammatory disease, tubal blockage and infertility.

Most women seeking abortion are married or live in stable relationships and already have several children. They have an abortion to limit the size of their family or to space births. Unsafe abortion is a problem in women of all ages, but particularly among young women who often know little about family planning and who do not have the social contacts or money that older women have to obtain a safe abortion. Young women also tend, more than older ones, to delay seeking help and to have the pregnancy terminated at a more advanced stage.

To reduce the heavy toll of death and disability caused by unsafe abortion, WHO urges steps to make sure that everyone has access to family planning and that communities are educated about reproductive health. WHO also recommends that safe abortion services should be available “to the extent allowed by the law”. Whatever the legal status of abortion, good quality management of post-abortion complications needs to be available 24 hours a day if lives are to be saved.

**Measure progress**

A maternal death is defined by WHO as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes”. The level of maternal mortality can be expressed in several ways. The maternal mortality ratio is the number of maternal deaths per 100,000 live births. The maternal mortality rate is the number of maternal deaths per 100,000 women aged 15-49 per year.

The lifetime risk is the probability of maternal death faced by a woman over her entire reproductive lifespan.

Maternal mortality is difficult to measure for several reasons. Although there are many maternal deaths every year, the death of a woman of reproductive age in a particular community is a relatively rare event. In any case, a maternal death may not be reported either because the death is not registered or because it is attributed to some other cause.

Today in many countries it is more important to analyse each maternal death in detail than to spend scarce resources on trying to measure maternal mortality levels. Each case of maternal death gives tragic but important information about what can be done locally to make motherhood safer. This information must be shared between the health care system and the community.

For the equally important monitoring of progress, process indicators should be used. For instance, measurement of the proportion of births attended by skilled health personnel or the geographic distribution of facilities providing essential obstetric care.

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**Elements of maternal health services**

**Antenatal care.** WHO recommends that pregnant women should have four antenatal visits for:

- Health promotion: advice on nutrition and health care, counselling on danger signs and to help plan for the birth.
- Assessment: history taking, physical examination, screening tests.
- Prevention: early detection and management of complications, prevention of malaria, hookworm and tetanus.
- Treatment: management of anaemia, sexually transmitted diseases and other conditions.

**Delivery care.** WHO recommends a skilled attendant at every birth who can:

- Provide continuing good quality care that is hygienic, safe and sympathetic;
- Recognize and manage complications, and carry cut life-saving measures for mother and baby;
- Refer promptly and safely when necessary.

**Postpartum care.** WHO recommends integrated care that includes:

- Identification and management of problems in both mother and newborn;
- Counselling, information and services for family planning;
- Health promotion for mother and newborn, including immunization, nutrition, advice on breast-feeding and on safer sex.
can indicate how far a goal has been achieved. Process indicators should be used to make sure that policies and programmes are based on reliable information. According to the programme, indicators should be directly relevant to specific interventions that are carried out.


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**PREVENTION OF HIV TRANSMISSION FROM MOTHER TO CHILD:**

**Meeting on planning for programme implementation**

**Geneva,**

**23-24 March 1998**

**Meeting statement**

**Background**

Transmission of HIV from mother to child can occur during pregnancy and delivery, as well as through breastfeeding. Such mother to child transmission of HIV represents a major cause of morbidity and mortality among young children, particularly in developing countries with a high prevalence of HIV infection. Interventions to prevent mother to child transmission of HIV, including recent breakthroughs in antiretroviral therapy, offer immediate opportunities to: (i) save children’s lives; (ii) reduce the impact of HIV on families and communities; and (iii) strengthen maternal and child health services.

In addition to the long regimen (ACTG 076) proven effective in 1994, a CDC-sponsored trial in Thailand demonstrated in February 1998 that the use of a shorter zidovudine regimen, which is more affordable and effective in developing countries, is also effective. This shorter regimen, involving the administration of zidovudine to mothers during the last four weeks of pregnancy and during delivery, has been shown to reduce mother to child transmission by half among women who do not breastfeed. An integrated prevention programme which combines the use of this regimen and the use of safe alternatives to breastfeeding would be effective in reducing mother to child transmission of HIV among breastfeeding populations. Recent cost-effectiveness data suggest that in many developing countries this intervention is comparable to other public health interventions. It is clear that there is an urgent need to begin to implement such interventions to reduce the transmission of HIV from mother to child.

**Taking interventions to scale**

Any national strategy to prevent mother to child transmission of HIV should be part of broader strategies to prevent the transmission of HIV and STDs, to care for HIV-positive women and their families, and to promote maternal and child health. The ability to make widely available, and as soon as possible, the interventions to reduce HIV transmission from mother to child depends on political will, affordability of the interventions, and the strength of existing human resources and infrastructures. Powerful means of effecting change lie in demonstrating the success of interventions to reduce mother to child transmission of HIV, as well as the costs of not acting to prevent this kind of transmission.

