Supporting guidance on providing Emergency Contraception (and Bridging Contraception – where appropriate)

Emergency Hormonal Contraception using Ulipristal 30mg (Ella One®) or levonorgestrel (via PGD) and Bridging Contraception using desogestrel (via PGD)

This guidance has been produced to support community pharmacists provide Emergency Contraception and Bridging Contraception services.

PGDs for Emergency Hormonal Contraception (EHC) are written and signed off at a local Health Board level – therefore there may be slight variation in some of the details of specific PGDs. *Please refer to the version published by the Health Board you are working in.*

The Bridging Contraception Service is underpinned by a national PGD signed off by NHS 24 on behalf of NHS Scotland in a "Once for Scotland" approach.

For detailed guidance, please refer to the Faculty of Sexual and Reproductive Health guidelines:

FSRH Clinical Guideline: Emergency Contraception (March 2017, amended July 2023) - Faculty of Sexual and Reproductive Healthcare

FSRH Clinical Guideline: Quick Starting Contraception (April 2017) - Faculty of Sexual and Reproductive Healthcare

Abbreviations
EC – Emergency Contraception
EC-LNG – Emergency Contraception Levonorgestrel
EC-UPA – Emergency Contraception Ulipristal
Cu-IUD – Copper intra-uterine device
UPSI – Unprotected Sexual Intercourse

Frequently Asked Questions

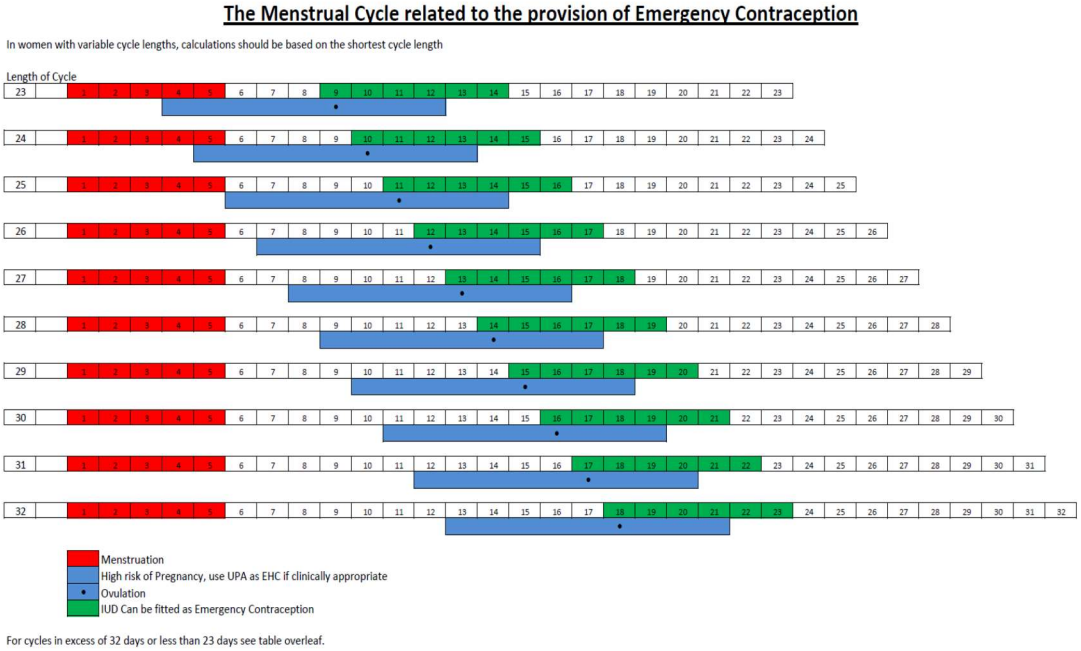
Do patients need to be registered with a GP in Scotland to access either EHC or Bridging Contraception services?

EHC – Eligibility for accessing EHC has not changed as part of the recent review: registration with a GP practice in Scotland is not essential to access this service.

BC – Eligibility for accessing bridging contraception has been extended to mirror eligibility for NHS Pharmacy First Scotland – it now includes all patients registered with a GP practice in Scotland or Defence Medical Services (on a permanent or temporary basis), or living in Scotland (including gypsy travellers or asylum seeker/dependent of an asylum seeker). Visitors to Scotland are excluded.

Which form of EC is most appropriate?

The tables below give an indication of when ovulation is likely to occur in relation to the length of the menstrual cycle.



