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EC AND MEDICAL ABORTION

Emergency contraception and medical abortion: What's the difference?

Emergency contraceptive pills (ECPs) are a safe and effective means of preventing pregnancy after unprotected sexual intercourse. They work by preventing ovulation (the release of an egg) or by stopping the egg and sperm from meeting. ECPs do not terminate or interrupt an established pregnancy.

ECPs are different from medical abortion regimens (which include mifepristone, sometimes referred to as the “abortion pill” or RU-486, and misoprostol, a prostaglandin). Both treatments are of critical importance for women’s reproductive health globally, but confusion between the two can present a barrier to broader emergency contraception access.

What is the difference between emergency contraception and medical abortion?

ECPs are a back-up contraceptive method used to prevent a pregnancy after unprotected sex or contraceptive failure. Medical abortion is a non-surgical option for terminating an established pregnancy.

Emergency contraception refers to contraceptive methods that work after unprotected sex but before pregnancy. These regimens can be taken up to 120 hours (5 days) after unprotected intercourse, well before a pregnancy begins. There are four main types of ECPs: Progestin-only (levonorgestrel), the Yuzpe method (higher doses of regular birth control pills containing estrogen and progestin), ulipristal acetate, and low-dose mifepristone. Mifepristone ECPs contain 10 to 25 mg of mifepristone and are available only in Armenia, China, Russia, and Vietnam.

Emergency contraceptive pills prevent pregnancy primarily, or perhaps exclusively, by delaying or inhibiting ovulation. They will not cause an abortion if a woman is already pregnant when she takes the pills. In the case of levonorgestrel, the most commonly available ECP, there is clear evidence that interference with ovulation is the primary mechanism of action. It is possible that levonorgestrel may interfere with other events *prior* to fertilization (such as impairing the migration of sperm), but it does not have effects *after* fertilization. No evidence supports the theory that levonorgestrel ECPs interfere with the implantation of a fertilized egg.^{1,2,3} The precise mechanisms of action for ulipristal acetate and mifepristone at doses used for EC have not been studied as extensively as those for progestin-only EC, so it is not possible to make definitive statements about how they work. However, evidence suggests that interference with ovulation is a primary effect of ulipristal acetate and mifepristone ECPs, and there is no positive evidence that they would prevent implantation of a fertilized egg. None of these regimens disrupt an established pregnancy.⁴

Medical abortion is used after a pregnancy has been established (when a fertilized egg implants in the uterine wall). While ECPs need to be taken within a few days after unprotected sex, medical abortion is administered after a pregnancy has already been confirmed. There are a couple of different regimens for medical abortion. The drug mifepristone (formerly known as “RU-486”) is approved for use in combination with misoprostol in a number of countries to terminate a pregnancy, but in these cases it is given in a much higher dose and at a different time than when it is used for EC. After a pregnancy is confirmed, the woman takes a large dose (200-600 mg) of mifepristone, typically followed by misoprostol, which causes uterine contractions.⁵ (If mifepristone is unavailable, a higher dose of misoprostol may be used alone for medical abortion.) The dose of mifepristone needed to induce an abortion is 8 to 60 times greater than the dose used for emergency contraception.

Why is this distinction important?

Confusion about the two methods has often led to barriers to accessing ECPs. Significant opposition to ECP access has emerged based on the assertion that ECPs cause abortion and therefore cannot be provided in settings where abortion is restricted. It is important that EC advocates are able to make a clear distinction between medical abortion regimens and ECPs while supporting access to both.

While mifepristone for medical abortion is administered under a health care provider's supervision, use of ECPs does not require prior medical screening. Women can determine their own need for ECPs, which offer a safe, simple, self-administered method to prevent pregnancy after unprotected sex.^{6,7} ECPs are extremely safe for the user and will not cause birth defects if the method fails and pregnancy does occur.^{8,9,10} For this reason, LNG ECPs are available without a prescription in many countries and can be obtained directly from pharmacies.

Why is broader access to ECPs important to women's reproductive rights and health?

ECPs are the only available contraceptive method that a woman can self-administer to prevent a pregnancy after unprotected intercourse. They are especially important in cases where women's rights have already been violated, such as in cases of rape or coerced sex. No matter why a woman needs ECPs, every woman should have the right to unrestricted access to all forms of contraception, including emergency contraception.

Recommendation

No medical or legal barriers should limit the use of ECPs. ECPs are a safe and effective back up means of preventing, rather than ending, unintended pregnancy. Policy makers, medical professionals, and other health advocates should continue to promote ECPs and support their universal availability, timely access, and affordability to women and couples worldwide.

References

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