Three factors that affect the affordability of interventions to prevent mother to child transmission are: (i) the cost of drugs; (ii) the cost of safe alternatives to breastfeeding; and (iii) the cost of HIV tests. WHO has added zidovudine for mother to child transmission to the Essential Drug List. Glaxo-Wellcome has recently offered zidovudine at substantially reduced prices. Further negotiations are planned to minimise the cost of each of these components.

Service delivery, including voluntary HIV counselling and testing, represents a further set of costs. In countries with well-functioning health systems, the additional service delivery costs of interventions to prevent mother to child transmission may be affordable. Other countries may require more substantial investments in order to strengthen their health infrastructure to allow for the incorporation of large-scale interventions. Where applicable, traditional health and community support systems should also be fully utilised. Such investments will have a broad beneficial effect on the health sector more generally and should be encouraged.


SHOULD EMERGENCY CONTRACEPTIVE PILLS BE AVAILABLE WITHOUT PRESCRIPTION IN EUROPE?

Introduction

Emergency contraceptives hold a special place in women’s health since they can be used post-coitally to prevent unintended pregnancy. Three methods are available in clinical practice in much of the developed world: the Yuzpe regimen, the levonorgestrel regimen, and insertion of a copper-bearing IUD.

Emergency contraception’s history, safety, and efficacy have been thoroughly reviewed elsewhere, but little public debate has taken place about whether the hormonal methods should continue to be available by prescription only, as has been standard throughout Europe.

Both the Yuzpe and the levonorgestrel regimens consist of ordinary oral contraceptive pills taken in alternative doses and timing schedules. Although many well-respected organizations have endorsed the method, access to emergency contraceptive pills remains extremely limited. In fact, in most developed countries, neither one of these methods can be obtained without a physician’s prescription even though several dedicated products are specifically marketed for emergency contraception in parts of Europe. These obstacles might be justified if emergency contraceptive treatment were complex or dangerous. In fact, emergency contraceptive treatment is neither complex nor dangerous. We and others have argued elsewhere that there is no compelling medical reason for oral contraceptives (when used as an ongoing method) to be restricted to prescription only status. The arguments are stronger still in the case of the hormonal regimens of emergency contraception.

A review of the evidence on this question is particularly timely in light of recent events in New Zealand and the United Kingdom. That have special relevance for Europe. In New Zealand, the German pharmaceutical company, Schering, pulled its dedicated emergency contraceptive product known as PC from the market after regulatory authorities there switched its status from prescription to over-the-counter. On the other hand, the London Times and BBC News reported that the same company recently reversed its position in the United Kingdom by agreeing to negotiate with the Department of Health to allow women to buy the pill from pharmacists without a doctor’s permission. The action followed a motion by British Member of Parliament Dr. Jenny Tonge.

Reasons for restricting drugs to prescription status

Consider the criteria that should govern the limitation of any drug to prescription status as set forth in a study by the Office of Health Economics in the United Kingdom thirty years ago.

While the use of oral contraceptives for ongoing contraception has been assessed against these criteria, it is interesting to apply the same criteria to the same drugs when used specifically for emergency contraception.

1. Can the woman make her own diagnosis? Clinicians now rely on women to diagnose their own need for emergency contraception and seek treatment at the clinic. In practice, few seek esse from the clinic, even when their risk of pregnancy is very low. In particular situations, such as rape, where the woman might first learn of the treatment through a clinician, the clinician could still provide emergency contraceptive pills directly to women, even if the pills were also sold over the counter.

2. Is the drug a complicated one to administer? As when they are sold by prescription, the pills used for emergency contraception are self-administered tablets. Women require no help in swallowing them.

3. Is the method complicated to use? The emergency hormonal regimens are simple: one set of pills swallowed anytime within 72 hours after unprotected intercourse, and another set swallowed 12 hours later. The only complicated aspects relate to the fact no products are yet specially packaged for emergency use in many countries, and clinicians must therefore know the number of tablets and brands to use, and must also avoid prescribing the inert tablets found in 28-day packaging of ongoing oral contraceptive pills. These regimens could be simplified even further by developing a single-dose regimen, extending the treatment window, or dedicating a specially packaged product to be sold over the counter.

4. Does the dose need to be adjusted to the particular details of the patient or her medical condition? Nearly all women presenting for emergency contraception currently receive the Yuzpe regimen. The tablets and dosing schedule are the same regardless of the woman’s characteristics.

5. Is an accidental overdose dangerous? Oral contraceptives (and by extension emergency contraceptives) are one of the few drugs with which it is apparently impossible to commit suicide. Deaths or serious medical consequences from overdose are unknown.

