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**DISSERTATION SUBMITTED IN PARTIAL FULFILMENT
OF THE REQUIREMENT AND FOR THE DEGREE OF MASTER OF MEDICINE
IN OBSTETRICS AND GYNAECOLOGY**

1999

DEDICATION

I WOULD LIKE TO DEDICATE THIS WORK TO MY HUSBAND, MR TENFORD PHIRI,
FOR HIS SUPPORT AND PATIENCE AND ALSO TO MY MOTHER MRS ROSEMARY
NG'ANJO FOR HER ENCOURAGEMENT THAT SHE HAS ALWAYS GIVEN ME.

ACKNOWLEDGEMENT

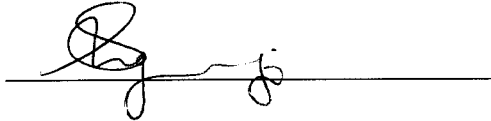
I would like to acknowledge the help of the following people.

1. WHO, for sponsoring the Reproductive Health Research Methodology workshop in Nairobi, Kenya.
2. Dr Yusuf Ahmed, my supervisor, without whose help this dissertation would not have been successfully concluded.
3. Mrs Mulima Ketata, my Research Assistant
4. Ms Moonga Simuyandi, from the Health Information System. UTH
5. The departmental secretaries : ms Rosemary Willombe and Mrs Emma Mutale
6. And above all, to the Alpha and the Omega, who holds all things for good to all who place their trust in him.

STATEMENT

I HEREBY STATE THAT THIS DISSERTATION IS ENTIRELY THE RESULT OF MY OWN PERSONAL EFFORT. THE VARIOUS SOURCES TO WHICH I AM INDEBTED HAVE BEEN CLEARLY INDICATED IN THE BIBLIOGRAPHY AND ACKNOWLEDGMENTS.

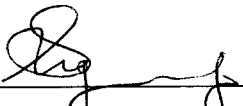
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DECLARATION

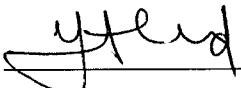
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SIGNED:



DR. SELIA NG'ANJO

APPROVED BY:



DR YUSUF AHMED (SUPERVISOR)

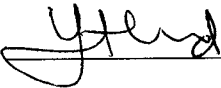
APPROVAL

THIS DISSERTATION OF DR. SELIA NG'ANJO IS APPROVED AS FULFILLING PART OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF MEDICINE IN OBSTETRICS AND GYNAECOLOGY BY THE UNIVERSITY OF ZAMBIA.

SIGNATURE

DATE





21.4.99



ABSTRACT

- Objective:** To explore issues of accessibility, administration, transition to regular family planning, training and management of side effects as applied to emergency contraceptive pills.
- Design:** Questionnaire survey and focus group discussions
- Setting:** University Teaching Hospital (UTH), five local clinics, University of Zambia in Lusaka.
- Subjects:** 52 Health care providers - 18 doctors practicing Obstetrics and Gynaecology and 34 nurse family planning providers. Five groups of up to 15 university students formed focus group discussions, 400 Clients who underwent termination of pregnancy.
- Main outcome measures:** Knowledge of the existence of emergency contraception, how to access it, its administration, handling side effects and acceptance as contraceptive need by clients and by health providers.
- Results:** Fifty-one out of 52 health care providers had heard about ECP, 75% offered emergency contraception as part of their family planning services. Most of those who did not offer it lacked adequate information and a few felt that it was an abortifacient. Most University Students lacked information on emergency contraception. The services were available at their clinic as well as the counselling centre but the students were not free to utilise them. Clients who had termination of pregnancy were mostly lacking in adequate information as well. Twenty-seven percent had experienced method failure whilst 44.8% of all clients said they could have tried to use emergency contraceptive pill if they had known about it.
- Conclusion:** For emergency contraception to have an impact on reduction of unwanted pregnancies more health care providers need to be trained in provision of emergency contraception services. Women need more education on when and how to use emergency contraception as well as its safety, effectively, side effects and where to obtain it from. Its only when women have the knowledge on emergency contraception the health providers would be comfortable to give advance distributions of the pill. Community distribution workers need special training in order to provide services in remote areas.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBDs	Community Based Distributors
COCs	Combined Oral Contraceptive Pills
EC	Emergency Contraception
ECPs	Emergency Contraceptive Pills
HIV	Human Immune Deficiency Virus
K	Kwacha
TOP	Termination of Pregnancy
WHO	World Health Organisation

INTRODUCTION

Contraceptive use has a tremendous impact on women's health. Contraception is saving the lives of women around the world from the hazards of unwanted pregnancy. Optimal child bearing is also contributing to infant and child survival. An unwanted or unplanned pregnancy can have serious physical, mental and social consequences for the woman. These account for a lot of avoidable suffering and avoidable deaths in the world today.

Whereas most family planning methods rely on use before intercourse, emergency contraceptive pills are a method of family planning used after exposure to intercourse to prevent pregnancy. Emergency contraceptive pills are sometimes called post-coital or 'morning after' contraceptive pills. They are usually constituted of two tablets of ethinyl-estradiol / levonorgestrel family planning oral contraceptive pills taken twice orally over a 12 hour period (known as the Yuzpe method (1) and are believed to prevent pregnancy in the exposed woman by mainly preventing ovulation and perhaps even by preventing fertilization (2) but will not affect an already implanted pregnancy. There is over 30 years experience in this method of family planning from all over the world (3) and is also a recognised and approved method of family planning in the Zambia Family Planning Policy Guidelines published in 1997 (4). However the Zambia Contraceptive Needs Assessment in 1995 had demonstrated that despite being available, this method is not well known by clients and providers (5) seriously hampering its use in preventing unplanned pregnancies. Information about, and access to, emergency contraception for women could be important in reducing the abortion rate, but they depend on the attitude of providers. Adolescents rarely use an effective method of contraception when they commence sexual activity and can be potential users. Knowing provider and prospective client views can help illustrate issues involved in

introducing the method as was demonstrated in six developing and developed countries (6) and increase utilization (7). The time frame within which women must use emergency contraception is short, therefore women must know about it before they can use it.

LITERATURE REVIEW

Knowledge about emergency contraception facilitates clients to seek the method, and also gives a chance for health care providers to inform their clients during provision of routine family planning services. In many parts of the world studies have shown that knowledge about emergency contraception is low in both clients and health care providers. This affects other issues in provision of this method such as accessibility, administration, management of side effects and transition to regular family planning. Training of staff and easy accessibility, to emergency contraception have been identified by most clients as some of the steps that need to be taken in order to improve service delivery of this method.

Prediction of contraceptive failure

A 1993 United Kingdom (UK) study to find out whether deregulation of emergency contraception was justified found that about 50% of all pregnancies in the UK were unplanned (8). It went on to report that more than 170,000 pregnancies were terminated annually. Contraceptive failure was responsible for almost 50% of the unwanted pregnancies. About 70% of unwanted pregnancies could be predicted because women knew that they were at risk after unplanned intercourse or an accident with a condom. Emergency contraception could prevent pregnancy in 98% of these cases. Since its failure rate is greater than that of conventional hormonal contraceptives, it is unsuitable for repeat use. Even though most women have heard of emergency contraception, few use it (70% and 3% respectively). Reasons for nonuse, the UK study went on to say, may include denial of pregnancy risk, not knowing where to get emergency contraception, and physicians control of access to it. Other obstacles are that it is embarrassing to

explain to a receptionist why an emergency visit with the physician is needed, and family planning clinics do not provide services seven days a week.

A survey carried out in England from 1994 to 1995, set out to determine whether contraceptive failure was predictable in unplanned pregnancies (9). 629 women attending the unplanned pregnancy counseling clinic at the Ella Gordon Family Planning Clinic in the South of England were interviewed to determine the contraceptive method being used at the time of contraception, whether contraceptive failure was predictable and whether emergency contraception should have been and was used. 47.9% of the women were using condoms at the time of conception while 25.1% were using no contraception. The oldest and youngest women were most likely to use condoms or no method. Oral contraceptive use peaked in the 20-29 year old age group. 64.7% of the unplanned pregnancies could have been predicted based on non-use of contraception or recognised contraceptive failure. Condom problems, oral contraceptive failures, and no contraception, in order of importance, accounted for most predictable failures. 79.5% of the women were familiar with emergency contraception. The results suggested that there were 310 potential users of emergency contraception of the 629 interviewed. The major reasons for non-use of emergency contraception among the remaining women were, in order of importance : unlikelihood of pregnancy, failure to think about it at the time, and no knowledge of emergency contraception. The association of unplanned pregnancy with condom use and a modest increase in the appropriate but failed use of emergency contraception show a clear need for improved patient and public education on emergency contraception.

Knowledge of emergency contraception in teenagers and young adults

Studies have shown a reduction in unwanted pregnancies in places where knowledge and use of emergency contraception is high. A study done in Scotland on teenagers' knowledge of emergency contraception showed that Scottish teenagers are well informed about the existence of emergency contraception and the teenage pregnancy rates have remained fairly constant despite increasing sexual activity (10). It was also found that more teenagers under the age of 16 were sexually active than previously reported, especially those who were low achievers academically. Use of emergency contraception, it was surmised, would increase only when potential users believe it to be safe and know where to obtain it and when to use it.