The Menstrual Cycle related to the provision of Emergency Contraception

High risk of Preganancy, use UPA as EHC if clinically appropriate
Ovulation
IUD Can be fitted as Emergency Contraception

Cycle length	Day of Ovulation	High Risk of pregnancy Days	IUD fitting start day	IUD Fitting End Day
19	5	1 to 8	5	10
20	6	1 to 9	6	11
21	7	2 to 10	7	12
22	8	3 to 11	8	13
23	9	4 to 12	9	14
24	10	5 to 13	10	15
25	11	6 to 14	11	16
26	12	7 to 15	12	17
27	13	8 to 16	13	18
28	14	9 to 17	14	19
29	15	10 to 18	15	20
30	16	11 to 19	16	21
31	17	12 to 20	17	22
32	18	13 to 21	18	23
33	19	14 to 22	19	24
34	20	15 to 23	20	25
35	21	16 to 24	21	26
36	22	17 to 25	22	27
37	23	18 to 26	23	28
38	24	19 to 27	24	29
39	25	20 to 28	25	30
40	26	21 to 29	26	31
41	27	22 to 30	27	32

Patients should be advised that Cu-IUD is the most effective method of EC.

- It may also be appropriate to provide oral EC as immediate treatment as well as referring the patient for Cu-IUD, in case it is not possible to access this service in the required time frame.
- If Cu-IUD is not appropriate or acceptable, patients should be advised that oral EC should be taken as soon as possible if there has been UPSI within the last 5 days.
- Patients should be advised that evidence suggests that **UPA-EC and LNG-EC are unlikely to be effective if ovulation has already occurred.**

UPA-EC is the most effective oral EC and should be considered as first line treatment, unless there are any contraindicating factors. It is licensed for use up to 120 hours post-UPSI.

LNG-EC may be considered first line if UPSI is unlikely to have occurred in a fertile period and quick starting of ongoing contraception is planned, patients with severe asthma managed by oral corticosteroids (UPA-EC is contraindicated in the circumstance), or a patient has recently taken a progestogen (e.g. missed pill). It is licensed for use up to 72 hours post-UPSI.

Comparative estimated efficacy of emergency contraceptive (EC) methods		
If 100 women have one episode of unprotected sex	**Days 9 – 18 of cycle**	**Days 1-8 or 19-28 of cycle**
Number of pregnancies if no EC used	20 – 30 pregnancies	2-3 pregnancies
Cu-IUD inserted before implantation i.e. Day 19, or < 120 hours after UPSI at any point in cycle	< 1 pregnancy	< 1 pregnancy
Levonorgestrel < 72 hours after UPSI	3-4 pregnancies	< 1 pregnancy
Levonorgestrel between 72 and 120 hours (unlicensed)	9 pregnancies	< 1 pregnancy
Ulipristal < 120 hours after UPSI	< 3-4 pregnancies	< 1 pregnancy

What advice should be given if patient is likely to have already ovulated at time of UPSI?

Cu-IUD can be used effectively as EC until Day 19 of a 28 day cycle, therefore should be advised as first line treatment.

Judging whether ovulation has occurred can be difficult, given that it can vary from patient to patient, month to month, and that the patient may not be aware when they ovulate.

EC can be offered on any day of a natural menstrual cycle, particularly if there is uncertainty as to whether ovulation has occurred, or if the patient requests treatment for peace of mind.

If the patient has ongoing concerns regarding their risk of conception, they should be referred to local Sexual Health Services.

What advice should be given to patients with a high Body Mass Index (BMI) regarding effectiveness of EC?

The effectiveness of Cu-IUD is not known to be affected by weight or BMI. The effectiveness of oral EC may be reduced in patients with a BMI > 26kg/m^2 or >70kg.

If CU-IUD is not indicated or not acceptable:

- Patients should be offered UPA-EC at normal 30mg dose.
- If this UPA-EC is not suitable, a double dose (3mg) of levonorgestrel is recommended. **Note this is an unlicensed indication.**

Can the patient be offered UPA-EC if they have taken a progestogen in the last 7 days?

If the patient has taken a progestogen in the last 7 days (as oral EC, regular contraception or a gynaecology prescription), the effectiveness of UPA-EC could theoretically be reduced by remaining circulating progestogen.

- Patients requesting EC due to contraceptive failure (CF) (i.e. missed pill) in the last 72 hours should be advised of this, and supplied LNG-EC if appropriate.
- If UPSI/CF has occurred between 72 – 120 hours and UPA-EC is supplied, the patient should be advised to stop taking their regular contraceptive for 5 days after taking UPA-EC to avoid compromising the ability of UPA-EC to delay ovulation.
    - Abstinence or a barrier method of contraception should be used for these 5 days, plus an additional further 7 days after re-starting the regular contraceptive (2 days if desogestrel POP is used).