6. Is the drug addictive? There are no reported cases of addiction to emergency contraception in the medical literature. Particularly if the drugs are sold over the counter, a black market for emergency contraceptives is unlikely. The Yuzpe regimen entails unpleasant side effects, particularly nausea and vomiting (experienced by approximately 50% and 20% of users, respectively), which are likely to dissuade frequent or gratuitous use of the regimen. Experienced clinicians note that even in clinical settings with easy access, women seldom use the method more than a few times per year, and most use it only once or twice in a lifetime.

7. Are there patients who should never take the medicine? The World Health Organization has concluded that there are no contraindications to the Yuzpe method, aside from pregnancy. A woman who has
had previous medical problems using hormones or has a serious medical condition would be free to consult with her clinician before using non-prescription emergency contraception, as is common for other over-the-counter products now. Pregnancy is a contraindication only because, like all contraceptives, emergency contraception will not work if a woman is already pregnant. 

There have been no conclusive studies on the issue of birth defects among babies born to women who were already pregnant when they took emergency contraceptive pills or to women who experienced failure of the regimen. However, studies that have examined births to women who inadvertently continued to take oral contraceptives without knowing they were pregnant have found no increased risk of birth defects. Nevertheless, a woman concerned about this possibility can use any of the widely available over-the-counter pregnancy tests before starting treatment. (Note, however, that most clinicians do not require a pregnancy test before prescribing the therapy). If the therapy fails, abortion services are safe and legal in most parts of Europe for women who choose them.

8. Is there a need to monitor long- and short-term side effects? The characteristics of the drugs involved—short duration of the therapy and short half-life of the hormones—make it unlikely that anticipated long-term or negative side effects would be observed. The short-term side effects are well known and can easily be managed by the woman herself. Since emergency contraceptives are used in 12 hours, even the minimal health risks attributable to ongoing use of oral contraceptives are likely to be trivial or absent.

9. Are all patients equally suited to every brand? Although no changes in clotting factors have been detected following treatment with the Yuzpe regimen, emergency use of levonorgestrel-only pills or insertion of a copper-bearing IUD may be preferable for a woman who has a history of prior thromboembolic disease such as stroke or blood clots in the lungs or legs and wants emergency contraceptive treatment. Labeling for a non-prescription Yuzpe regimen could advise such women to consult with a clinician before deciding on emergency treatment.

The special case of prescription contraceptives Some defenders of prescription status point to public health concerns that separate contraceptives from other categories of drugs. One concern is that women would become less diligent with their ongoing contraceptive method if they know that emergency treatment is widely available. We argue that other considerations mitigate this concern. First, women are entitled to know about all existing contraceptive options and to have them available in the most convenient manner feasible consistent with safe and effective use. Secondly, if used as a primary method, emergency hormonal contraceptive therapy might be significantly less effective than any of the available ongoing contraceptive methods. Also, the incidence of undesirable side effects like nausea and vomiting might be halved by antiemetics, but not eliminated. Furthermore, reported evidence with providing emergency contraception, although limited, suggests that women who are the most diligent about ongoing contraceptive use are those most likely to seek emergency treatment when the need arises. In short, consideration of the general criteria for determining prescription status and the additional concerns for contraceptive products reveals no persuasive arguments in favor of restricting emergency hormonal contraception to prescription status.

There are, moreover, several additional reasons to remove such restrictions. The window for using emergency contraception is short. Requiring women to make an unnecessary visit to a clinician for a prescription may put this option out of reach for many who need it. Similarly, if efficacy might be higher when treatment is initiated earlier after unprotected intercourse, the requirement for a prescription might actually harm women by delaying them. (We note, incidentally, that it is not clear that efficacy does decrease over time, although some have suggested that it does).

Finally, in a time of spiraling health costs, it is wasteful to require physician permission to use such a simple, safe, and effective product. A compromise position could be to allow women to obtain emergency contraception from pharmacists, rather than over the counter. Such provisions would allow the pharmacist to prescribe emergency contraceptive pills directly to women in accordance with an approved protocol established in advance between the pharmacist and a physician.

Conclusion Emergency contraception has the potential to reduce significantly the incidence of unintended pregnancy and the consequent need for abortion. This potential could be better realized by making emergency contraceptive pills available without prescription. Emergency contraception is especially important to the millions of women at risk of pregnancy but not using a regular method, and to the millions more women who rely on condoms for protection against pregnancy. The harm entailed by keeping this safe, simple, and effective option out of the hands of women almost certainly exceeds the harm that could result from making emergency contraceptives widely available. It is time that the special paternalistic scrutiny accorded to contraceptive methods used by women be relaxed.

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References are available from the authors upon request.
WHAT IS THE ROLE OF WHO IN FGM IN EUROPE?