The use of emergency contraception in adolescents is influenced by attitudes of health providers towards this age group. A national survey of adolescent health experts in Pittsburgh, USA showed that 84% of the physicians interviewed prescribe contraception to adolescents, but only 80% of these prescribe emergency contraception, generally a few times a year at the most (11). Some 12% of respondents said they believe that providing emergency contraception to adolescents would encourage contraceptive risk-taking, 25% said it would discourage correct use of other methods and 29% said they believed repeated use of the method could pose health risks. Physicians may restrict use of the method by limiting treatment to adolescents who seek it within 48 hours after unprotected intercourse (29%), by requiring a pregnancy test (64%) or an office visit (68%), or by using the timing of menses as a criterion for providing the method (46%).

Although young age alone generally poses no biomedical contraindications to selection of any type of contraception, psycho-social and cultural factors may be salient to contraceptive choice

(12). Counseling should include basic information on sexuality and the menstrual cycle, peer pressure, communication difficulties, and sexual inexperience. Barrier methods are especially appropriate for young people since they are affordable, accessible, effective, and confer protection against both pregnancy and sexually transmitted diseases. However, condoms in particular, require partner participation and communication - difficult skills for most youths. In young adults sex is often unplanned and sporadic, the study suggests, and they should accordingly be informed about the option of emergency contraception.

A survey of knowledge and attitudes about emergency contraception among students at Princeton University, USA, showed that basic awareness and approval of the contraceptive pill were widespread, yet students lacked detailed knowledge, which did contribute to health and ethical misgivings about the regimen (13). Students with accurate information, especially those students who know that the therapy is a large dose of regular oral contraceptives and that side effects are generally minor, were significantly more likely than others to report favourable attitudes. Many students confused the pills dispensed by the University Health Services with the abortifacient RU 486. Students noted that discussion of the method is rare, and many wanted to know more about it. Most students agreed that the pills should be easy to obtain when needed, and most thought that the University Health Center should provide them.

Knowledge of emergency contraception in women

In a New Zealand study to determine why women do not use emergency contraception it was found that many women knew about emergency contraception but few were using it (14). The authors indicate that the discrepancy between the numbers of women who knew of the

emergency contraceptive pill (72%) and the numbers who used it to try to prevent pregnancy (7%) indicates that there are barriers to obtaining and using the emergency contraceptive pill. The study demonstrated a lack of knowledge of the emergency contraceptive pill in women attending the abortion clinic. The majority of women seeking termination of pregnancy would have used the emergency contraceptive pill if they had it available at home or over the counter through a pharmacy. The study went on to suggest that doctors prescribing the pill and barrier methods of contraception should consider providing a supply of emergency contraceptive pills at the same time and consideration should be given to over-the-counter prescribing of the emergency contraceptive pill in New Zealand.

A survey of women's knowledge and attitudes in Aberdeen, Scotland, found that knowledge is deficient mainly in relation to the correct timing for the use of the emergency contraception (15) suggesting that publicity should concentrate on the timing of its use. However the survey reported that the popular media are an important publicity vehicle and that many women felt that advertising and over-the-counter availability of emergency contraception should be more widespread.

Knowledge of emergency contraception amongst health providers

The results of a study on general practitioners' knowledge, attitudes and practices in New South Wales, Australia, reflected the difficulty of access to information about emergency contraception for general practitioners and, hence, a real deficiency in access to information for the wider community (16). The likelihood of women being made aware of, or being prescribed emergency contraception in New South Wales depended upon the sex, attitude and knowledge of the

general practitioner consulted. The study recommended that there was a need to further educate both the public and practitioners about emergency contraception.

Providers' attitudes on provision of emergency contraception

American Obstetricians and Gynaecologists, volunteer information of the existence and availability of emergency contraception to only a handful of clients even though 77.5% are very familiar with emergency contraceptive pill and 72% are not opposed to prescribing them (17). Seventy percent report having prescribed emergency contraceptive pills during the preceding year on a very infrequent basis, generally five or fewer times, while 48% of physicians who do not perform abortion for ethical, moral or religious reasons, prescribed emergency contraceptive pills infrequently, but at least once in the previous year.

In countries where emergency contraception is offered, its availability and use vary widely, according to such factors as regulations and policies regarding the method, providers' and women's understanding of, and attitudes toward it, as well as the cost. The experiences with the method in six countries, namely the UK, the Netherlands, Malaysia, China, Mexico, and Nigeria, illustrates a range of issues involved in introducing and encouraging the acceptability of emergency contraception.

In the UK and the Netherlands, the method is an accepted part of family planning practice and is well known among doctors and women. This acceptance may be partly due to the inclusion of the method in the health insurance systems of these countries. Another factor explaining the established role of emergency contraception, at least in the Netherlands, is the lack of moral

debate surrounding the method. Only its side-effects and efficacy seem to engender controversy. The need for emergency contraception is acknowledged and accepted, even for teenagers.

In Malaysia, as in other countries where abortion is strictly regulated, emergency contraceptive methods are marketed legally, but family planning organisations shy away from offering them. In China, emergency contraception methods have long been offered by the government family planning service. However, the methods have not been separated into those advocated for emergency use only and those recommended for ongoing use. In Mexico and Nigeria, awareness of emergency contraception continues to be low among both health care providers and the public. In China the focus of emergency contraception has been on a “visiting pill” for ongoing use by couples who are only frequently exposed to the risk of pregnancy.

Accessibility

In the UK, community family planning services close on ‘bank holiday’ weekends which can stretch up to 3 days (including Mondays). However, people still have unprotected intercourse and women need emergency contraception. Some of the women who seek emergency contraception from community family planning clinics immediately after extended weekends may be beyond the 72 hour limit required for emergency contraception using the Yuzpe method. A pilot study was therefore conducted to assess the feasibility of improving access to emergency contraception services during weekends and ‘bank holidays’ through cooperation between hospital and community-based services (18). The presence of these women attending the hospital ward did not increase the late night or early morning workload of hospital staff. This approach in improving the accessibility and availability of emergency contraception outside of community clinic hours

of operation could therefore be a feasible, viable, and cost-effective complement to existing services.

Sources of information and supplies

A study on women's knowledge and preference about emergency contraception in rural North Wales showed most women would like to obtain information from health professionals although they had previously received most information from the media (19). 36% of women reported their interest in being able to obtain emergency contraception from a pharmacy.

Consideration should be given to alternative suppliers, with publicity targeted through doctors as well as the media. In New Zealand, the Royal New Zealand College of General Practitioners stated that availability of emergency contraception over-the-counter could reduce the number of abortions and unwanted pregnancies, although the best place for women to obtain emergency contraception was from their general practitioners (20). Obtaining such contraceptives from pharmacies, however, may preclude getting the medical advice that general practitioners routinely provide when administering or prescribing such contraception. The New Zealand Medical Association also has serious reservation about the free availability of such a medication because it could be used as normal contraception. The Ministry, however, wants to make pills available through pharmacies for easy availability to improve the limited access to them from general practitioners. People get abortions because of the difficulty in obtaining emergency contraception available through pharmacies without going through a physician first. This would improve access to emergency contraception, but keeps many young girls from making their first contact with a health practitioner.

In the UK and the Netherlands, emergency contraception is an established part of family planning practice and its cost is covered by the national health insurance system (21). The experience in those two countries points to the need both for education of providers and potential acceptors and for a comprehensive network of sources of method supply. In the UK, where the Department of Health has approved emergency treatment for up to 72 hours post-coitally, there is support for making PC4 (each of the 4 tablets contains 50mcg of ethinyl estradiol and 0.5 mg of norgestrel) available from pharmacists without a physicians prescription. A PC4 dose costs US\$14-74 and saves the government health services US\$727-806 per unwanted pregnancy averted. Emergency contraception users in the Netherlands often tend to be adolescents who have never been pregnant and seek the method from a family planning clinic.

Advance distribution

Studies are underway to determine if women who rely on condoms or other barrier methods for contraception should be given emergency contraception to use as a back-up in the event unprotected intercourse or if method failure occurs (22). There is some concern that the availability of emergency contraceptive pills will lead some women to use their barrier method less consistently. Women who are given emergency contraceptive pills prior to unprotected intercourse should be counseled about use, potential side effects, problems requiring further treatment, and what to do in case of emergency contraceptive failure.

Administration

The Vietnamese Government's goal of reducing the number of unwanted pregnancies is supported by increased availability of emergency contraception. A series of focus group

discussions and in-depth interviews conducted in 1995-96 with hospital-based family planning workers from Ho Chi Minh City, revealed widespread support for the concept of emergency contraception, but a lack of accurate information about method use (23). Emergency contraception was regarded as especially appropriate for rape victims, unmarried adolescents, those not in a permanent union, and peri-menopausal women. Providers from eight of the nine hospital sites had heard of or used Postinor (a levonorgestrel only regimen of emergency contraceptive pills) while participants at seven sites were familiar with the Yuzpe regimen and post-coital insertion of a copper-bearing intrauterine device. Providers typically learned about post-coital methods during medical school or at a continuing education seminar. However, even those aware of emergency contraception had substantial misinformation about dosages, intervals between dosages, and the maximum length of time after intercourse that the regimen can be initiated. Moreover, they tended to exaggerate side effects and specify unnecessary contraindications. All participants expressed a need for more comprehensive training. Because these methods are often available from pharmacies, respondents urged that pharmacists be trained to counsel women about the correct use of emergency contraception and suggested that the regimens be specially packaged with clear, simple instructions.

