

FIGO statement on emergency contraception

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Abstract

Emergency contraception remains an essential component of comprehensive contraceptive care and reproductive autonomy. Despite being safe, highly effective, and associated with almost no absolute medical contraindications or age limits, emergency contraception is often underutilized due to systemic barriers, limited access, persistent misconceptions, and inconsistent clinical guidance, provider knowledge gaps, or stigma. This FIGO Committee statement provides an evidence-based overview of the current landscape of emergency contraception, including available methods such as the copper-bearing intrauterine device, levonorgestrel, and ulipristal acetate pills and combined oral contraceptives as well as their mechanisms of action, safety, repeated use, and key implementation challenges. The statement also presents practical recommendations to improve equitable access and uptake, including integrating emergency contraception into routine family planning, sexual violence, and sexually transmitted infection care as well as promoting advance provision, strengthening provider education, and supporting advocacy and policy efforts to reduce barriers to access. FIGO calls upon governments, donors, and health professionals to uphold every individual's right to timely access to emergency contraception, affirming this is not only a clinical issue but a matter of reproductive justice.

KEYWORDS

contraceptive access, emergency contraception, family planning, global health, sexual and reproductive health

1 | INTRODUCTION

Emergency contraception (EC) is defined by the World Health Organization (WHO) as methods used to prevent pregnancy that can be used after sexual intercourse.¹ Given the high rate of unintended pregnancies worldwide—whether from factors such as a lack of

contraceptive use, method failure, incorrect use, or sexual assault—EC is a vital medical and social resource.^{2,3}

Emergency contraceptives are highly effective when used within 5 days of unprotected intercourse and remain the only effective method of pregnancy prevention after a sexual encounter.¹ With almost no absolute medical contraindications or age limits, they serve as

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an accessible and equitable option to prevent unintended pregnancies and reduce unsafe abortions and maternal morbidity and mortality.^{1,4}

Demand for emergency contraceptives is rising, making access, provision, and counseling an important area for physician focus. According to a United States Agency on International Development (USAID) report, since 2010, emergency contraceptive pills have been one of the fastest-growing methods offered in the public sector, rising from 48% of countries in 2010 reporting offering EC to 78% in 2021.⁵

This statement outlines evidence-based recommendations to strengthen access, clinical guidance, and policy support for EC globally.

2 | LANDSCAPE

Methods utilized for emergency contraceptives include:¹

- Copper bearing intrauterine devices (Cu-IUDs)
- Levonorgestrel pills (LNG): single dose (1.5 mg) or as a split dose (one dose of 0.75 mg of LNG followed by a second dose of 0.75 mg of LNG 12h later)
- Ulipristal acetate (UPA) 30mg single-dose pill
- Combined oral contraceptives (COCs)
- In some countries, LNG IUDs and mifepristone are also used as EC^{6,7}

2.1 | Mechanism of action

The Cu-IUD interferes with sperm maturation and motility and is the most effective method of EC, with efficacy exceeding 99%.⁸ It can be fitted up to 5 days after earliest ovulation; however, it does require a clinic visit and a trained provider.⁶ The Cu-IUD used for emergency contraception confers the dual benefit of preventing the current unintended pregnancy risk while simultaneously providing effective long-term contraception for those wishing to avoid future pregnancies. Emergency contraceptive pills (ECPs) work by preventing or delaying ovulation and are likely ineffective after ovulation has occurred.⁸ ECPs are not abortifacients.^{1,9} ECPs should be taken as soon as possible after unprotected intercourse and remain effective for up to 120h after exposure, though efficacy decreases as the interval from intercourse increases.¹⁰ Although ECPs are still effective between 72 and 120h, UPA may be more effective during this later window than LNG or combined estrogen-progestin methods and may be more effective in those with an elevated body mass index.^{10,11} UPA and LNG ECPs are generally preferred over combined ECPs because they are associated with fewer adverse effects, including nausea and vomiting.¹²

Despite their safety and proven effectiveness, knowledge and use of EC remain low. A multi-country Guttmacher study found that the proportion of women who had heard of EC ranged from 2% in Chad to 66% in Colombia, and the proportion of sexually

experienced women who had used it ranged from less than 0.1% in Chad to 12% in Colombia.¹³ Barriers include limited availability, cost, misinformation, restrictive regulations, and social stigma.^{14,15} Disparities are particularly pronounced in low- and middle-income countries (LMICs), rural areas, and among adolescents, who often face the greatest challenges in accessing timely care.¹⁴

2.2 | Safety profile

According to the 2025 WHO Medical Eligibility Criteria (MEC), all EC options are effective, safe, and generally well tolerated.⁴ The Cu-IUD can be safely inserted in both parous and nulliparous women and caution should be used in individuals with sepsis or active pelvic infections (category 4), heavy vaginal bleeding, or thrombocytopenia (category 2/3).⁴ LNG, UPA, and COCs are also safe and effective options, though each method has specific contraindications as outlined in the WHO MEC. For example, COCs are contraindicated in individuals with certain cardiovascular conditions, thrombosis risk, severe liver disease, or migraine with aura.⁴ Overall, EC methods remain safe, and method selection should be guided primarily by timing, medical eligibility, and patient preference.