Female Genital Mutilation (FGM) is one of the issues of concern to WHO with regard to Women’s Health in Europe. It primarily affects families which have migrated to Europe from countries where FGM is practised. Throughout the world it is estimated that approximately 130 million women have experienced FGM. Of those about 80% experience some form of excision and about 15% have the more severe form of circumcision, infibulation. In Europe, the numbers of women affected are, relatively speaking, much smaller.

Nevertheless, the problem of FGM is considerable in the European region and a conference was recently convened (Gothenburg, 1-3 July 1998) to discuss these issues by the Committee of the Regions of the European Union and the City of Gothenburg. In all 180 participants from 16 countries including Sweden, Denmark, Norway, Finland, the UK, Ireland, France, Germany, the Netherlands, Greece, Italy, Portugal, Spain, Belgium, Switzerland and as far afield as the USA, Canada and New Zealand, attended. Most of the major agencies advocating against FGM throughout the world were represented including such groups as the Inter-African Committee, Forward, Rainbo, Gams, Pharos Foundation, WHO, IPPF and the Organization for African Unity (OAU). The conference was supported by the Swedish National Board of Health and Welfare, the National Institute of Public Health, Save the Children (Radda Barnen) and others.

There are two issues of concern in Europe. These are:

1. The continued practice of FGM in this part of the world; and
2. The provision of appropriate health care, and reproductive health care in particular, for women with previous exposure to FGM.

The first issue is the most difficult to deal with: FGM should be considered not only a health issue but a human rights issue as well. Health services, education services and legislation should be directed towards eliminating FGM in a culturally sensitive way. Policy against FGM should be agreed between all the member states and cooperation on legislation to prevent loopholes is recommended. It is the WHO policy to bring an end to FGM in all its forms and to prevent it from becoming institutionalized into the formal health care system (Working group meeting on health issues of minority women living in Western Europe, WHO Copenhagen, November 1997).

Some approaches to prevention of FGM may be directed through education services and, from a WHO perspective, collaboration with
died with cultural sensitivity and with respect for human rights? This is a fair challenge for us all.

The second issue is perhaps a little easier to address: how can we meet the health care needs, and particularly the reproductive health care needs, of women with previous experience of FGM? In this regard we need technical guidelines for the care of women with FGM for obstetrics, gynaecology and family medicine in general. We also need guidelines for paediatricians for the care of children with FGM. All of these professionals need guidelines and support for counselling against FGM at the time of birth, at all health care contacts while the child is growing up and particularly at the time of potential circumcision.

In my part of the world, Canada, as in many parts of Europe, we are grappling with the difficulty of providing appropriate perinatal care for women with FGM as very few health care providers have any experience or training in their obstetric or gynaecological care. To overcome some of these problems, and to develop guidelines for appropriate care, I am in the process of conducting a survey of Somali women’s experiences of birth in Canada together with my colleague, Kowser Omer-Hashi, a Somali midwife and respected advocate against FGM. Women

The conference delegates agreed on a number of recommendations which were incorporated into a “Gothenburg Declaration” and agreed to by all.

These included:

- The need to provide considerable information on FGM to professionals within health care, social services, and cultural ethnic groups;
- That every nation concerned should initiate a special programme for prevention of FGM;
- That International Agencies should coordinate their efforts in this field with special aim at the grassroots level;
- That WHO-Euro be asked to undertake a special responsibility regarding FGM, together with WHO-HQ;
- That representatives of various religious groups should be encouraged to begin a constructive dialogue on FGM;
- That medical schools, midwifery and nursing faculties include FGM into the curriculum, taking care that FGM does not become institutionalized.

WHO is committed to the prevention of FGM and the amelioration of its effects once it has occurred. It endorses a strategy to advocate against the practice, to support research and development in this field, to support groups working against FGM and to train health professionals in the prevention and management of FGM. Conferences such as this one are crucial steps in achieving these goals.

The European Health Promoting Schools Programme may be an avenue worth exploring. This is a collaborative programme of the Council of Europe, WHO-Euro and the European Commission. It may be possible to introduce preventive education for both teachers and pupils through this programme. At the same time, we will have to be careful not to be punitive but to respect the rights to health and well-being, as well as dignity and individual choice, which are due to all.

The difficult debate arising from this is the extent to which newcomers to a country can follow their old practices when these are in contradiction to the norms of their adoptive country. Can this debate be han-
are being interviewed by her in their homes. They have all had infibulation and have all had a baby in Canada within the past five years. Preliminary data analysis of their reports of their care (N=54) indicate a severe limitation in the skills of their caregivers and even more so in the quality and sensitivity of care given to them during pregnancy and birth; for example:

- Most women are afraid of seeking antenatal care (88.9%) and about a quarter seek antenatal care from family and friends only (25.9%);
- Birth is all too often conducted by means of caesarean section (46.3%) frequently with a general anaesthetic. Women themselves, almost without exception, do not want caesareans but would prefer vaginal deliveries.