Transition to regular family planning

By offering emergency contraception information and services to their clients, family planning programs can help women avoid unintended and undesired pregnancy. Emergency contraception services can also serve as a first contact point between family planning providers and women who are not using regular contraception but wish to avoid pregnancy.

Obstacles to use of emergency contraception

Awareness of emergency contraception was investigated in a survey of all women seeking pregnancy termination at free-standing clinics in South Wales, Australia (24). Of 2249 women (94% of the total who completed the survey questionnaire), 1567 (70%) had heard of the “morning after pill”. Only 10% women who were aware of the method attempted to obtain it. There was no significant difference in knowledge of this method between the 49% women who were using contraception at the time they became pregnant and those who were not. The authors felt that failure to seek out emergency contraception is presumed to result from a combination of factors, including risk taking, denial, inadequate information, accessibility problems and ambivalence about the pregnancy. Many women, confused by the term “morning after pill”, were unaware that the method can be used up to 72 hours after unprotected intercourse. The authors conclude that a significant reduction in induced abortions could be achieved through more aggressive promotion of post-coital contraception among health care providers and women, provision of an emergency contraceptive pack to acceptors of barrier methods for the use in case of a mishap, and an extension of family planning clinic hours to seven days a week. Similarly in the US, more widespread use of emergency contraception has been hindered by equating the method with abortion, the misperception that pills must be taken the morning after unprotected sex, lack of staff training, lack of consumer awareness of its availability and source, concerns women will substitute the method for consistent contraceptive use, and the lack of any formulation specifically marketed for this purpose.

Efforts to improve use of emergency contraception

The International Planned Parenthood Federation (IPPF) has promoted and offered guidance on emergency contraception for more than 10 years. In 1994, the IPPF surveyed its affiliates on their practices with regard to the provision of emergency contraception (25). On the basis of these results, as well as review of the available research literature, IPPF developed a revised, broadened policy statement on emergency contraception. The IPPF experience with emergency contraception is as follows: despite the IPPF leadership's strong support for emergency contraception, many affiliates do not offer it; at least one affiliate in every region except the Arab world offers emergency contraception; the lack of an approved product designed and marketed specifically for emergency contraception is an obstacle to at least some affiliates which are willing to offer the service; the lack of a perceived need reported by several affiliates may reflect ignorance about the therapy; the survey data indicate that women may need emergency contraception at any age during their reproductive years, for a variety of reasons; staff at all affiliates should be trained to provide emergency contraception and be familiar with the protocols for its use, whether or not the family planning association can currently offer emergency contraception; and emergency contraception needs to be positioned as an option distinct from abortion.

While most reproductive health specialists in America consider the regimen safe and effective and have no objections about prescribing it, few have actually done so. Strategies to increase use of emergency contraception include routine distribution of an appropriate regimen of oral contraceptives, over-the-counter availability, and producing a directory of providers. A national survey on public knowledge and attitudes on contraception and unplanned pregnancy determined

that 47% of adult women in the US potentially facing on unplanned pregnancy would probably use emergency contraceptive pills (17). However, many women are uninformed or misinformed about the emergency contraceptive pill option and few have ever used them. Only 20% of women knew that the pills are effective up to 72 hours after unprotected sexual intercourse. All this pointing to more and better information requirements (17).

Emergency contraception in developing countries

Available information on emergency contraception in developing countries is extremely limited. Although additional research will answer important policy questions, increase awareness of the methods, and help standardise medical practice, existing research is sufficient to suggest that emergency contraception should be provided to women in developing countries while new knowledge is gained. The need in these countries is important because many induced abortions may be illegal and unsafe with serious consequences; women face risks of maternal mortality several times higher than those faced by women in Europe and North America; economic and social conditions prevail that contribute to lower coital frequency such as migration patterns and polygamy; rape has been used as a weapon of political intimidation where social upheaval has led to warfare; increased prostitution with poverty; and a youthful age structure. Currently studies are under way in South Africa and Kenya on issues surrounding emergency contraception.

Making emergency contraception widely available

A consensus statement by various bodies identified three main hurdles to making the option of emergency contraception available to all women who require it (26). Firstly, women and providers are uninformed about the methods. Particularly because of the short time-frame within

which women must use emergency contraception following unprotected intercourse, women must know about the methods before they need them. They encouraged the prophylactic provision of emergency contraceptives so that women could have them on hand as needed. Secondly, there were few products marketed for routine contraception. Thirdly, service providers were too often reluctant to provide this method because of misunderstanding of it being an abortifacient. On the contrary emergency contraceptives prevent unwanted pregnancy.

The April 1995 Bellagio Conference on emergency contraception was sponsored by South to South Cooperation in Reproductive Health, Family Health International, The International Planned Parenthood Federation, the Population Council, and the World Health Organisation with the support of the Rockefeller Foundation. Twenty four experts who met at the conference argued that millions of unwanted pregnancies could be averted if emergency contraception were widely available (27). Recommendations were presented with regard to research, policy, information and communication, and the introduction of emergency methods into health service delivery programs. These included recommendations that governments and non-governmental organisations include emergency contraception in all family planning programs and on all national essential drugs lists; drug regulatory authorities require explicit description of emergency use in the labeling of oral contraceptives and copper IUDs which can be used for emergency purposes; all women seeking emergency contraception, from health providers should be offered emergency contraception and further research be conducted on the use of anti-progestogens for emergency contraceptive use.

RESEARCH QUESTIONS

There are a number of research questions regarding emergency contraception. Some of the major issues are set out as follows:

1. How much do clients and health providers know about this method and how do they accept it?
2. Are there any barriers to its easy accessibility, administration and follow up of clients?
3. Is there a smooth transition to a regular family planning method and is there a need for further training of health care providers ?

With regards to Zambia, little is known about most issues surrounding the use of emergency contraception.

STUDY JUSTIFICATION

Information that clients receive on emergency contraception depends on how much the health care providers know and how they provide this service to the client. It also depends on the attitude of the health care providers towards emergency contraception. As shown in the previously cited Contraceptives Needs Assessment in Zambia (5) most people in the general population, including health providers, seem to be lacking in knowledge about emergency contraception.

It was, therefore, seen necessary to carry out a study to determine how much clients and health care providers know about this method and what their views are. This would help to find out if there are any barriers in trying to introduce emergency contraception more widely. Similarly studies cited in the literature review show that patients undergoing termination of pregnancy could potentially have been users of emergency contraception. Whether this could have been so was deemed worth exploring. As the literature suggests that adolescents appear to be a vulnerable group, their views on emergency contraception were deemed worth exploring.

OBJECTIVES

1. To determine family planning provider perspectives on emergency contraception.
2. To determine the views of University students on emergency contraception.
3. To determine the views on emergency contraception of clients undergoing termination of pregnancy.

METHODOLOGY

1. 34 nurse family planning providers and 18 doctors practicing Obstetrics and Gynaecology were interviewed for their views on emergency contraception using a structured questionnaire with some open ended questions . The number is comparable to reports of studies in regional countries (e.g. Kenya) who had been similarly introducing emergency contraception into their National Family Planning Programme (unpublished). Se Appendix for Questionnaire.
2. Five groups of up to 15 University students each, were invited to focus group discussions on the subject of family planning in general and emergency contraception in particular. The help of a professional focus group facilitator was utilised to assist in the discussions and also to tease out themes (see below).

Participants were invited to take part and they did so voluntarily. No names were recorded. Notes were made during the discussions which typically lasted about an hour. The only other person apart from the author was the facilitator and student counsellor.

3. 400 Clients who underwent termination of pregnancy and were due to go home were invited to give their views on emergency contraception using a questionnaire. This was to explore whether clients could identify the at-risk period and whether any clients would have known about emergency contraception or been in a position to use them.

All clients already had their termination of pregnancy and were ready to go home. Administration of the questionnaire (see Appendix 2) took less than 15 minutes. Signed consent was obtained.

In all the data collecting activities the themes were consideration of the following five issues as were determined to be of relevance in the literature review :

Accessibility (of the product)

Administration

Transition to regular family planning

Managing side effects

Training

ANALYSIS

The analysis was predominantly in the form of summaries of the main issues in a qualitative manner as opposed to being quantitative. The focus was more on the issues rather than numbers and statistics. Results are accordingly mainly in the form of narrative.

RESULTS

I. HEALTH CARE PROVIDER INTERVIEWS

The providers

There were 52 health care providers who were interviewed of which 18 (35%) were doctors (7 females and 11 males) and 34 (65%) were nurses (33 females and 1 male).

Altogether there were 40 females (77%) and 12 males (23%).

Forty (77%) of the health care providers had specialized training in family planning and 12 (23%) did not.

The providers' years of experience ranged between 3 and 37 years.

Forty-five (87%) knew that their facility provided emergency contraceptive pills (ECPs) but 5 (10%) did not know.

Fifty-one providers (98%) had heard about ECPs whilst only one had not.

