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Methods of Contraception

By the end of this lesson you should be able to:

- Describe the differences in how hormonal, barrier, and abstinence methods work to prevent pregnancy; and,
- Define each method of contraception.

In addition to thinking about STI prevention, you may also need to consider pregnancy prevention depending on what you’re doing and what body parts are involved.

In this lesson, we’ll cover the different methods of contraception and explain how they work to prevent pregnancy.

Some people may want to tune out this lesson because they think the information doesn’t apply to them. This could be a person with a penis thinking that pregnancy prevention is the responsibility of the person with the vagina. But let’s be real; it takes two people to make a baby and it’s your job to prevent a pregnancy if you are not trying to have a child. It could also be people identifying as gay or lesbian who think pregnancy prevention is a concern for only straight or bi people. In actuality, young people who identify as gay or lesbian are more likely to experience an unintended pregnancy compared to their straight peers.¹ Why is that? Gay and lesbian youth may have sex with someone of a different sex because they want to prove to others that they are straight, or it might be out of simple curiosity, among other reasons. Societal pressures, stigma, and fear still exist around sexual orientation. Remember, sexual orientation does not dictate sexual behavior. In addition, gay or lesbian youth may not have paid attention to previous sex ed lessons that addressed contraception, especially if that education was not inclusive to people of all sexual orientations. As a result they may not have been as prepared to use contraception when they did have sexual contact that had a pregnancy risk.
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Due to these reasons, it’s important for every person to know how to prevent a pregnancy. Someday you might need to know this information in order to protect yourself.

How concerned are you about pregnancy right now?

Video Transcripts
Robin: Absolutely, I am very concerned about becoming pregnant. I'm on a very distinctive path. I still have college to finish up. I already know what my career plan is gonna be for the next 5 years. And I know where I'm want to move and what I'm gonna do. And having a baby right now is not something that really fits into that.
Danica: I don't lay awake at night and worry that I'm pregnant. I mean sometimes it crosses your mind but I really don't see it as happening. So, and I'm careful.
Abby: As a woman, I think I'm always concerned about unintended pregnancy.
K-anna: If I was in a relationship, if I was sexually active, then I feel like pregnancy would be on my mind because I wouldn't want to get pregnant at this time, especially if I wasn't married. So, I would definitely go for a birth control route.
Ashlee: It would really suck to get pregnant right now. I just have so much going on. I want to get done with school and get into a stable job and get a house and all that kind of stuff before I have kids. So, to prevent that, I'm currently taking birth control and then I also use condoms when I have sex with my boyfriend.
Laura: I'm not too concerned about getting pregnant.
Dan: If my partner got pregnant, it wouldn't be the end of the world. I think we're at a point in our lives where we would be open to that. But we're not trying to have a kid yet.
Devyn: If I do have sex with somebody who could potentially become pregnant or somebody who could impregnate somebody else there's always like some sort of a condom there.
Chris P: My concern isn't that bad about pregnancy. My wife's is. She definitely doesn't want to get pregnant for another couple of years. So, therefore I'm concerned. Although, I think if we had a kid right now, I'd be really excited. Ashlee: As much as I love children, I just want to wait to have them.
Robin: It doesn't mean that I don't want to have kids at some point in my life which I'm still not even sure I do, but it just definitely doesn't fit for right now.
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Contraception works in a few different ways depending on the method used.

The main way it works is by keeping the sperm from reaching an egg. This can be done through hormones, barriers, or abstinence.

Hormonal methods work in two ways to prevent pregnancy.

The first is by sending a chemical message to the ovaries to put on the brakes and not release an egg each cycle, which means it prevents ovulation from occurring. If there is no egg available to fertilize, you don’t have a chance of pregnancy. The second thing hormones do is thicken cervical mucus so that it is more difficult for sperm to swim into the uterus. In order to ensure that these processes are happening and prevent pregnancy, the body needs a certain level of hormones on a regular and consistent basis. If hormone levels drop below that critical point, an egg may release or the cervical mucus might thin. All of these factors could lead to a pregnancy. That is why it is so important that hormonal methods are used consistently and correctly.