What advice should be given if the patient has already had UPSI/CF (with or without oral EC) within the current cycle?

It may be more appropriate to refer these patients for review by GP or SHS for a review of their contraceptive options.

However, if clinically appropriate, or dictated by circumstance e.g. weekend/evening, oral EC can be offered to a patient if they have had UPSI earlier in the same cycle as well as within the last 5 days, as evidence suggests that they do not disrupt an existing pregnancy and are not associated with foetal abnormality.

If a patient has already taken UPA-EC, LNG-EC should NOT be taken in the following 5 days to avoid compromising the ability of UPA-EC to delay ovulation. UPA-EC could theoretically be less effective if taken in the following 7 days after taking any progestogen, therefore use of LNG-EC rather than UPA-EC may be considered.

Note: Some Health Boards stipulate in their PGD that LNG-EC can only be supplied once per cycle, but this varies across Scotland. **Please check the PGD issued by the Health Board you are working in.** Additional supplies within the same cycle could be sold if clinically appropriate.

What options are provided for patients with UPSI/CF more than 120 hours prior?

Following referral, sexual health practitioners may decide it is still appropriate for patients to receive Cu-IUD or oral EC. They can also discuss and supply more suitable ongoing contraception.

Why are patients who have given birth up to 3 weeks ago not suitable for oral EC?

Contraception is not required until Day 21 after childbirth. Patients should be reassured that they cannot become pregnant at this time.

What advice should be given to breastfeeding mothers regarding oral EC?

Breastfeeding is not recommended for 7 days following ingestion of UPA-EC. Advise the patient to express and discard the breast milk during this time.

There is limited evidence regarding the use of LNG-EC in breastfeeding, but there is no suggestion of adverse effects on breastfeeding or the infant.

Does oral EC affect the ability to drive or operate machinery?

UPA-EC (Ella One®) may have minor or moderate influence on the ability to drive or use machines as mild to moderate dizziness is a common side effect. Advise patients not to drive or operate machinery if they experience dizziness.

No studies of the effect on the ability to drive and use machines have been performed on LNG-EC.

Why is there a PGD for the supply of LNG-EC but not UPA-EC?

UPA-EC (Ella One®) is a Pharmacy Only medicine and therefore does not require a PGD to supply to patients. The PGD for LNG-EC allows access to the more cost effective Prescription Only Medicine products rather than supply the Pharmacy Only medicine Levonelle.

How long should written records of EC consultations be kept for?

Details of record keeping requirements can be found at:

Scottish Government. *Scottish Government Records Management.* Edinburgh 2020. Available at **SG-HSC-Scotland-Records-Management-Code-of-Practice-2020-v20200602.pdf** (Accessed 5th April 2024)

Record Type	Minimum retention period
Adult	6 years after date of last entry or 3 years after death if earlier.
Children's health records	Retain until the patient's 25th birthday or 26th birthday if the young person was 17 at the conclusion of treatment, or 3 years after death.

Are transgender patients eligible for EC?

Patients are eligible for oral EC if they are physiologically at risk of becoming pregnant (e.g. trans men) regardless of gender or physical appearance.

LNG-EC or UPA-EC can be used alongside hormones used for gender reaffirming treatment. These hormones are not being used as contraception and will not necessarily be sufficient to prevent pregnancy.

These patients will likely not have regular menstruation so a pregnancy test should be used to exclude pregnancy.

When in the menstrual cycle can Bridging Contraception be started?

When to start		Additional contraceptive precautions required?	Notes
Day in cycle when starting desogestrel			
• Day 1 - 5		No	
• Day 5 – end of cycle	"Quick start" possible if reasonably certain patient is not pregnant	Yes – for first 48 hours	Follow up pregnancy test at least 21 days after last UPSI See "What is Quick starting contraception" question in this document for further information
Following EHC			
• LNG - EC	Can be started / restarted immediately	Yes – for first 48 hours	Follow up pregnancy test at least 21 days after last UPSI
• UPA – EC	Delay starting for 5 days following EHC	Yes – for first 48 hours	Follow up pregnancy test at least 21 days after last UPSI
Changing from combined oral contraceptive (COC)			
	Can be started immediately providing COC has been taken consistently and correctly.	No	Pharmacist must be reasonably certain patient is not pregnant and there has been no risk of conception.
After birth			
• Up to Day 20		No	
• Day 21 onwards		Yes – for first 48 hours	
Following miscarriage or termination (surgical or 2nd part of medical termination)			
• On the day or up to 4 days following		No	
• Day 5 onwards		Yes – for first 48 hours	

Which conditions are classed as UKMEC 3 or UKMEC 4?