Reinfibulation is a difficult issue. It is illegal in Canada but women have concerns. Almost half the women interviewed wish to be reinfibulated (48.1%). Almost two thirds of the sample (63%) say that their husbands would want them to be reinfibulated.

It is customary to have the husband present at both the labour and delivery in Canada. This custom is being imposed on Somali women. 44.4% of women had their husband’s present during labour and 35% during delivery. In only 11.1% for labour and 7.4% for delivery was this their own choice. If left to their own preferences only 3.7% of women would want their husbands with them during labour and none would like him there for the delivery itself.

In general women say their care left much to be desired with:

- 83% experiencing hurtful comments from their caregivers;
- 50% of the doctors expressing verbal surprise when first viewing their perineum;
- 70.4% expressed non-verbal surprise;
- 40.7% expressed disgust;
- 42.6% called a colleague to come and look, and only;
- 11.1% asked the woman’s permission to do so.

Women report that they are touched roughly:
- 68.5% prenatally and 55.6% in labour.

Most doctors do not discuss birth plans with women, for example:

- 77.8% do not discuss the possibilities for birth with women;
- 74.1% do not discuss caesarean section;
- 61.1% do not discuss pain management prior to delivery.

- 66.7% do not discuss pain management post-partum.

Most women do not judge their caregivers as being competent to care for them (68.5%)

Women also report that nurses view them as lazy and reluctant to cooperate (90.7%). Many nurses appear to be insensitive to the women’s post-partum pain (50%) and some are unaware that there is increased pain for women with previous FGM after delivery (21.2%)

Most women were so unhappy with their care that very few would choose the same nurse again for another baby (1.9%) or the same doctor (22.2%) or the same hospital (25.9%)

Of course, we should not forget that there are benefits too: 72.2% report that their babies were born healthy (72.2%), a few report some health problems (14.8%) and only a very few report moderate health problems (3.7%) with their new-borns. But perhaps these figures could be even better with more sensitive and supportive care.

It is clear that we need to build on studies such as these, conducted in the European region as well, to provide a sound basis on which to build policies for practice and from which to develop sound technical guidelines for care.

Dr Beverley Chalmers, WHO Collaborating Centre in Women’s Health Centre for Research in Women’s Health University of Toronto, Toronto, Canada

IF LAST NIGHT WENT WITH A BANG

YOU’VE GOT 3 DAYS TO DEFEAT THE SITUATION

Emergency contraception isn't just for the morning after. It can be started up to 3 days (72 hours) after unprotected sex. Emergency contraception is free and confidential - ask your doctor or family planning advisor for further information.
RESOURCES

Scientific Database on Emergency Contraception Accessible on Internet
The Special Programme of Research, Development and Research Training in Human Reproduction (WHO/HRP) is assembling abstracts of all technical papers on emergency contraception written since 1966, including papers in private collections at WHO/HRP. The activity is supported by the Consortium for Emergency Contraception.
http://www.wfo.ch/hrp/

The Consortium for Emergency Contraception has an e-mail newsletter with all the latest developments in emergency contraception from around the world. To be added to the list or to obtain Consortium materials, contact PATH (ewells@path.org)
The Consortium's Web site address is:
http://www.path.org/cec.htm

EC Client Materials Book Available
The new booklet, Emergency Contraception: Client Materials for Diverse Audiences, produced by PATH and the Northwest Emergency Contraception Coalition (NWECC) in Seattle, Washington, USA, is ready for distribution. The purpose of the booklet is to help medical providers improve women's awareness of emergency contraception and access to EC services. The booklet contains Instructions for Use and a one-page, double-sided prototype brochure in English and nine other languages including Russian and Spanish. These brochures were designed to be easily reproduced by photocopying or printing. The booklet also contains consent forms in English and Spanish, a telephone screening protocol and a prescription blank that can be photocopied or adapted as needed. An on-line version of selected languages is available on the Internet (http://www.path.org) for easy adaptation.

Emergency Contraceptive Pills: Safe and Effective But Not Widely Used, Outlook, Volume 14, Number 2 (September 1996)
A special issue of Outlook focusing on Emergency contraception, published by PATH, can be found on the Internet:
http://www.path.org/html/14_2_fea.htm

PATH, the Program for Appropriate Technology in Health, is an international, non-profit organization whose mission is to improve health, especially the health of women and children. PATH works in partnership with host-country governments and local agencies to assess health problems and identify and implement creative and effective solutions.

Contraceptive Technology Update Series Module on EC
Family Health International (FHI) is currently in the process of developing a slide and lecture module specifically on emergency contraception.