The second type of contraception is barrier methods. Like the name implies, these methods create a physical barrier between the sperm and the egg.

Finally, the third type of contraception is abstinence methods. By strategically choosing when to have sex, a person can eliminate or reduce their risk of pregnancy.

We’re going to give a brief overview of each type of contraception in order from most to least effective.

When we talk about effectiveness for each method, we’ll be using the phrases typical and perfect use. Perfect use refers to the rate of pregnancy when the method of contraception is used without any user error. So, out of 100 people with a uterus using a particular method perfectly, how many are likely to get pregnant over the course of a year? On the other hand, typical use refers to the rate of pregnancy when there is a typical level of user error, which takes into account the fact that people make mistakes and may not use the method consistently and correctly every time. This could include not taking the pill at the same time every day, putting the condom on halfway through sex, or forgetting to change the patch every week. To give you an example of these rates, if the typical use rate is 92%, that means that over the course of a year and out of 100 people, 8 pregnancies are likely to occur as a result. We’ll talk more about possible user error throughout the lesson.
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This lesson is not meant to be your only source of information on contraception; it’s just an overview to get you thinking about a variety of available options. A healthcare provider or sexual health educator can provide you with more detailed information and answer your questions. Note that many forms of contraception require a consultation with a healthcare provider.

The first method that we’re going to talk about is the only one that is 100% effective when used perfectly: abstinence. If you’re not letting sperm get anywhere near the vagina, then you’re not at risk of pregnancy. While everyone’s definition of abstinence is a little different, for the purposes of pregnancy prevention, abstinence is refraining from sexual activity that has any sort of potential for semen to get on or near the vulva or vagina. Sticking to abstinence can require a lot of will power. Abstinence works whenever a person uses it, but it is very important for people to use it correctly and think about ways to help them either stick to being abstinent for a time, or think about a back-up plan if they decide to have sex. Abstinence also doesn’t mean a person hasn’t had sex before; it just means they aren’t having it right now.

The next most effective method is the implant, which is a flexible plastic rod-shaped device that is inserted under the skin of the upper arm. It’s very small—approximately the size of a matchstick—and contains the hormone progestin. A healthcare provider numbs the area and injects the rod under the skin on the inside of the upper arm. No stitches are needed—just a small bandage. A person using this method should be able to feel the implant if they press gently on the implantation site. The implant lasts for 3 years, but can be removed at any time. To remove the implant, the provider makes a small incision near the end of the device to pull it out. When inserted properly, the implant is very effective, with less than 1 pregnancy out of 1000 users in a year.

Next in efficacy is sterilization. There are a few different methods of sterilization based on the body involved, and how the person wants to proceed.

The first method is a vasectomy, which is for folks who are equipped with working testes. In this procedure, the provider makes one or two small incisions through the scrotum. They locate the vas deferens, a set of tubes that carries sperm through the rest of the
reproductive tract, and separate each one. This can be done by using surgical clips, cauterization, or cutting the tubes and tying off the ends. There is another procedure that doesn’t involve an incision; instead a provider creates a small puncture in the skin. These procedures stop sperm from traveling any further than the vas deferens. When this happens the testes continue to produce sperm, but the body just absorbs them. Ejaculation still occurs, but there aren’t any sperm present. This method is nearly 100% percent effective when done correctly and is meant to be permanent. In very rare cases the tubes can grow back together. After the procedure, with perfect use a person would use a backup method for about three months, or until a lab test shows that there is no longer sperm in the ejaculate. Having sex before this time can result in a pregnancy, and thus is the main cause of failure rates for typical use.