Thirty nine health providers (75%) offered ECPs as part of the family planning services whilst 13 (25%) did not offer emergency contraception.

Of the 39 who offered ECPs did so, reasons cited were : because it was part of method mix in family planning (11 responses, 11/39=28%), it helped the rape victims and reduced the number of unwanted pregnancies and abortions (6 responses, 15%) it was available at the clinic (18 responses, 46%), it was a personal choice (10 responses, 26%) and because clients had requested it (7 responses, 18%).

Most of 13 who did not offer emergency contraception said they lacked adequate information and a few thought it was an abortifacient.

Twenty-seven of the 52 providers (52%) had heard about ECPs at their local facility, 14 from workshops, 7 from training abroad and 2 from literature or the media. Thirty nine of the 51 (76%) who had heard about ECPs, had done so within the last 5 years.

Accessibility

Of the total of 52 providers interviewed, 49 (94%) correctly responded that their facility was open morning and afternoon during the week whilst the other 3 (6%) wrongly thought that their facility offered services only in the afternoon during the week. Ten providers (19%) correctly said that their facility was open in the morning only on Saturdays. Only the emergency gynae ward at the University Teaching Hospital was open throughout the day, including weekends. The rest of the clinics were closed on Sundays. According to providers, typical clients were those who had unprotected intercourse or had method failure (22 responses, 42%), rape cases (12 responses, 23%), those with prior knowledge of emergency contraception (4 responses, 8%), the young, anxious and ignorant (12 responses, 23%).

Health providers would offer emergency contraception to those clients who had unprotected intercourse within 72 hours (23 responses, 44%), if the clients requested it (14 responses, 27%), after ruling out contraindications such as pregnancy (11 responses, 21%), in rape cases who had attained menarche, (5 responses, 10%), in those who were married (1 response, 0.5%).

Most health care providers felt that emergency contraceptive pills should be made available in the health facility or family planning clinic (47 responses, 90%). Other places cited were the chemist

(11 responses, 21%), through community based distribution agents (6 responses, 12%) at markets (3 responses, 6%), through seminars (2 responses, 4%) from counselling centres (1 response, 2%) on radio, television and posters (2 responses, 4%) and even the church (1 response, 2%).

There were different ways identified by the 52 providers by which to inform women about emergency contraception. These were : health education in clinics and the hospital, 47 responses (i.e. cited by 90% of providers), the media, 22 responses (42%), literature such as pamphlets, 15 responses (29%), circle of friends, 12 responses, (23%), drama or visual aids such as posters, 8 responses (15%).

Fifty-one of the 52 health care providers said they would like to have emergency contraceptive pills more easily available at their site and one would not like it easily available. Those who wanted to have emergency contraceptive pills more easily available felt that this would reduce the number of termination of pregnancies, 9 responses (18%), would enhance continuity and broaden the method mix of family planning, 6 responses (12%).

Administration

Amongst the regimens of emergency contraception that were offered, PC4 (Schering) was the most commonly offered, (cited by 35 providers, 67%). Nine (17%) offered combined oral contraceptive pills like microgynon and two (4%) offered the intrauterine device.

Counselling on emergency contraception included information, education and communication (IEC) on emergency contraceptive pills, 29 responses (56%), side effects expected and what to do, 22 responses (42%), how and when the pill is taken, 13 responses (25%), transition to regular family planning, 21 responses (40%), and the need for further follow up, 6 responses (12%).

Twenty-three health providers said they had publicity materials for clients and 16 had written guidelines. These included information that is provided in the emergency contraceptive pill packet. Further information had been obtained during training.

One of the problems encountered in administration of emergency contraceptive pill was that clients came to the health facility late, that is, after 72 hours, five responses (10%).

Most health providers felt that emergency contraceptive pills should be distributed by physicians, nurses, community based distributors (CBD) workers, pharmacists and clinical officers, 39 responses (75%). However some felt that CBD workers could only be allowed to distribute if they were given more training.

A number of problems were identified by providers which they felt would prevent emergency contraceptive pills from being widely used. Common ones cited included lack of adequate information by clients as well as health providers, 18 responses (35%), problems with availability, accessibility, and affordability, 17 responses (33%), confidentiality about sex, 1 response (2%), misconceptions such as thinking it was an abortifacient, 9 responses (17%), abuse of the drug, 8 responses (15%), negative attitude by providers, 4 responses (8%), religious beliefs, 8 responses (15%), and side effects, 9 responses (17%).

Administration- Advance distribution

Distribution of E.C.P. in advance to clients was supported by 22 health providers (42%) whilst 30 (58%) did not support this idea. Those who favoured advance distribution said that this was good as long as the criteria was met concerning which people could receive ECPs (12 responses, 23%) and as long as women were well informed about when to use them, their side effects and need for

further regular contraceptive use (6 responses, 12%). Those who did not favour advance distribution of ECPs said that most women lack adequate knowledge (5 responses, 10%) and that there would be abuse of the drug for regular family planning and procuring termination of pregnancy (21 responses, 40%). Twenty-five (48%) feared that provision of ECPs in Zambia may lead to abuse. Twenty-seven felt it was good with adequate information to the clients and one felt it was an impossible idea.

Providers suggested that those clients identified as suitable to receive advance supplies were the literate, mature and well informed (21 responses, 40%), those known to have had method failure (11 responses, 21%), those who have had an abortion or unwanted pregnancy (6 responses, 12%), married (5 responses, 10%), those with infrequent sexual encounters (5 responses, 10%), areas with inaccessible health facilities (3 responses, 6%), the young and inexperienced (7 responses, 13%), those in transition of changing a contraceptive method (4 responses, 8%).

Transition to regular family planning

During counselling of patients who are offered ECPs, transition to regular family planning was mentioned by 21 of the 52 providers (40%). More providers feared that the clients may abuse ECP by tending to use it as their regular FP method.

Managing side effects

Twenty-two of the 52 health providers (42%) informed clients about side effects of ECPs during counselling, and what to do when they occur. Nine respondents (17%) said that side effects were one of the problems that would prevent ECP from being widely used.

Training

Training of more health providers was identified by 21 respondents as a means to overcoming one of the challenges in offering ECPs, so that adequate information is given to clients, to prevent abuse and to meet the high demand. Training of health providers could be done through workshops and train other health staff who are in other departments in the hospital. Training for CBD agents was important so that they could handle side effects and clear misconceptions in the community. Another suggestion was to train more nurses in emergency gynaecology wards since they deal with rape victims.

Common Questions asked by providers during administration of the questionnaire

Accessibility and Availability

- Are there enough stocks?
- Are we assured of enough stocks if more people are sensitized to use ECPs?
- Can providers keep emergency contraceptive pills at home and give them out when requested?
- If widely used in Zambia, how many people are using it?
- Are emergency contraceptive pills readily available?
- Will emergency contraceptive pills be sold ?

- Can it be given to men (either young or old?)
- Is it possible to provide it to school children ?
- Are religious leaders going to be interviewed?

Side effects

- Are there major side effects if emergency contraception is used more than once?

Training

- Have you any plans to train more people ?

II. FOCUS GROUP DISCUSSIONS WITH UNIVERSITY STUDENTS

Composition of different focus groups

Group	No. of Participants	Sex	Average Age	Marital Status	Average No. of Children	Year of study	School
UNZA Main Campus	14	2 M 12 F	23	13 Single 1 Married	0	Third (9) Second (3) Fourth (1)	Various
UNZA Main Campus	4	1 M, 3 F	22	4 Single	0	Second (1) Third (3)	3 Education 1 Humanities
UNZA Main Campus	8	8 M	35	Married	4	Third	1 Veterinary 7 Education
UNZA RW	11	11 F	23	Single	0	Fifth	11 Medicine
UNZA RW	9	9 M	25	Single	0	Fifth	9 Medicine

F=Female, M=Male, UNZA=University of Zambia, Main=Main Campus, RW=Ridgeway Campus.

The first two groups at Main Campus of the University of Zambia were mixed by sex and from different schools. The third group consisted of adult male students. The 4th and fifth groups were of medical students, separated by male and female and discussions were held separately.

Knowledge of Family Planning In General

Most of the participants had a good understanding of family planning. Most of them said it was a way of preventing unwanted pregnancies and spacing children. They said the number of children that a couple would decide to have was determined mainly by their economic means. The groups knew most of the methods of family planning. Those mentioned included natural family planning, condom, pill, loop, withdrawal, vasectomy and tubal ligation. Traditional methods mentioned included men wearing something around the loin “to keep the scrotum at high temperature to prevent spermatogenesis”, females wearing some herbs around the waist, adding some powder in porridge, the mother visiting her breast-feeding daughter to reinforce abstinence. A woman would jump up and down after having sex if she did not want to become pregnant. Some women would chew roots.

When the participants were asked which method of family planning was the best, they all noted that all methods had advantages and disadvantages. The best depended on a couple and the type of sexual relationship they were in. The condom was however very suitable. Most of them said it was best because it prevented unwanted pregnancies as well as sexually transmitted diseases including the Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The female condom was very unpopular and some thought it was embarrassing to use although the woman was to some extent in control of the situation.

Most married students said that abstinence was good, however the couple needed to know each other very well. Natural Family Planning was popular amongst the married students

since it had “no side effects”. There was no interference with the hormones in the woman. They noted that the problem was that some women had irregular cycle.