Contact: fita Frankel, Instructional Design Associate, FHI, PO Box 13950, Research Triangle Park, NC 27709 USA, Tel. (919) 544-7040
Fax (919) 544-7261, E-mail: rfrankel@fhi.org

Emergency Contraception Training and Education Tools
The Emergency Contraception Pilot Project conducted by Kaiser Permanente of San Diego has developed the ECP Tool Box, primarily for staff training but with some aspects suitable for patient education. A video called: Once a Secret, Now an Option! illustrates a couple's experience after having discovered that they have had unprotected sex to explain past and current barriers to use of EC, social consequences of and facts about unintended pregnancy, what EC is, mode of action, efficacy, side effects, etc. Along with the video will be slides for presenters, written materials, an outline, objectives and a post-test (so the training can be used for Continuing Education Units).

Contact: Debbie Postlethwaite
Kaiser Permanente, 10992 San Diego Mission Road, 3rd floor, OB Support Services, San Diego, CA 92108, Tel. (619) 641-4404
E-mail debbie.postlethwaite@kp.org

A statement on emergency contraception developed by the International Medical Advisory Panel (IMAP, 1994) is available from the International Planned Parenthood Federation, Regent's College, Inner Circle, Regent's Park, London NW1 4NS.
Tel. (+44) 71-486 9741

New Information Packet from American College of Obstetricians and Gynecologists (ACOG)
A comprehensive new information packet on emergency contraception is now avail-
able to US health-care providers from the American College of Obstetricians and Gynecologists. The project was initiated and is being funded by the Henry J. Kaiser Family Foundation in California.

The centerpiece of the information packet will be a resource book for health care providers, with current information about prescribing practices for both emergency contraception pills and IUDs, counseling issues and legal and service delivery considerations. The resource book will also contain sample instructions for clients in English and Spanish, prescription blanks, prototype informed consent forms and screening protocols that can be photocopied for use by any provider. The packet will also contain a small waiting room poster, client brochures for young adults and older clients and a fact sheet on emergency contraception. A similar packet on emergency contraception was distributed in 1996 to health care providers throughout England by a coalition led by the UK Family Planning Association. The UK materials are believed to have been a major factor in the substantial increase in the availability and use of emergency contraception in England.

Contact: Janet Chapin, Associate Director, ACOG 409 12 Street SW, Washington, DC 20024-2188

Intrauterine Devices: What Health Workers need to know (WHO 1997) is part of a series of 40-page booklets of key questions and answers. This time the focus is on IUDs. Available free of charge from WHO, Division of Reproductive Health, CH-1211 Geneva 27, Switzerland.

Readings on Emergency Contraception
(Family Planning Perspectives and International Family Planning Perspectives 1992-1996) covers the history of emergency contraception, the effectiveness of different regimens, the international experience and the method's potential impact on unintended pregnancy. These articles compile the latest findings and analysis from leading researchers.
64pp, 1996, $15.00, ISBN 0-939-253-42-9, Item # FP33. The Alan Guttmacher Institute, 120 Wall St., NY, NY 10005 e-mail: buyit@agi-usa.org

Guidelines for Monitoring the Availability and Use of Obstetric Services (UNICEF, WHO, UNFPA 1997) have been developed in response to the need to monitor progress in attaining the goal, put forward by several international conferences, to reduce maternal mortality by half between 1990 and 2000. These guidelines propose an alternative approach based on monitoring the processes, or interventions, aimed at reducing maternal mortality. They present a series of process indicators that assess the availability, use and quality of obstetric services and provide guidance on data collection and interpretation.
Available from United Nations Children's Fund, 3 UN Plaza, NY, NY 10017, USA Web site: www.unicef.org

Sexually transmitted diseases: policies and principle for prevention and care (WHO/UNAIDS 1997) discusses the significance of STDS as well as prevention and STD care services. STD programme management, supervision, monitoring and evaluation are highlighted in the second half of the document. Available free of charge from WHO/UNAIDS (UNAIDS Information Centre).

Impact of HIV and sexual health education on the sexual behaviour of young people: a review update (UNAIDS 1997) includes conclusions from a number of intervention studies and international and national comparison studies. The document also includes an extensive reference list. Available free of charge from WHO/UNAIDS (UNAIDS Information Centre).

Effect of Yuzpe Regimen of ECPs on Uterine Receptivity
A study is underway to evaluate the effects of the Yuzpe regimen on biochemical markers of uterine receptivity, such as integrins. Nineteen women using non-hormonal contraception participated for two menstrual cycles: one control cycle, and one treatment cycle, in which they ingested the regimen on the day LH was first detected in the urine. We expect to complete the analysis within the next few months.