The next methods of sterilization are for people with a uterus and work by blocking off the fallopian tubes, which is known as tubal ligation. Similar to a vasectomy, a healthcare provider cuts the tubes, which prevent an egg from reaching the uterus, and thus possible sperm. They can tie, clip, or use electrical currents to seal them off. This method is effective almost immediately. Another strategy involves placing little inserts into the fallopian tubes so that tissue grows on them and blocks them. This method can take up to a few months to be effective and requires testing to verify that the tubes are blocked. Both methods are nearly 100% effective when the procedures are performed correctly. Like the vasectomy, if a person has sex before they get the go ahead from their provider, they’re risking the chance of pregnancy. These methods are considered permanent, so a person should be completely sure of their decision before they go ahead with sterilization.
The intrauterine device, or IUD as we like to call it, is the next most effective method after sterilization.
The IUD is a tiny T-shaped device made out of plastic that is approximately 1 inch long and is inserted through the cervix and stays inside the uterus to prevent pregnancy. Tiny filament strings, which are similar to fishing wire, are attached to the end of the IUD and hang through the opening of the cervix to assist with removal of the device.

There are three different types of IUDs, two that contain hormones, and one that doesn’t. Mirena© contains the hormone progestin and can stay in the uterus for 5-7 years. Skyla© also contains the hormone progestin, but in a slightly lower dose and can stay in the uterus for 3 years. ParaGard© does not contain hormones, but it is wrapped in copper and can stay in the uterus for 12 years.
All types of IUDs work in similar ways. They basically make it hard for sperm to move around, which makes it really difficult for them to fertilize an egg. The Mirena® and Skyla® have added hormones, which thicken the cervical mucus. For some people, these hormones also tell the egg not to release from the ovary. IUDs are over 99% effective, with less than 1 pregnancy out of 1000 users occurring in a typical year. ParaGard® is effective immediately after insertion, while it may take up to a week for the hormonal IUDs to reach their full efficacy. User error is uncommon because once the IUD is properly inserted, there isn’t much to do. Users should check to feel the filament strings once per month to make sure the IUD is in place. A provider can remove the device at any time if a user decides they want to try another method or get pregnant, or in the rare case they have already gotten pregnant.

Some people are hesitant to get an IUD because of the history of the device. This most likely originates from an IUD in the 1970s called the Dalkon Shield. This particular IUD had strings that were made out of a multifilament wicking material, which transferred bacteria from the vagina into the usually sterile environment of the uterus, causing pelvic inflammatory disease. This resulted in some users becoming infertile and suffering other complications. Rest assured, today’s IUDs are super safe and STIs cannot travel up the monofilament string. Some healthcare providers are hesitant to insert an IUD in someone who has never been pregnant because they think that the uterus is more likely to expel the IUD. Current research shows that this isn’t the case. So...
really, this assumption is based on information that doesn’t even apply today. If you have a provider who won’t insert an IUD because of this reason, be vocal about what you know. If they still won’t budge, consider going to a sexual health clinic that regularly inserts IUDs.

The shot, otherwise known as Depo-Provera®, is an injection of the hormone progestin that is administered every 3 months.

It’s very important to get the shot every 12 weeks to make sure that hormone levels don’t dip down to a level that would release an egg. It can take up to a week after the initial shot to be effective. Other than getting the shot on time, every time, the user action is pretty minimal. Providers do recommend that users exercise and get plenty of calcium and vitamin D while on the shot to mitigate the temporary change in bone density. With perfect use, less than 1 pregnancy out of 100 users will occur in a year. With typical use, about 6 pregnancies will result. This is the one method of contraception that can take a longer amount of time to regain full fertility once it is stopped. The thing about a shot is that once it’s injected, it can’t be sucked out. The hormones have to run their course. It may take up to 6-10 months after injections have stopped to regain full fertility, though for some people it takes much less time.