The pill was said to be a good method because it prevented ovulation. Its disadvantage was that it did not help protect against sexually transmitted diseases unless it was used in combination with a condom. It also had side effects like headaches, pimples, and increase in weight. It was thought they may not work especially for those that were just starting to use it.

Permanent methods were encouraged by married students. Those who had the required number of children they wanted could opt for permanent methods. They indicated that these methods, however, brought out a lot of negative reaction from the extended family. Most families would like to have a big number of children. There was also suspicion from one partner of the spouse having another partner elsewhere.

Injectables had an advantage over the pill in that one did not have to take it everyday. Norplant was said to be best for students to help them plan, and it allowed them to complete their education without getting pregnant as it lasted a number of years.

The participants were asked whether they were using any family planning method. Most of them, that is both females and males, said that they were using condoms. Most females and a few males said that they were abstaining. They said “abstinence is the best, “No disease, no pregnancy”. However, they all acknowledged that it was not easy to abstain.

On inquiry as to who made the decision for the most suitable method of family planning for a couple, the students all said that it was important for a couple to discuss and agree on which was the best for themselves. They said that the couple had to be responsible and agree on one

thing if they wanted to avoid unwanted pregnancies. There were a few who felt that the final decision had to come from the woman, since she would suffer the side effects. Some women tend to leave the decision to the husband due to male dominance.

Knowledge on Emergency Contraceptive Pill

A lot of students were ignorant of the emergency contraceptive pill. All the groups were given a scenario of a woman who had been raped or had a condom breaking or forgot to use a pill and therefore suspected that she could become pregnant. All the groups were asked what she could do to avoid the pregnancy. There were different responses such as “I read from a magazine and I heard from friends saying that the woman has to drink a lot of water and then jump up and down to prevent pregnancy”. All the female students in the second group and some in the first group had a good knowledge of emergency contraception. They said that it was being offered freely at the University of Zambia (UNZA) clinic. The students in the second group said that they came to know about it when they had a workshop on emergency contraception in the second semester. They did not know whether a lot of people at the university were using the pill or not. They could not remember how many pills were to be taken. They correctly said that emergency contraceptive pill was taken within 72 hours after unprotected sex. They said that it prevented the eggs from ‘fusing’. There was a good number of male students who had an idea or had heard of it. Most of them said that they had either heard or read about taking a double dosage, or an ‘overdose’ of microgynon, and they said that it was like the woman had aborted.

The group was then told what the emergency contraceptive pill was, how it works, the side effects and when it was supposed to be used. After the explanation, the groups were asked what their views were. All the groups welcomed it .

They expressed:

“I like it because it can be used in case of an emergency like when a condom breaks. It can improve on other methods.”

“Solves the problem in case of rape and the woman does not want to have a child born from rape. The only problem she will remain with is psychological trauma.”

“It would prevent a lot of cases of abortion that happen on campus.”

“Although we have not tried it, I think this method is very effective.”

Others felt that many people will not welcome it on moral and religious grounds.

“Many people think that any intervention after any sexual act to stop pregnancy is considered as an abortion.”

“When does a woman become pregnant? Is it at the time of fertilisation or when the pregnancy is implanted? For many churches, pregnancy begins when fertilisation takes place. As long as many churches believe that fertilisation is the beginning of pregnancy they will shun it on the basis that it is another form of abortion.”

“People will shun it on the basis of religion. Moreover, a lot of churches are against any form of contraception.”

“This is the same as an abortion.”

Other students speculated on the attitude of the people towards emergency contraceptive pill:

“People might begin to use it regularly.”

“If there are side effects, people will definitely shun it.”

“People will have the same attitude as they have to any other contraceptive. They will feel shy to ask for it.”

“It will encourage promiscuity since it will be a refuge for doing wrong.”

“The people that will understand it are those that understand ovulation, fertilisation and implantation.”

“Others will shun it saying that they would rather have something that works regularly.”

Accessibility

Most students both at the Main campus and at Ridgeway campus did not want to go to places to obtain contraceptives where they were known. They all preferred to go to a private place where they would not be known. The counselling center and the UNZA clinic were unpopular because most people think that when one went to the counselling center then they had a very big problem. Some students feel shy to go to the clinic and ask for any family planning method if they were not married because their friends would see them as being immoral. Most medical students at Ridgeway campus opted to have their family planning services at the UTH

although some felt that it was better to buy from the chemist because no one would question them. However, their objection to having these services at the campus did not mean that the services were unnecessary. They felt that family planning services were necessary at the campus for those that had a partner on campus.

Most students at main campus said that the services at the campus were available. They have a family planning clinic every Wednesday afternoon. Others said that the services were underutilised because of the fear of stigma and confidentiality. They felt whoever saw them going to the clinic on Wednesday afternoon would know that they are going for family planning services. Other obstacles cited for the services not being utilised included unfriendly attitude of the nursing staff at the clinic. One student said she was told, “You have already had it at your age! You are too young. You may not have children when you finally want them.”

Administration

Most of the students who knew that emergency contraceptive pill was a large dose of the usual contraceptive pill did not know what dosage or how many pill were to be taken. They gave suggestions as to who should distribute the emergency contraceptive pill. Nearly everyone said that it should be distributed by those that understand the pill properly and can therefore explain to the public well. Some of them suggested that the medical staff should be given to distribute them. Others said that it should be done by those who were already involved in the distribution of other family planning methods. However, the community based distribution (CBD) workers were unpopular since they felt that CBD workers may not understand it well. Whilst some suggested that it should be distributed by pharmacists, others objected because

letting it into the chemist would make it very expensive. They felt that some chemists would not give advice to clients or proper instructions assuming that the instructions had already been given by the doctor.

There was a suggestion from the main campus by the married students that they could form a group call "circle of friends" from the focus group so that they teach and counsel other students.

The students from Ridgeway campus generally wanted to be involved in counselling and teaching about emergency contraception but there were mixed feelings.

"I am very ready to do that after considering all the problems that are associated with pregnancy. However, I would feel guilty that I am encouraging promiscuity."

"I would not mind taking part. I would not even feel guilty for doing that. All I know is that I will be helping people make informed decisions."

Managing of side effects

The students were interested in finding out what side effects could be experienced. In all the groups, the question of side effects was raised towards the end of the discussions even when they had been told during the course of the discussion that the side effects noticed so far from a few people were mild. One of the students wanted to know if there was any reported association with cancer. Some of them wanted to know what might happen if it was taken more than 72 hours after sex.

Transition to regular family planning

The students suggested formation of a “circle of friends” amongst themselves. This group could be involved in teaching and counselling fellow students as well as following up those who may use it so that they are advised on use of a regular family planning method.

Training

The major concern for most of the participants was to make people understand what emergency contraception was. Some of them suggested having a workshop to explain this in full. Most of them felt that proper education for the public was important to avoid misuse. Peer counselling was one of the common suggestions on how best to educate other people. Some suggested having some fellow students trained in counselling about emergency contraception.

III. TERMINATION OF PREGNANCY (TOP) CLIENT INTERVIEWS

Demographics

Interviews of 400 clients who had termination of pregnancy (TOP) were carried out. The clients were interviewed after the procedure of termination of pregnancy was done so as to avoid them thinking that their answers would influence the decision of whether the TOP would be done or not. The age range was 14 to 46 years old with a mean of 26.7 years. Most of the women were between 20 and 29 years old, (44.3%). 23.8% were between 35 to 39 years old and 6% were more than 40 years old.

Fifty percent of the women had attained secondary school education, 31% had reached college or above, a 14% had reached primary school education and five percent were of less than primary school education.

Willing to discuss events leading to pregnancy

Of the initial 400 clients, 263 women, (65.8%) were willing to discuss the pregnancy which they had just terminated. Of these 263, 47 (18%) did not know how many weeks pregnant they were, whilst the other 216 (81.7%) did.

Which act led to pregnancy and prior contraceptive use

Out of the 263 clients who were willing to discuss, there were 226 (86%) who at least had an idea which act of sexual intercourse may have led to pregnancy.

- **Not currently on contraceptives**

Regarding those who had an idea as to which act of intercourse may have led to pregnancy, most clients (165 out of 226, 73%), had not been using any form of family planning at the time they got pregnant. Out of 165 not having used contraceptives before, 66 (40%) had never used a family planning method before whilst the other 99 (60%) had previously used a method. Most of the 99 who had used a family planning method before had used mainly the pill, (56.6%), or condoms, (28.3%). However, no contraception was used at the time they got pregnant because some had run out of their contraceptive supply, some forgot to take it, and some simply said they did not know why. Some clients had suspected they might become pregnant (28.3%) but the majority (71.7%) did not.

- **Had been on contraceptives before**

61 of the 226 (27%) of clients who had an idea as to which act of intercourse may have led to pregnancy had been using some form of family planning method at the time they had sexual intercourse. These included the pill 32 users (52.5%) while 14 (22.9%) were using condoms, 5 (8.2%) used withdrawal, 2 (3.3%) used intrauterine device (IUD), 2 (3.3%) used the rhythm method. Of the 61 who were using a family planning method, 13 (21.3%) had suspected that they might become pregnant. Most of the condom users (12 of the 14) and one pill user were aware that they were not using the method properly.