Contact: Dr Elizabeth Raymond Family Health International, P.O. Box 13950 Research Triangle Park, NC 27709, USA Tel: (+1) 919 544 7040, Fax: (+1) 919 544 7261

Refinements to the Yuzpe regimen studied. The Population Council, in partnerships with clinics in the United States
and Great Britain, is undertaking a study to examine several alternatives to the Yuzpe regimen. This study seeks to answer the following questions:
- Can a wider range of currently available OCs be used effectively for EC?
- Is the second dose necessary for EC to be effective?
- Can the Yuzpe regimen be used effectively between 72 and 120 hours after unprotected intercourse?

Contact: Dr Charlotte Ellerton, The Population Council, Apartado Postal 105-152 11560 Mexico, D.F., Mexico Tel: (+52) 5 659-8541 or 8537 Fax: (+52) 5 554-1226 Email: celledt@mexc.org

**Antiemetic to prevent nausea associated with the Yuzpe regimen of ECPs**

In this study, women who are not in need of EC are randomly assigned to one of three groups: EC alone, EC preceded by a single dose of the antiemetic drug meclizine, or EC preceded by a single dose of a placebo. During the 48 hours after taking the drugs, participants complete three questionnaires, which ask about nausea, vomiting, and other side effects. About 60% of the required participants have completed the study. We hope to have results by the fall.

Contact: Dr Elizabeth Raymond
Family Health International (see above)

**Study of the effect of Progestin-only ECPs on ovulation, Corpus Luteum function and the endometrium.** A study being conducted by Dr Marta Durand, a former FHI fellow, in Mexico, evaluates the effect of the levonorgestrel regimen of EC on ovulation, endometrial histology, markers of endometrial receptivity, and luteal phase progesterone levels. The treatment is given at three different times in the cycle. About 40% of the participants have completed the study so far.

Contact: Dr Elizabeth Raymond
Family Health International (see above)

**World Health Organization Studies**

*Research Group on Post-ovulatory Methods for Fertility Regulation Ongoing emergency contraception studies*

1. **A randomized, double-blind, multinational study to compare mifepristone and two regimens of levonorgestrel in emergency contraception (Project 97902)**

This randomised double-blind, multicentre trial will compare the efficacy and side-effects of 10 mg of mifepristone (Roussel-Uclaf) and two treatments of levonorgestrel, i.e. two doses of 0.75 mg of levonorgestrel administered at 12-hour interval, and when the compound is given in one single dose of 1.5 mg, in emergency contraception up to 120 hours after unprotected intercourse. 16 centres: Beijing, Geneva, Helsinki, Hong Kong, Ljubljana, Manchester, Nanjing, New Delhi, Quebec, Shanghai (2), Stockholm, Szeged, Tbilissi, Tianjin and Ulaanbaatar.

2. **A clinical study using Cu IUDs in emergency contraception (Project 96506)**

This multicentre study will be coordinated by the National Research Institute for Family Planning (NRIIP), Beijing, and carried out in 20 Chinese centres. The objectives of the project are to investigate:
- the efficacy and side effects of the TCU380A in emergency contraception
- contraception in parous and nulliparous women;
- the occurrence of complications, such as upper genital tract infections in these women; and
- the continuation rate of IUD use up to one year after insertion for emergency contraception.

3. **Mechanism of emergency contraception (Project 95052)**

This two-year project being carried out in Beijing is designed to study likely modes of action of emergency contraception. The methods of emergency contraception being investigated are: (i) the levonorgestrel regimen, i.e. 0.75 mg of levonorgestrel administered twice at 12-hour interval; and (ii) one dose of 10 mg of mifepristone.

Please contact Dr Helena-von Herten at WHO-Genève for information regarding the three WHO studies mentioned above:
Telephone number (+41) 22 791 3373,
Fax: (+41) 22 791 4710
E-mail: vonhertzenh@who.ch.
NEWS

New French association for the promotion of emergency contraception
L'Association pour la Promotion des Méthodes de Contraception d'Urgence has been formed in France under the direction of Dr Elisabeth Aubeny, a leading gynaecologist at the Hopital Brousse in Paris. The Association brings together physicians, pharmacists, family planning providers and demographers in order to advance research and mobilise the public and private sectors behind efforts to inform women and health care providers and evaluate new methods, such as those based on progesterins or antiprogestins. The Association believes wider availability of emergency contraception in France could help reduce the need for abortion.