The ring is just what it sounds like: a clear and flexible plastic ring that contains low levels of estrogen and progestin

The user inserts the ring into the vagina where it hangs out near the top by the cervix. The vaginal muscles conveniently hold it in place. The top two-thirds of the vagina lack nerve endings, so the user doesn’t even feel that it’s there. Some people’s partners can say they can feel the ring during intercourse, but many don’t even notice. The ring remains in place for three weeks and removed for one week, which is typically when the user
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has a period. After that, a new ring is inserted and the process starts again. The hormones that are inside the ring slowly release into the bloodstream during the course of the three weeks.

With perfect use, less than one pregnancy out of 100 users will occur. With typical use, around 9 pregnancies result. There is usually less user error with the ring as compared to the pill because there is less action required. Error is most likely to occur if a person forgets to insert it or remove it at the proper times, or takes it out of the vagina for more than a total of 3 hours over the course of the three weeks. Sometimes it can slip out of place, which can happen if there is a penis, toy, or finger in the vagina. It can take up to a week to become effective after it is initially inserted.

The patch is comprised of a thin plastic beige-colored square that contains estrogen and progestin.

It measures in at approximately 2 x 2 inches. The patch is placed on the body for one week, and then removed and a new patch is reapplied. A user does this three times during the course of a month. Three weeks with a patch, a different one for each week, and one week off. For optimum effectiveness and safety, the patch should only be placed on certain areas of the body: the outer upper arm, buttocks, stomach, or upper torso. It’s important not to place the patch on the breasts because of the hormones.

With perfect use, you’re looking at less than 1 pregnancy out of 100 users per year, and 9 pregnancies with typical use. Folks can reduce the risk of user error by doing a couple of things. The patch should be applied to clean skin that is free of any oil or lotion. It should stick like an adhesive bandage, so it should be held down when applying it to make sure it’s sealed securely. To ensure that the patch doesn’t come loose, lotions or other oil-based products shouldn’t be applied directly around it. Users can shower and get in hot tubs with the patch without worrying about it coming off. It can take up to a week for the patch to become effective after it is initially applied.

Now we’re moving on to the hormonal method that started it all: the pill.

This form of contraception has come a long way since its debut in the 1960s.

While there are many different brands of pills to choose from, they vary by the hormones and dose, and can be grouped within several common types. First is the standard combination pill. These contain a combination of estrogen and progestin. Different brands have unique chemical formulas with varying levels of
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hormones, but they all work in a similar way. For this type of pill, a user ingests one active pill a day for three weeks, and then takes a week off. During the week off, the package of pills contains 7 days of placebo sugar pills that some people like to take in order to keep their daily routine in place. During the course of the month, the hormones build up to a certain level and then start to go down during the off week. This is the week when a period is likely to occur. While it’s not a true period because an egg isn’t released, the body still sheds the uterine lining. The ring and patch work in a similar way by altering hormonal levels.

Another type is the mini-pill, which is progestin only. With the mini-pill, users get 4 weeks of active pills and no placebo pills. Some people get their period during the fourth week, some don’t, and others get spotting during the month.

Finally, another type includes pills that limit the number of yearly periods. Instead of taking a week off of the hormonal pills once a month, the user takes a week off once every 3 months. This means that most people will only get 4 periods a year. Certain brands sell pills like this, but depending on insurance and the provider’s prescription, a user can do the same thing with regularly packaged pills by purchasing an additional month of pills. Some brands are designed for continuous use so that the user keeps taking active pills and never takes placebo pills, which can result in the complete absence of a period. This method is more likely to cause some spotting during the first 6 months of use. Always consult with your healthcare provider before making any of these changes.

With perfect use of the pill, regardless of type, less than 1 pregnancy out of 100 users will occur, rising to 9 pregnancies with typical use. Because of the daily nature of the pill, it requires more user action, and therefore has a higher chance of user error. Usually this is because people forget to take the pill every day. With the mini-pill, it’s particularly important to take it at the same time every day; not doing so can cause an egg to release from the ovary. Getting into a routine, like setting a daily alarm, can help some people remember to take the pill on time every day.