See **UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) - Faculty of Sexual and Reproductive Healthcare** (Accessed 16 September 2024) for further details.

Table 3: Medical conditions that are UKMEC3 or UKMEC4 for use of the progestogen-only pill[45]

Condition	UKMEC category for POP use	Comments
Current and history of ischaemic heart disease	UKMEC3 for continuation (UKMEC2 for initiation)	Duration of use of POP in relation to the onset of CVD should be carefully considered when deciding whether continuation of the method is appropriate (this is a precaution in case the POP somehow contributed to development of CVD)
History of stroke	UKMEC3 for continuation (UKMEC2 for initiation)	
Current breast cancer	UKMEC4	For individuals with a history of breast cancer, any decision to initiate hormonal contraception may be best made in consultation with their oncology team
Past breast cancer	UKMEC3	
Severe (decompensated) cirrhosis (associated with, eg, ascites, jaundice, encephalopathy or gastrointestinal haemorrhage)	UKMEC3	
Hepatocellular adenoma or carcinoma	UKMEC3	

Initiation: Starting a method by an individual with a specific medical condition.
Continuation: Continuing with the method already being used by anindividual who develops a new medical condition.
CVD, cardiovascular disease; POP, progestogen-only pill; UKMEC, UK Medical Eligibility Criteria for Contraceptive Use.

UKMEC	Definition of UKMEC category
Category 1	A condition for which there is no restriction for the use of the method.
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable.
Category 4	A condition which represents an unacceptable health risk if the method is used.

Which conditions are classed as UKMEC Category 2?

UKMEC Category 2 conditions – the advantages of using desogestrel generally outweigh the theoretical or proven risks. See **UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) - Faculty of Sexual and Reproductive Healthcare** (Accessed 16 September 2024) for further details.

When can a further 3 months of desogestrel be supplied to the same patient?

Professional decision making will be required to decide whether a second supply of 84 desogestrel tablets is appropriate. Consideration should be given to the patient's ability to access a continuing supply from an alternative source, as well as the risk of unplanned pregnancy.

What is “Quick starting” contraception?

FSRH Clinical Guideline: Quick Starting Contraception (April 2017) - Faculty of Sexual and Reproductive Healthcare

- Healthcare practitioners can be reasonably certain that a patient is not currently pregnant if any ONE or more of the following criteria are met and there are not signs or symptoms of pregnancy:
    - They have not had unprotected intercourse since the start of their last normal (natural) menstrual period, since childbirth, abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
    - They have been consistently and correctly using a reliable method of contraception (For the purposes of being reasonably certain that a patient is not currently pregnant, barrier methods of contraception can be considered reliable providing they have been used consistently and correctly for every episode of intercourse).
    - They are within the first 5 days of the onset of a normal (natural) menstrual period.
    - They are less than 21 days postpartum (non-breastfeeding women).
    - They are fully breastfeeding, amenorrhoeic AND less than 6 months postpartum.
    - They are within the first 5 days after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
    - They have not had intercourse for > 21 days AND has a negative high-sensitivity urine pregnancy test (able to detect hCG levels around 20mIU/ml). (In pharmacy testing not required.)
    - If a patient wishes to wait to start contraception once pregnancy is excluded, they should be advised to do so following a negative pregnancy test no sooner than three weeks following the last episode of UPSI (Vaginal bleeding following EHC cannot be relied on as a marker of non-pregnancy).

- Additional contraception e.g., barrier method should be used for the first 2 days when desogestrel is started outwith the first 5 days of a normal menstrual period.
- When quick start is offered, the patient should be informed of the potential risks and advised to carry out a pregnancy test 21 days after last UPS.

What is the role of the community pharmacy in supporting people who disclose they have experienced rape or sexual assault?

At times of crisis many people struggle to identify services that may support them - this is particularly true in cases of sexual violence. For population groups who are further disadvantaged this may be compounded by barriers they already face in accessing care. The accessibility of community pharmacies could provide a valuable resource in supporting people who have experienced rape or sexual assault.

People who have experienced rape or sexual assault may need to access EHC and therefore attend their local pharmacy as a first step.

You may be seeing the person in the immediate aftermath of the rape, or asking if they are seeking EHC as a result of a sexual assault may lead to a disclosure of past abuse. Remember, people who have experienced rape or sexual assault can present in many different ways – upset, angry, completely calm, practical and business-like, distracted and dissociative, confused, or unsure of what actually happened.

What is routine enquiry?