Contact: Doctor Elisabeth Aubeny
Hopital Brousse Bâtiment Maurice Raynaux
96 rue Didot, F-75014 Paris, France
Tel/Fax: (+33) 1 45 41 13 99

UNHCR supports ECPs for refugee camps
The United Nations High Commissioner for Refugees (UNHCR), in collaboration with the United Nations Population Fund (UNFPA), UNICEF and WHO, has recently defined emergency contraception as part of a Minimum Initial Service Package (MISP) to be provided in the world's refugee camps. In defining essential emergency reproductive health services, the interagency task force guidelines note that: "Sexual and gender-based violence is strongly associated with situations of forced population movement. In this context it is vital that emergency post-coital contraception supplies are available to those women who request this". The document notes that emergency contraception is not a substitute for other contraceptive methods, nor should it be considered abortifacient, since "it inhibits the ovulation and modifies the development of endometrium before implantation". UNHCR, UNFPA and WHO/HRP are already working with humanitarian and emergency relief groups, like the International Rescue Committee, to develop an emergency reproductive health care kit. Meanwhile, emergency contraceptive pills are already provided in refugee camps in Kenya, Ethiopia and Uganda. The pills have been donated to UNFPA by Schering AG, which manufactures a four-pill packer of high-dose combined oral contraceptives, marketed as Tetragynon or Pc4.

Contact: Dr Daniel Pierotti
UNFPA Senior Advisor for Emergency Relief Operations, United Nations Population Fund
9 Chemin des Andémons, CH-1219 Genève Chatelaine, Switzerland
Tel: (+41) 22 979 9314, Fax: (+41) 22 979 9049
E-mail: unfpaero@unfpa.org

Provision of Emergency Contraception to Tibetan Refugees
The Department of Health (DOH) of the Tibetan Government in Exile, the governing body for Tibetan refugees, initiated a reproductive health institutionalisation effort in 1997. The initial project focus has been on ensuring the delivery of the minimal initial service package (MISP) of reproductive health services outlined in the UNHCR/UNFPA Field Manual for Reproductive Health in Refugee Situations in ten settlements within India and Nepal. The provision of emergency contraception (EC) is one element of the MISP and has been introduced to health staff through a newly developed RH training program. During a recent evaluation visit to nine of the ten sites, project staff noted that EC services are almost universally available, although lack of public knowledge about this treatment has kept demand low. For more information on the Tibetan Refugees Reproductive Health Project contact:

Department of Health, Gangchen Kyishong, Dharamsala 176215, District Kangra H.P. India
Tel: (+91) 1892-22718, Fax: (+91) 1892-24697
Email: health@tecdlinux.tibet.org.in

Emergency Contraception Seminar in Egypt Stimulates the Development of New Research Agenda
About 50 distinguished Egyptian MDs and Senior government officials attended a meeting organized by the Population Council in Cairo, at which Charlotte Ellerton gave a presentation. As a follow-up to this meeting the Population Council's operations research staff with local collaborators brainstormed a list of potential OR studies. These proposed studies were approved by the senior undersecretary of the Ministry of Health and Population and await funding. This demonstrates that a short and highly targeted meeting has been effective in garnering support for pursuing operations research on EC, stimulating local policy-makers' thought about approaches to introducing EC, and laying the groundwork for introducing the method into the Egyptian family planning program.

Contact: Dale Huntington, Ph.D
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Dokki 12211, Cairo, Egypt
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E-mail: dhunt@pccairoorg

WHO adds ECPs to list of essential drugs
The World Health Organization had added emergency contraceptive pills (ECPs) to its published list of Essential Drugs. The entry covers products containing four tablets of 50 mcg ethinyl estradiol and 250 mcg of levonorgestrel (the standard Yuzpe regimen). National governments use the Essential Drugs list to help guide pharmaceutical procurement for public sector programs. Only five other hormonal contraceptives are currently on the WHO list, which is revised every two years. Products meeting this description are currently manufactured by Schering AG in Berlin and Gedeon Richter in Hungary.

Contact: Mr Peter Hall, WHO/HRP
CH-1211 Geneva 27, Switzerland
Tel: (+41) 22 791 2111, Fax: (+41) 22 791 4171

Consortium news. Sharon Camp steps down as Consortium Coordinator
Sharon Camp, who coordinated and helped found the Consortium for Emergency Contraception, recently resigned from her position as Consortium Coordinator, in order to dedicate more time to the Women's Capital Corporation. WCC was established to bring a levonorgestrel-based second-generation dedicated emergency contraception product to the United States and Canada. It is generally assumed that U.S. F.D.A. approval for the new, improved levonorgestrel regimen will help accelerate its adoption worldwide. Elisa Wells, from PATH, the Program for Appropriate Technology in Health, will replace Sharon Camp as Consortium coordinator. She can be reached at: ewells@path.org

Tentative schedule of ICPD + 5 events:

Round table on "Population and macroeconomic linkages", 4-7 November, Bellagio, Italy.
United Nations Regional Commission review:
Economic Commission for Africa (ECA), September, Addis Ababa, Ethiopia; Economic Commission for Europe (ECE), 7-10 December, Budapest, Hungary.
The Hague Forum: An international Forum on ICPD achievement will be held in The Hague from 8-12 February 1999.
General Assembly: The United nations will convene a special session of the General Assembly from 30 June-2 July 1999 to review the implementation of the Programme of Action.