With whom the suspicion of pregnancy was discussed with

Nearly all clients who suspected that they might become pregnant discussed this with someone and predominantly it was their partner.

CLIENTS TOLD ABOUT EMERGENCY CONTRACEPTION

Now knowing about them, would clients have tried ECPs?

The clients were told what emergency contraception is. They were then asked whether they might have tried to use emergency contraception. Two hundred and three (50.8%) said no, 18 (4.5%) did not know and 179 (44.8%) said yes.

Why would they not have tried ECPs?

Those who said no, 69.2% said they never suspected they would get pregnant, 5.7% said it was not yet familiar so they would not have know what to do, 4.8% were concerned it may cause health problems, 1.8% had no access to contraceptive pills, 5.3% had not access to adequate information about emergency contraception and 5.3% did not know. Most of them did not have family planning pills on hand at the time that they could have used, (78.2%).

Where would ECPs be obtained from?

To obtain pills, the majority could find a health provider within 72 hours after they had sex. Others said they would obtain the pills from the chemist, some from the friend who told them about emergency contraception, while a few did not know.

Would clients use existing pill packets for EC

Of the 32 clients who had the family planning pills available on hand, 6 (18.8%) said they would have known how to take them because they learnt about it from the hospital, while the other 26 (62.5%) would not have known how much to take and most of these. Three quarters would have tried to contact someone for more information. The person they would have most likely contacted was the health provider, whom they felt would have been available within the crucial 72 hours. The pharmacist would have been contacted by a few of the clients who also felt that he would be available within the 72 hours. Some would have contacted the friend who told them about emergency contraception.

QUESTIONS ASKED BY CLIENTS

Accessibility and availability

- Are there any restrictions in obtaining it ?
- Is it available in all local clinics ?
- Is it available in clinics or chemist ?
- Can pill be kept in readiness ?
- Do I need partner consent ?
- Does one need a prescription to buy it ?

- Do I need to open a card to get emergency contraceptive pill ?
- How expensive is emergency contraceptive pill from the chemist ?
- Most women do not have information on emergency contraception ?
- Where can I get the supply from ?
- Why taking long to disseminate information on emergency contraception ?
- Where can one get literature on emergency contraception pills ?

Safety and effectiveness

- How effective is it ?
- It is safe ?
- Is it safe for someone sickly to take it ?
- Is the effect of emergency contraceptive pill reduced if one is on medication ?
- Can a hypertensive patient take the emergency contraceptive pill ?

Administration

- How many and how often are emergency contraceptive pills taken ?
- How often can one take the pills ?

Side effects

- Any more complications apart from nausea and vomiting ?
- How severe is the nausea and vomiting ?
- Can anyone in danger of pregnancy use emergency contraception ?
- Can emergency contraception disfigure one - become too thin or too fat ?
- Can emergency contraceptive pill side effects be compared to regular pills ?

Transition to regular family planning

- Can it be used as family planning ?
- Which method can I use ?

Others

- Is it okay to tell other people about emergency contraceptive pill ?
- When can I have a VDRL test (for syphilis)?
- Why not give samples for trial ?
- Give me some now.
- What is the response from the public ?

DISCUSSION

Only one of the 52 health care providers was not aware of the existence of emergency contraceptive pills (ECPs), although only three quarters of them offered it as part of the Family Planning services. The others who did not offer ECPs mainly lacked adequate information and some thought it was an abortifacient. This shows the need for more information to be given to health care providers so that they can be able to explain to their clients and provide it confidently.

The awareness of the existence of emergency contraception by health care providers was high, although this did not correlate with the number of providers who provided this service as part of family planning because of their attitude. This was also shown in the study in New South Wales (16) where the likelihood of woman being made aware of emergency contraception depended upon the knowledge and attitude of the general practitioner consulted. However, in the Netherlands the method is well established because it has been well accepted as part of family planning practice by both health care providers and the women (21).

University students had a good understanding of family planning but a lot of them were ignorant of the emergency contraceptive pill. The few students who knew about it had attended a workshop on emergency contraception on campus. This means that more workshops need to be carried out with the students in order for them to be aware of this method and its importance and to reduce a number of unwanted pregnancies whilst still studying .

The lack of adequate knowledge that was seen in University students reflects partly on the attitude of health providers towards this age group. The national survey of adolescent health experts in Pittsburgh, USA (11) also showed that some respondents believed that providing emergency contraception to adolescents would encourage contraceptive risk-taking or discourage correct use of other methods. On the contrary, the Scottish study on teenagers' Knowledge of emergency contraception showed that Scottish teenagers were well informed about the existence of this method of contraception and therefore teenage pregnancy rate do not seem to be increasing (10).

The lack of awareness was also seen in women who had come for termination of pregnancy. Seventy-three percent of those with unplanned pregnancies had unprotected sex whilst 27% if they had been using a family planning method. Amongst the ones who were using a family planning method, 21.3% of them had suspected that they might be pregnant either because of method failure or not using the method properly. For all these women half of them would at least have tried to use emergency contraceptive pill if they had known about it before.

Half the women who had come for termination of pregnancy indicated that they would have used emergency contraception if they had prior information about it. However, despite the knowledge about it, there should be no obstacles for the women in trying to use or obtain the pills. In New Zealand (14) it was found that many women knew about emergency contraception but few were using it due to a number of barriers such as accessibility and knowledge of its safety.

Health care providers all need to know which days and times their facilities are open so that they are able to instruct their clients accordingly. The University teaching Hospital family planning unit is open Monday to Friday, mornings and afternoons. The emergency gynae ward is open everyday, day and night. The family planning units in the clinics are open Monday to Friday mornings and afternoons as well as Saturday mornings. There is need for the emergency contraceptive pill to be available during the weekends as well in the clinics and so this could be made available with other units that remain open in the clinics during weekends.

There are other places which have been suggested by healthcare providers of emergency contraceptive pill. These are chemists, community based distribution agents. Most providers however, felt that the community based distribution agents would need more training on emergency contraception before they started distributing it.

Ways in which information can be made accessible include health education in clinic and the hospital when women come for under five clinics, antenatal clinics and family planning clinic, the media, on radio and television; literature such as distribution of pamphlets; circle of friends; drama in recreation centres or visual aids such as posters.

Although most health care providers felt that clinics and hospitals were more ideal for distribution of the emergency contraceptive pill since they can easily give advice, many university students felt comfortable with the clinic within their premises mainly because of the fear of being seen entering a family planning clinic by colleagues . They felt they could easily go to chemists. If they went to family clinics they would like to see youth friendly nursing

staff who will not start blaming them. Forming circle of friends would help in distributing information to other students.

Most of the TOP clients would have contacted a health care provider if they had known of emergency contraception whilst a few would have gone to the pharmacist.

The most commonly prescribed regimen of emergency contraception is the PC4. This is manufactured and packaged for emergency contraception and is therefore easy to give instructions and easy for the clients to remember how to take it, that is two tablets within 72 hours of unprotected sex and two tablets repeated 12 hours later.

However the clients should be told how to take the combined oral contraceptive pill in case of emergencies. Advance distribution of emergency contraceptive pills was supported by only 42% of health care providers. Most of the providers felt that many of our women are not yet ready for such advance distribution due to lack of adequate information and this would result in abuse of the drug. More information, education and communication (IEC) for the people is required.

Counselling on emergency contraception should include how and when its taken, what side effects to expect, transition to regular contraception and the need for follow up.

The side effects such as nausea, vomiting, breast tenderness need to be explained and that these are usually bearable. Most clients would like to know what to expect in terms of side effects. The need to be told that once pregnancy has be established then the pill will have no effect. This would relieve the fears that they are engaging in abortion, or that the baby would be born deformed.

Emergency contraceptive pill can act as an entry point to regular contraceptive use. All clients that are given emergency contraceptive pill should be counselled on the need to continue with regular contraception and what methods are available. Most clients who have not been pregnant before seem not to be sure where to obtain information on what family planning method to use. This would be an opportunity for them to learn all the different methods and to choose a method. This also includes those who felt they could not use a pill because of some contraindication or some side effects.

For more clients to be provided with services in terms of information and supplies, more health care providers need to be trained. More workshops need to be organised. Community based distribution workers would also need more training in order to carry out their part of service provision more efficiently especially in remote areas.

Students in colleges and Universities need workshops since most of them do not visit family planning clinics till its late. Health care providers only need to add this information to the health education which is given to women and mothers during the antenatal visits, under five clinic and family planning clinics.

The critical issue for our women in a developing country is to reduce the number of unsafe abortions which have serious side effects. This problem has been seen in other developing countries as well. Women need to be given more information on when to use emergency contraception and where to obtain it without facing discouragement.

Emergency contraception is not a replacement for but a complement to regular contraception for women who are sexually active.

CONCLUSION

Many health care providers are aware of emergency contraceptive pill but more providers need to be trained as the number of people who will come to know about EC will be increasing. Many providers would like to see the emergency contraceptive pill more easily available at their sites. There are a few health care providers who are hindered in provision of this method due to religious values. Emergency contraceptive pill has its own advantages and limitations. It certainly helps in preventing a number of unwanted pregnancies including those arising from rape, and therefore reduces the number of abortions. It is easy to be administered and convenient for those who engage in sex infrequently.