*The diaphragm is a hormone free method of contraception that is composed of a shallow and flexible silicone disk that covers the cervix.*
By forming a barrier between the sperm and the cervix, it prevents the sperm from potentially reaching an egg. In order to use this method, a person has to go to a healthcare provider to get properly fitted for a diaphragm so that it will match their internal shape. The diaphragm is not left in over a continuous period of time, rather it’s inserted before intercourse is going to occur. To use the diaphragm, the user coats the inside of the cup and rim with spermicide and then squeezes the ends together and inserts it into the vagina so that it forms a seal around the top of the cervix. The spermicide has the added protection of killing any sperm that it comes in contact with. After intercourse, the diaphragm must be left in place for 6 hours before being removed; this gives the spermicide time to work its magic.

Diaphragms generally last for 2 years before they need to be replaced. With perfect use, 6 pregnancies out of 100 users will occur in a year, and that increases to 12 pregnancies with typical use. As you can see, there is a noticeable decrease in effectiveness levels as compared to hormonal methods. This is because most hormone free methods have to rely on creating a barrier between the sperm and the egg, rather than being able to control the release of an egg. Failure rates with the diaphragm can be attributed to a couple of different things. Tears or holes in the diaphragm, not using spermicide, or removing it too soon after sex are all possible causes. A significant weight gain or loss can change the internal fit of the device and can cause it to not seal around the cervix, requiring the user to be refitted. Also, oil-based lubricants can break down the silicone.

*We’ve talked a lot about the external condom in terms of STI protection, but we want to say a few words about effectiveness rates for pregnancy prevention.*

With perfect use, 2 pregnancies out of 100 users will occur in a year. With typical use, that number jumps to 18 pregnancies. This disparity highlights the significant role user error plays in unintended pregnancy.

As mentioned in the safer sex lesson, common user errors include:
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- Using an expired or punctured condom
- Putting on the condom in the wrong direction, then flipping it over the right way
- Putting on the condom too late
- Not pinching the reservoir tip
- Not rolling the condom all the way down to the base of the penis
- Not withdrawing immediately after ejaculation

The internal condom is slightly less effective for pregnancy prevention as compared to the external condom.
Perfect use results in 5 pregnancies out of 100 users and typical use results in 21 pregnancies. User error is likely to occur if the condom is expired or punctured, is not inserted before sexual activity begins, or if the penis goes around the side of the condom rather than inside of it.

Withdrawal does not require a prescription or a trip to the store.
This method is pretty simple in terms of the idea, but more difficult in the execution. Withdrawal involves removing the penis from the vagina before ejaculation occurs. Depending on the people who are involved, this may be more difficult to accomplish. One or both partners may want to continue despite knowing that they need to pull out. Also, the person with the penis may not be as familiar with their body and exactly when they will ejaculate. It can take time and experience for a person to know when they are past the point of no return. All of these things can impact the effectiveness of this method, particularly if alcohol or other substances are used.

With perfect use, 4 pregnancies out of 100 users will result. Typical use comes in at 27 pregnancies a year. There are ways to improve the individual effectiveness of withdrawal. A person can try using another backup method of contraception while they work on understanding their body and knowing when to pull out. They should urinate before and between ejaculations and wipe pre-ejaculate off of the penis before vaginal sex. It’s important to ejaculate in an area that is nowhere near the vagina or vulva. This may not be a method to solely rely on because of the varying level of effectiveness. Though, if a person is in a pinch and is going to have sex regardless, withdrawal is certainly more effective than not using any contraception at all.

The sponge is another type of barrier method.
The sponge is made out of plastic foam that contains spermicide. It’s about 2 inches in diameter and looks like a disc with a large dimple. The sponge contains a convenient nylon loop on the end that makes for easy removal. Sponges are single use and come individually wrapped like condoms. The user wets the sponge under water and squeezes it to activate the spermicide. It is inserted deep into the vagina and covers the cervix. It can be put in any time before sex, even up to an entire day. Like diaphragms, the sponge must be left
in for 6 hours after intercourse before it can be removed. It’s versatile because it can be used for multiple acts of intercourse for up to a total of 24 hours. Considering the 6-hour waiting period after sex, the sponge should not be inside the vagina for more than 30 hours.