2.3 | Repeated use

Repeated use of ECPs within the same menstrual cycle is permitted without restriction (MEC category 1).⁴ Although to date there are limited data on this, available evidence does not demonstrate significant safety concerns. A recent study assessing provider knowledge, comfort, and counseling demonstrated that repeated use of EC as well as pre- and peri-coital use of EC is being practiced in many countries, although it is not endorsed as a substitute for ongoing contraception.¹⁶ Importantly, ECPs prevent pregnancy only from acts of intercourse that occurred before their use and do not provide ongoing protection against pregnancy from subsequent intercourse. Therefore, individuals remain at risk of pregnancy shortly after taking ECPs unless another contraceptive method is initiated. Individuals may resume or initiate regular contraceptive methods after ECP use in accordance with method specific guidance; for example, after taking LNG EC, hormonal contraception can be quick-started immediately whereas with UPA waiting 5 days is recommended.¹⁷ On the other hand, as before mentioned, the IUD provides ongoing contraception after placement.

3 | CHALLENGES

Even though EC methods remain safe, effective, and well tolerated, there remain challenges in awareness, access, and uptake. Regulatory and policy barriers including prescription requirements or lack of inclusion in national essential medicine lists inhibit access. Providers may lack training in methods, be misinformed about mechanisms of action or have moral objections to provision. There is also

stigma surrounding EC in situations where it is equated with abortion. On top of these, cost, stock outs, and lack of integration with other aspects of reproductive and primary care lead to underuse, delayed access, and inequitable distribution of EC.^{18–20}

4 | RECOMMENDATIONS

1. Integrate EC into routine family planning care: Ensure all pregnancy capable individuals are counseled on EC during routine contraceptive counseling. This includes training providers and midwives to dispense all available forms of EC per evidence-based guidance and to counsel without bias. All individuals presenting for EC should also receive counseling on regular contraceptive methods to help reduce reliance on EC as a primary form of contraception.
2. Incorporate EC into gender-based violence (GBV), postpartum, post-abortion, and sexually transmitted infection (STI) care: This includes ensuring that EC is included in protocols for post-rape care, postpartum and post-abortion counseling, and humanitarian settings. Particularly important in this is integrating STI screening alongside EC provision for those who had unprotected intercourse, as well as considering their risk factors and need for possible post-exposure prophylaxis.
3. Enable concurrent provision with other contraceptive methods: Offer EC concurrently with initiation of other contraceptive methods, when appropriate.
4. Promote advanced provision of EC: Support the practice of allowing individuals to obtain EC in advance of need, particularly among adolescents. A systematic review showed that use of EC was 2–7 times higher among women who received an advance supply of pills and confirmed the safety of advanced provision.²¹ Another study in Sweden found that advanced prescription shortened the time interval from unprotected intercourse to pill intake without jeopardizing contraceptive use and without increasing sexual risk-taking.²²
5. Strengthen research and monitoring: Encourage research into other EC methods, use as regular or pre-coital methods, and patterns of use and access. Collect data on access, utilization, and method mix through national monitoring systems.
6. Integrate EC into policy and supply systems: Governments should include EC in essential medicine lists, allowing it to be available over the counter when safe and appropriate.
7. Invest in provider education and advocacy: Strengthen pre-service and in-service training. FIGO and its partners urge professional associations, ministries of health, and civil society to collaborate on public education campaigns to dispel myths and promote accurate information.

5 | CONCLUSION

FIGO calls upon governments, donors, and health professionals to uphold every woman's right to timely access to EC. Obstetricians share a responsibility to ensure that no woman or adolescent is

denied the means to prevent an unintended pregnancy due to misinformation, stigma, or systemic barriers.

Access to EC is not only a clinical issue—it is a matter of reproductive justice and gender equity.

AUTHOR CONTRIBUTIONS

All authors were involved in the writing and reviewing of this statement.