Routine enquiry means asking everyone that attends the pharmacy for EHC if they are doing so as a result of a rape or sexual assault. This is regardless of whether there are any indicators or suspicions of abuse.

As up to 90% of EHC consultations take place in community pharmacies, this provides an opportunity to sensitively enquire whether the need for EHC is the result of assault and provide information and referral to other services if needed.

You may feel unsure about what to say during routine enquiry or following disclosure and are concerned about causing distress. This is understandable and reflects your care for your patients.

Routine enquiry of domestic abuse and/or sexual abuse is already established in maternity, sexual health, health visiting, substance misuse and mental health settings in recognition of the disproportionate number of women accessing these services who have experience of abuse.

It is important to think about when would be the most appropriate time during the consultation to ask the question? It's not the type of question that should be tagged on at the end of a consultation.

A useful way of introducing the question is to set out the context of why you are asking, letting them know it is routine and that everyone seeking EHC is being asked. Reassure them that it is not for the purposes of informing the police. See below for an example of how you can do this, however it is important that you find a form of words that you are comfortable with.

Setting the context: "We know that many people who are asking for EHC might be doing so because they didn't consent to the sexual act and are afraid they may become pregnant, so we're asking every woman who comes to us for contraception if this was the case."

Provide more information to help their understanding: "It doesn't have to have been forced or violent, because we know that for many women, they don't have a choice or they might be unable to say no because of the consequences."

Asking the question: "Did you consent to your last sexual contact?" or "Are any of these points something that has happened to you?".

Do not ask if:

- They cannot be seen on their own
- They don't have adequate language support (friends and family must not be used as interpreters)

- They are in distress or crisis
- They are too heavily under the influence of alcohol or drugs
- It would be unsafe for you or the person
- There is insufficient time to respond
- You cannot have a private, confidential space to hold the conversation

What do I do if someone discloses they have been raped or sexually assaulted during the EHC consultation?

Guidance is currently available on the "Right Decisions" website **Disclosure of rape or sexual assault (SARCS) | Right Decisions (scot.nhs.uk)**, which can be printed out for use in a pharmacy setting.

There is a training module for all healthcare professionals in responding to disclosures of rape and sexual assault currently in development. Details of this will be communicated to the community pharmacy network when it becomes available.

The revised EHC assessment form has space for the pharmacist to note whether there are any concerns in regard to unsafe relationships / adult protection issues or if there has been a disclosure of sexual assault / rape.

If available, you should provide the 'Turn to SARCS leaflet', as the person may not wish to take anything home with them.

What is a Sexual Assault Response Coordination Service (SARCS)?

A SARCS is a dedicated NHS service which provides the healthcare and support to people in the days after a rape or sexual assault.

Health Boards in Scotland have a statutory duty to provide forensic medical services to people who have experienced rape or sexual assault. The details of this duty are laid out in the **Forensic Medical Service (Victims of Sexual Offences) (Scotland) Act 2021 (FMS Act).**

The FMS Act also allows for people aged 16 years and over to self-refer to a SARCS for a forensic medical examination (FME), subject to professional judgement. This means that people can access a FME and healthcare at a SARCS, without first having to make a report to the police.

There is a SARCS in every Health Board area. You should familiarise yourself with the contact details / location of the centre closest to where you practise.

Further information on SARCS can be accessed at **Turn to SARCS | NHS inform**

As part of the 'Turn to SARCS' national awareness raising campaign, several information videos were developed to explain the role of SARCS:

- **Turn to SARCS promotional video Turn to SARCS (YouTube)**
- **What is a SARCS and how can it help? – (YouTube)**
- **How can the NHS Sexual Assault Response Coordination Service (SARCS) help me? (youtube.com)**

Are there leaflets available to give patients?

Patients can be directed to:

Contraception | NHS inform

Emergency contraception | Contraception Choices

Emergency contraception | NHS inform

How do I claim for EHC or Bridging Contraception services?

Claims for both EHC and Bridging Contraception should be submitted via Universal Claim Form (UCF) system.

EHC – as part of the update to the EHC service specification, payment will now be made for the completion of a consultation rather than just on supply.

Service	Claim options		
EHC	Advice only	Treatment supplied	Refer to other healthcare professional
Bridging Contraception	Advice only	Treatment supplied	Refer to other healthcare professional
EHC + Bridging Contraception	This option has been removed from PMR systems. Claims should be processed separately under each element rather than using the joint option.		

Flowchart for Emergency Contraception (EC)

Ulipristal Acetate (UPA-EC) versus Levonorgestrel (LNG-EC) if Copper IUD (Cu-IUD) is not appropriate or acceptable.