The sponge has different rates of effectiveness depending on whether or not the user has delivered a baby vaginally before. For users who have never given birth, perfect use results in 9 pregnancies out of 100 users and typical use results in 12. For users who have given birth, perfect use results in 20 pregnancies and typical use results in 24. As you can see, there is quite a difference in effectiveness rates for people who have given birth versus those who haven’t. That is because delivery changes the shape, size, and opening of the cervix. The sponge does not come in different sizes, so it may not provide as much of a physical barrier to people that have delivered a baby vaginally.

**The cervical cap is a barrier method that is comprised of a silicone dome.** It kind of looks like a naval sailor’s hat for the cervix, with one end that has a loop to tug for removal. The cap is fitted by a provider to make sure that it fits the individual user. It’s similar to the diaphragm in that prior to intercourse the user coats the device with spermicide and then inserts it deep into the vagina so that it seals around the cervix. After intercourse, the cap has to stay put for 6 hours before it can be removed. If a user wants to have sex again, they have to insert more spermicide. The cap can be left in longer than other non-hormonal methods, for up to 48 hours. Removing the cap requires more practice than similar barrier methods. The user has to grasp the loop, turn the cap, and push down on the dome to break the seal. A user should know how to insert and remove the cap before they leave the fitting with their provider.

Like the sponge, the cervical cap is more effective for people that have never given birth vaginally, with 14 pregnancies out of 100 users occurring per year. For
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folks who have vaginally delivered a baby, the number goes up to 29 pregnancies. User error can occur if the cap is old or damaged, not properly inserted or sealed, or removed too early, or if spermicide is not used.

**Fertility awareness-based methods involve the user monitoring their body in different ways to try to predict when they are the most and least fertile throughout the month.**

They can choose to abstain from intercourse or use a barrier method on the days when they are more fertile. The four methods are the calendar, cervical mucus, temperature, and symptothermal method.

The calendar method involves recording the start of the period and keeping track of multiple months to look for patterns in ovulation cycles. By doing some quick calculations, a person can figure out their safe and unsafe days. One of the calendar methods is called the standard days method and involves using a set of colored beads, called cycle beads, to help the user keep track of where they are in their cycle. Certain colored beads indicate safe or unsafe days. With perfect use, this method results in 5 pregnancies out of 100 users and typical use results in 8-25 pregnancies.

**The mucus method requires users to monitor the consistency of their cervical mucus throughout the month.**

During the ovulation cycle, the cervical mucus can change between dry, tacky, cloudy, wet, or slippery. Recording what days these stages occur can help the user identify a pattern to track their ovulation. Efficacy varies depending on the particular instructional models that a user follows. With perfect use, this method results in 1-4 pregnancies out of 100 users and typical use results in 2-22 pregnancies.

**The temperature method involves the person taking their basal body temperature via an oral or rectal reading and charting the results.**

Like the mucus method, a person’s body temperature changes slightly during the course of their cycle, sometimes as small as one-tenth of a degree. Charting these temperatures can help predict ovulation and determine safe days to engage in sexual intercourse. Relatively few research studies have addressed specifically the efficacy of basal body temperature in terms of perfect use vs. typical use as most major studies were done in the 60’s, but this method results in 1-19 pregnancies out of 100 users.4, 5
Finally, the symptothermal method is a combination of the previous three methods.

Alone, each of these methods are not as effective; they work best when used in conjunction. With perfect use of all three methods together, it’s less than 1 pregnancy out of 100 users a year, but with typical use can yield 2-8 pregnancies. Before beginning any of these methods, a person should get thorough training on how to use them from a family planning professional who is also supportive of using barrier methods for unsafe days. People who have irregular cycles may struggle with these methods. Fertility awareness-based methods are some of the most user-involved because they can require collecting multiple forms of personal data to predict a person’s ovulation cycle and then acting accordingly based on those safe or unsafe days. In addition, it’s best if a person has a partner who is also committed to using these methods.