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CONFLICT OF INTEREST STATEMENT

All authors of this paper are members of the FIGO Committee on Contraception. The authors have conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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REFERENCES

1. World Health Organization. Emergency contraception. 2021. <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>
2. World Health Organization. High rates of unintended pregnancies linked to gaps in family planning services: New who study. 2019 <https://www.who.int/news/item/25-10-2019-high-rates-of-unintended-pregnancies-linked-to-gaps-in-family-planning-services-new-who-study>
3. United Nations Population Fund. Nearly half of all pregnancies are unintended—a global crisis, says new UNFPA report. 2022 <https://www.unfpa.org/press/nearly-half-all-pregnancies-are-unintended%E2%80%94global-crisis-says-new-unfpa-report>
4. Medical Eligibility Criteria for Contraceptive Use. sixth ed. World Health Organization; 2025 Licence: CC BY-NC-SA 3.0 IGO.
5. USAID. Emergency Contraception Trends from the Contraceptive Security Indicators Survey. 2023 https://www.ec-ec.org/wp-content/uploads/2023/03/EmergencyContraceptives_TechBrief_Final_March2023.pdf
6. Salcedo J, Cleland K, Bartz D. Society of Family Planning Clinical Recommendation: emergency contraception. *Contraception*. 2023;121:1–11.
7. European Consortium for Emergency Contraception. Descriptive analysis of price and availability of emergency contraceptive pills in 127 countries. 2025.
8. Goldstuck ND, Wildemeersch D. Practical advice for emergency IUD contraception in young women. *Obstet Gynecol Int*. 2015;2015:986439. doi:10.1155/2015/986439
9. American College of Obstetrics and Gynecology. Access to emergency contraception. 2017 <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/07/access-to-emergency-contraception>
10. Centers for Disease Control and Prevention. Emergency contraception. 2024 <https://www.cdc.gov/contraception/hcp/usspr/emergency-contraception.html>

11. Cleland K, Wagner B, Smith NK, Trussell J. "My BMI is too high for plan B" a changing population of women seeking ulipristal acetate emergency contraception online. *Women Health*. 2020;60(3):241-248. doi:[10.1080/03630242.2019.1635560](https://doi.org/10.1080/03630242.2019.1635560)
12. Matyanga CMJ, Dzingirai B. Clinical pharmacology of hormonal emergency contraceptive pills. *Int J Reprod Med*. 2018;2018:2785839. doi:[10.1155/2018/2785839](https://doi.org/10.1155/2018/2785839)
13. Palermo T, Bleck J, Westley E. Knowledge and use of emergency contraception: a multicountry analysis. *Int Perspect Sex Reprod Health*. 2014;40(2):79-86.
14. Johnston BK, Janssen PA, Ohtsuka M, et al. Barriers to contraception access and use among youth: a scoping review in high-income countries. *Int J Gynaecol Obstet*. 2026;173(1):74-86. doi:[10.1002/ijgo.70637](https://doi.org/10.1002/ijgo.70637)
15. Eastham R, Milligan C, Limmer M. Qualitative findings about stigma as a barrier to contraception use: the case of emergency hormonal contraception in Britain and implications for future contraceptive interventions. *Eur J Contracept Reprod Health Care*. 2020;25(5):334-338. doi:[10.1080/13625187.2020.1806998](https://doi.org/10.1080/13625187.2020.1806998)
16. Koch MR, Robahn M, Kidula N, Kiarie J, Sridhar A. Global landscape of pre- and peri-coital contraception: a qualitative study of gynecologists. *Int J Gynecol Obstet*. 2026;173:868-875. doi:[10.1002/ijgo.70682](https://doi.org/10.1002/ijgo.70682)
17. The Faculty of Sexual & Reproductive Healthcare. FSRH Guideline Quick Starting Contraception. (pp. 1-32). 2017 <https://www.cosrh.org/Common/Uploaded%20files/documents/1fsrh-guideline-quick-starting-contraception-april-2017.pdf>
18. European Consortium for Emergency Contraception. Global trends on use of emergency contraceptive pills - A summary of available data from selected countries. 2025 https://www.ec-ec.org/wp-content/uploads/2025/11/ECEC_Global-trends-use-of-ECPS_Nov2025.pdf
19. Herrera-Ramirez I, Orozco-Nuñez E, Guerra G, Dreser-Mansilla A, Molina-Salazar RE. Access to essential medicines in low- and middle-income countries: a systematic review of barriers and facilitators. *Int J Public Health*. 2026;71:1608754. doi:[10.3389/ijph.2026.1608754](https://doi.org/10.3389/ijph.2026.1608754)
20. National Women's Law Center. Emergency contraception: Barriers to access. 2011 http://nwl.org/wp-content/uploads/2015/08/ec_barriers_to_access_3.29.11.pdf
21. Rodriguez MI, Curtis KM, Gaffield ML, Jackson E, Kapp N. Advance supply of emergency contraception: a systematic review. *Contraception*. 2013;87(5):590-601. doi:[10.1016/j.contraception.2012.09.011](https://doi.org/10.1016/j.contraception.2012.09.011)
22. Ekstrand M, Larsson M, Darj E, Tydén T. Advance provision of emergency contraceptive pills reduces treatment delay: a randomised controlled trial among Swedish teenage girls. *Acta Obstet Gynecol Scand*. 2008;87(3):354-359. doi:[10.1080/00016340801936024](https://doi.org/10.1080/00016340801936024)

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