The limitations can be reduced by giving proper counselling and training. High failure rate is much less if the pill is not used on a regular basis. This fear of abuse is eliminated if the clients are counselled on the need and use of the emergency contraceptive pill when they are being provided with it. Instructions should be given that this is only to be used in emergencies within 72 hours. For this reason most providers felt that advance distribution of emergency contraceptives pill is good for the literate women who can read and understand instructions months after they have been given. A few feel that women living in areas far from health facilities can be given in advance once the provider is certain that they will follow the instructions. Otherwise everyone is eligible for immediate distribution except when they are already pregnant.

The most common place for people to rush to when in need is the family planning unit in the health centres. Doctors, nurses, and clinical officers in these places should always be ready to provide both the information and supplies to client. In a few instances where people are not

free to go to the family planning clinic, they rush to chemists. In remote areas where health facilities are quite distant and transport may be a problem the people rely on the community based distribution workers. These workers therefore need prior training in order to handle any side effects or misconceptions effectively.

Apart from informing clients about this method only when they come to the hospital or clinic, they can also be informed on the radio, television, distribution of pamphlets in shops and market places, through peer counsellors and through circle of friends. Workshops can be organised for those in colleges and universities.

In rural areas teaching sessions can be conducted where emergency contraception is included in the teaching of family planning. These sessions need to involve both males and females in order to break cultural barriers where men seem to dominate the wives decision on use of contraceptives. Once information is disseminated widely the community can easily support the distribution of these pills. With more knowledge on emergency contraception the attitude of the people is more favourable but lack of knowledge in both clients and providers can be met with a lot of obstacles in trying to introduce this method widely. When people come to realise when to use and in what situations to use this pill the benefits of reducing unwanted pregnancies can later be seen and appreciated. Contraception is the greatest thing that has been discovered for the fertile woman.

RECOMMENDATIONS

1. The local clinics should incorporate provision of emergency contraception during weekends and holidays into departments that are open during this period in order to facilitate easy accessibility.
2. Availability of emergency contraceptive pills should be through health facilities or family planning sources, and chemist. These are the most popular and acceptable. Those receiving the pill for the first time are encouraged to obtain it from a health facility or family planning source where they can receive counseling.
3. Community based distribution workers need more training before they start distributing the emergency contraceptive pill.
4. Students in the university need more information about emergency contraception through workshops or seminars and through circle of friends or peer counseling.
5. Considering that 27% of TOP clients had been using some family planning method which either failed or was not used properly, advance distribution of emergency contraceptive pills to those that can comprehend and understand instructions should be considered.
6. Emergency contraception needs to be clarified to churches by giving talks during various church activities in order to avert the misconception that it is an abortifacient.

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APPENDIX 1

IN-DEPTH INTERVIEW WITH PROVIDER IN LUSAKA QUESTIONNAIRE

Provider sex (circle one): Female Male

Name of facility: _____

Location of facility: _____

Interview date: _____

Interview start time: _____ Interview end time: _____

Interviewer's initials: _____

Introduction.

Thank you for seeing me. I am here today because we are introducing emergency contraception more widely into Zambia. We are interviewing health providers as well as policy makers, university students and family planning clients.

In order to help us plan the introduction and to evaluate it later on, we would like to ask you some questions. Please try to answer the questions honestly. Do not worry if you are not sure about the answer. The interview should not last more 30 to 45 minutes. We will not report your name in any way when we write up the final results. We wish only to collect it for our records. All the individual information we collect will be kept confidential, and only information that cannot be linked back to you will be shared outside the research project.

Are you willing to participate in our project? We will share the results of these findings with you and all others involved in family planning.

Demographic information.

Before we begin, can we get some background information?

1. When were you born? _____

2. What is your job here? (Circle one). Physician Nurse Clinical officer

Other: _____

4. How many years of experience do you have in providing health services: _____

5. Have you had any specialized training in family planning? (Circle one). Yes No

If yes, please specify:

Description of facility and services currently offered.

Let us begin by talking a little bit about the health services your facility offers now.

6. Which family planning method do you offer? In each case, can you tell us whether you offer information or also supplies? Please try to estimate how many women receive each method in an average month. *(Complete grid below). If you do not know say so.*

Method	Number of clients offered information on the method (in an average month)?	Number of clients provided with supplies (in an average month)?
IUD		
Pills		
Minipills		
Condoms		
Diaphragms/Caps		
Vasectomy		
Tubal ligation		
Emergency contraception		
Other:		

8. Which brands of oral contraceptives do you normally stock? *(Record exact response).*

9. Which of these brands do you have in stock right now? *(Circle brands in stock from brands listed above in question 8).*

10. Do you encounter any difficulties keeping pills in stock? *(Record exact response).*

11. What other reproductive health services do you offer? *(Ask each category and circle one response).*

Diagnostic:	Pregnancy testing?	Yes	No
	STD screening?	Yes	No
Curative:	STD treatment?	Yes	No
	Evacuation?	Yes	No

12. How would you describe your typical client/patient population? (*Ask each category and circle one response*).

Average age:	Young	Medium	Older
Age range:	Varies a lot	Varies somewhat	Does not vary much
Income:	Low	Medium	High
Range in income:	Varies a lot	Varies somewhat	Does not vary much
Education:	Low	Medium	High
Range in education:	Varies a lot	Varies somewhat	Does not vary much

13. How many clients or patients does the facility generally see each week for all services combined?

14. Do you generally charge for family planning services? (*Circle one*). Yes No

15. How do you charge for oral contraceptives? (*Record exact response. Examples might be that the price is included in consultation fee, OCs are free, OCs form a separate charge of K _____*).

16. What days and times is this facility open? (*Note times for each day the clinic is open*).

Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

Definition of emergency contraception.

Now let's talk about emergency contraception. Some people have heard of it. Some people have not heard of it.

17. First of all, have you heard of it? (*Circle one*). Yes No

If answer is "no," skip question 19.

18. People have different ideas about what emergency contraception is. Can you tell me what impression comes to your mind when we think of this term? (*Record exact response*).

19. Can you tell me when you first heard of it and where? (*Record exact response*).

When: _____
Where: _____

Just to be sure we are all working from the same idea, I'd now like to give a short summary of the method. In case you weren't sure, emergency contraception is a term used to describe methods of contraception that women can use *after sex* to help *prevent* pregnancy. For example, regular oral contraceptives used in a higher dose and taken within a few days after unprotected sex work well as emergency contraceptives. Sometimes this therapy is called the morning after pill. Emergency contraceptive pills must be started within 72 hours after unprotected sex and they are about 75% effective. The ingredient is the same as the regular birth control pill, but a larger dose. Some women who take it experience relatively minor side effects, such as nausea and vomiting. Emergency contraception is used widely overseas, for example in England and in the United States. Although it is possible to get emergency contraception in Kenya, it has not yet widely known. As you can see from the name, the method is for contraceptive emergencies and not for use as a regular method.

20. Do you have any questions about this method? (*Note the questions and answer them*).

Current provision of emergency contraception.

21. Do you offer emergency contraception? (*Circle one*). Yes No

If answer is "no," skip to question 34.

22. When did you start offering emergency contraceptives? _____

23. Why did you start to offer emergency contraceptives? (*Record exact response*).

24. How often do you give emergency contraception on average in a month? _____

25. Can you describe the typical emergency contraceptive clients? (*Record response*).

26. Do you offer emergency contraception to some clients but not to others? What are the selection criteria you use? (*Record response*).

27. Do you see any variation in the need for EC at different times during the year? Please describe. (*Record comments*).

28. Which regimens do you offer? (*Record exact protocol and brands used*).

29. What if anything is the typical counselling you offer on emergency contraception? *(Record comment.)*

30. Do you have any client materials on emergency contraception? *(Circle one)*. Yes No

(If "yes," request a copy).

31. Do you have any written guidelines that you use for emergency contraception? *(Circle one)*. Yes No. *(If "yes," request a copy).*

32. Do you charge for emergency contraception? *(Circle one)*. Yes No
If yes, how much? K_____

33. What problems have you encountered with offering this service? *(Record comment.)*

(Skip the next question.)

34. If you do not offer emergency contraception, why not? *(Record comment.)*

Perceptions of emergency contraception.

Now let's talk about emergency contraception very generally.

35. What do you think about this method? *(Record comments).*

36. Do you think it could be a useful method for your facility? Why or why not? *(Record comments).*

37. What are the advantages you see? *(Record comments).*

38. What limitations? *(Record comments).*

39. What about for Zambia generally? Do you think it could be a useful method? Why or why not? *(Record comments).*

40. If the method became more widely available in Zambia, who do you think should be able to offer it? *(Probe: Only physicians? Nurses? CBD workers? Pharmacists? Clinical officers? Other?)* Through what channels should it be made available? *(Record comments.)*

41. What would be the best ways to inform women about emergency contraception? *(Record comments).*

Advance distribution.

In some other countries such as Scotland and the United States, providers are giving packets of pills to women in advance. The women can take them home and use them as emergency contraception in case they need them without having to come back to the clinic.

42. What do you think of this idea for Zambia? *(Record comments).*

43. Would this be a suitable idea in this facility? *(Record comments).*

44. Which women would be suitable to receive advance supplies? *(Record comments).*

Future plans for emergency contraception.