Spermicide is a type of substance used to kill sperm.

It can also help create a barrier to the cervix by making it hard for sperm to move. It comes in a variety of preparations, such as gels, foams, creams, suppositories, and dissolvable sheets of film. A person uses their fingers or an applicator to insert the spermicide all the way to the back of the vagina. The package will indicate how long a user needs to wait to have intercourse before the spermicide is effective. If a user is going to go at it again, they have to insert some more spermicide beforehand. Some condoms come pre-lubricated with spermicide, so it’s a good idea to check this out before using them.

The most available type of spermicide contains a chemical called nonoxynol-9. This substance can create irritation or micro-tears to the skin and mucous membranes if used multiple times a day, which can increase the likelihood of HIV and other STI transmission. Talk to your provider if you have any concerns about the use of spermicides.

Spermicide is usually used in combination with other methods like condoms, diaphragms, cervical caps, or imbedded in sponges. It can also be used by itself, although it is far less effective this way, with perfect use yielding 15 pregnancies out of 100 users and typical use resulting in 29 pregnancies.

Breastfeeding is one of those methods that doesn’t apply to most folks, but we still want to mention it.

With perfect use, this method results in less than 1 pregnancy out of 100 users, but with typical use is 2 pregnancies. There are many things that have to happen in order for this method to be used perfectly, and the shelf life is a max of only 6 months post-delivery. The mother has to breastfeed or pump at least every 4 hours throughout the day and every 6 hours at night. The baby cannot be fed any other food. Why all of these criteria? These factors combined stop the body from
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producing the hormone that signals the release of an egg. If there are no hormones, then a user doesn’t have to worry about an egg getting fertilized. However, having a period indicates that breastfeeding is no longer effective for pregnancy prevention. As you can see, this is one of the methods that requires more user action.

Emergency contraception is a backup form of contraception that comes in two different forms: the pill and the copper IUD.

It’s for times like when a person forgets to take their birth control pill or change their patch, has a condom that breaks, withdraws too late, or is sexually assaulted.

The pill form of emergency contraception is commonly referred to as the morning-after pill, or by one of its brand names like Plan B®. These pills are basically concentrated birth control pills that work to send an emergency signal to the ovary to halt the release of the egg. They can work up to 120 hours after exposure, but are really the most effective when used right away and especially within the first 24 hours. They come in a single dose, or two doses taken 12 hours apart. You might have heard rumors that the morning-after pill causes abortions. False. If a pregnancy has already occurred, the pill will not terminate the pregnancy. It’s legal for anyone to purchase the single dose version of Plan B® over-the-counter. However, to obtain all other forms of emergency contraception pills, including generic, and two-dose formulations, you must provide legal proof of age to purchase them over-the-counter, or visit a healthcare provider for a prescription. The restrictions on age limits and access have been changing frequently, so it’s a good idea to research current policies to keep up-to-date. Keep in mind though, you don’t have to scramble in the middle of the night to find a place to get emergency contraception; you can get pills in advance of when you might need them. However, emergency contraception pills should not be used as a primary form of pregnancy prevention.

Resources

CDC - U.S. Selected Practice Recommendations for Contraceptive Use
WHO - Selected Practice Recommendations for Contraceptive Use

The second form of emergency contraception is the copper IUD, or ParaGard®. The IUD can be inserted by a healthcare provider up to five days after unprotected intercourse to help prevent a pregnancy. As a reminder, the copper IUD can be left in the uterus for up to 12 years and is intended as a long-term form of contraception.
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Resources
Current emergency contraception guidelines
Information on How to Access Emergency Contraception

Bedsider Interactive method chart
Please visit the Bedsider Interactive Birth Control Methods chart website or return to page 29 of the online lessons to visit this site.

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