45. Would you like to see emergency contraception become more easily available at your site? *(Record comments).*

46. What do you see as the main challenges in offering emergency contraception here at your site? *(Record comments).*

47. What about in Zambia generally? Would you like to see emergency contraception become more easily available? *(Record comments)*.

48. Do you have any ideas to share with us for overcoming these challenges as we plan our pilot project? *(Record comments)*.

49. Some people are in the process of developing a special package that would contain the right dose of oral contraceptives and the right directions for use as emergency contraception. Even though the pills are the same, a pilot test will see if providers prefer the special package. Do you think such a special package would be useful? *(Record comments)*.

50. What do you think are the main ways we could tell if such a pilot project has been a success? *(Record comments)*.

Conclusion.

We have now reached the end of the prepared questions I have for you.

51. Is there anything else you would like to add? *(Record any comments)*.

52. Would you like to ask me any questions? *(Note questions and answer them)*.

Thank you very much for your time. We will contact you in about one month to invite you to the meeting where we can share the results from this research.

(Note ending time of interview: _____ . Also mark ending time on front page).

APPENDIX 2

Survey of Termination of Pregnancy clients at University Teaching Hospital, Lusaka

Study information.

Survey population: All women admitted to University Teaching Hospital for termination of pregnancy. Interviews anticipated to take between 10 and 15 minutes each

Data collection: Surveys with fourteen closed-ended questions and three open-ended questions administered orally.

1. Recruiting clients

a) Over the four month period, July to October, all women admitted to UTH for termination of pregnancy were requested to participate in the survey. Candidates for this survey were recruited during the post operative convalescent period to avoid any risk of clients assuming TOP services to be contingent upon their participation in the study. If the client volume was too heavy to interview every client, every third or fourth client was chosen.

b) Clients were asked if they were willing to take part in a short survey. It was not necessary to elaborate in great detail about the objectives of the survey, except to say that women who have experienced an unwanted pregnancy – such as themselves – were in a unique position to teach health care providers how they might help other women avoid such pregnancies in the future. It was made clear, however, that participation in the study was not mandatory. Potential clients were told that the information would be kept confidential and not shared with the clinic staff and that the survey would last about 10 minutes.

c) If willing to participate, a room was used that would have the fewest interruptions, and that is the most quiet and private.

2. Administering the survey

a) All clients were thanked for participating.

b) The Consent Form was signed after it was explained.

c) The date, place, and starting and ending times of the survey were noted. Care was taken not express surprise or any other emotion while the survey was going on. Wrong answers or misperceptions were not corrected.

d) Unless otherwise noted, when the questions were multiple choice, the choices were read to the woman before she answered so she could select the answer she liked best.

SURVEY FORM

Date of interview: _____

Start time of interview: _____ End time: _____

Site: _____

Client number: _____ (*Number consecutively*)

Interviewer initials: _____

Introduction

You have been asked to participate in a study which is designed to provide women with a broader range of options to avoid pregnancy, either in situations where they know their regular family planning method has failed them or even in cases where they were not using a family planning method to begin with. To accomplish this, the study must first learn from women such as yourself, what you believe your family planning options to be. It does not matter whether you are using a contraceptive method now or whether you have used one in the past.

Your involvement in this study will involve answering a number of questions about yourself. The survey will take less than 10 minutes. We will not collect your name, and the information will not become part of your clinic record. You do not have to participate if you do not want to, and this will not affect your service here at the clinic in any way. We also promise to keep all information we collect confidential. Are you willing to participate? (*At this point, have client sign the Consent Form*).

Background information.

The first questions are for background purposes only. Now because this interview is completely anonymous, I will not have access to your medical file or any of the information contained in it. All I will ever know about you is what you tell me during this interview. For that reason I may be asking some questions that you have already answered previously. If that is the case, I apologise and ask you to bear with me.

1. How old are you? _____
2. What level of education have you completed? (*Tick one*):
 - Less than primary school
 - Primary school
 - Secondary school
 - College or above
3. How many deliveries have you had before? _____
4. How many miscarriages have you had before? _____
5. How many pregnancies have you had terminated before? _____

History of Current Pregnancy.

Now, to begin with, I would like to ask you a few questions about the pregnancy that was terminated earlier today. Is that all right with you ?

No (*Skip to section on Emergency Contraception, page 8*)

Yes

6. First of all, do you know how many weeks pregnant you were when you arrived at the hospital today?

No
Even if you don't remember the exact date, can you at least identify which act of sexual intercourse led to this pregnancy?

No (*Skip to question 12*)

Yes (*Skip to question 7*)

Yes
If yes, can you tell me how many weeks: _____

7. Thinking back to the act of sexual intercourse that led to this pregnancy, were you or your partner using any form of family planning at the time? (Tick "yes" or "no" and complete appropriate section)

No

Have you ever used a family planning method before?

No

If no, why not? _____

(Skip to question 9)

Yes

What was the last method you used? (Circle one)

- a) condoms
- b) foam/tablets
- c) pill
- d) withdrawal
- e) rhythm
- f) traditional
- g) other: _____

Why did you not use it that time? (Circle one)

- a) had none left
- b) couldn't find them
- c) forgot
- d) don't know
- e) other: _____

Did you suspect, either during or after sexual intercourse, that you might become pregnant?

- yes (skip to question 10)
- no (skip to question 11)

Yes

What method were you or your partner using at the time?

- a) pills
- b) condoms
- c) IUD
- d) female sterilization
- e) male sterilization
- f) withdrawal
- f) withdrawal
- g) rhythm
- h) other: _____

8. Although you were using a family planning method at the time, did you ever suspect either during sexual intercourse or within the first three days thereafter that you might become pregnant?

No (skip to number 11)

Yes

What made you suspect that you might become pregnant ?

- The family planning method failed
- Aware that she was not using the method properly.
- Wasn't sure the method was working.
- Don't know
- Other: _____.

(skip to number 10)

9. Were you concerned or suspicious, either during sexual intercourse or within the first three days thereafter that you might become pregnant ? (this question for non-users of family planning only)

No

Since you were not using any kind of family planning method, why did you think that your chances of becoming pregnant were *not* that great?

- Had had unprotected sex in the past and never (or rarely) became pregnant.
- Believed she and/or her partner were infertile.
- Was breastfeeding at the time.
- Didn't care whether got pregnant or not.
- Doesn't know
- Other: _____.

(skip to number 11)

Yes

On *this* occasion, was there any particular reason you felt you were at greater risk of becoming pregnant than on any other previous occasion when you did not use a family planning method?

- Yes**
Why? (Circle one)
 - a) Client was mid-cycle.
 - b) Doesn't know
 - c) Other _____

No

10. Did you talk to anyone about your suspicion? (tick "yes" or "no" and complete section)

Yes

With whom? (tick all that apply)

- Partner
- Health provider (specify: _____)
- Chemist.
- Relative/other family member (specify: _____).
- Friend

How soon thereafter did you consult them?

- Within the first three days after intercourse.
- After three days, but within the first week.
- After at least a week or more.
- Other: _____.
- Don't know.

What did they tell you? _____

(Skip to section on Emergency Contraception, page 8)

No

Why not? (tick all that apply)

- There wasn't anything anyone could have done.
- Didn't know who to go to.
- Other (specify): _____.
- Don't know.

(Skip to section on Emergency Contraception, pages 8)

11. When did you finally begin to suspect that you *might* be pregnant? (read out options)

- After three days, but within the first week after intercourse.
- After at least a week or more after intercourse.
- Don't know.

12. What was it that prompted you to suspect that you might be pregnant?

- Felt different (explain _____).
- Missed period.
So before that, you *never* suspected you were pregnant?
 That is correct, I never suspected.
- Other: _____.
- Don't know.

13. Did you talk to anyone about your suspicion? (tick "yes" or "no" and complete section)

Yes
With whom? (tick all that apply)

- Partner
- Health provider (specify: _____)
- Pharmacist.
- Relative/other family member (specify: _____).
- Friend

How soon thereafter did you consult them?

- After three days, but within the first week.
- After at least a week or more.
- Other: _____.
- Don't know.

What did they tell you? _____

No
Why not? (tick all that apply)

- There wasn't anything anyone could have done.
- Didn't know who to go to.
- Other (specify): _____.
- Don't know.

Emergency Contraception

Now I would like to tell you something about a kind of family planning method that can be used by women *after sex* to help *prevent* pregnancy. The method goes by lots of different names, but generally most people refer to it as emergency contraception. Basically, emergency contraception involves taking a certain number of birth control pills within three days after unprotected sex. Some people just take the pills they need from an ordinary packet of birth control pills, others use pills specially packaged for emergency contraception. Now, because the dose or number of pills is greater than one would normally take in a single day, some women experience relatively minor side effects, such as nausea and vomiting. Also, emergency contraception is not as effective as taking birth control pills on a daily basis, as they are supposed to be taken. Nevertheless, emergency contraception is widely used overseas, and is even available here in Zambia. Did you understand what I just explained to you? (*Clarify or repeat any points made previously, but try not to provide any new information*)

Now, I would like you to imagine yourself, lets say, a week before you had had the sexual relations that resulted in your recent pregnancy.... Suppose that a friend had told you *exactly* the same information about emergency contraception that I just told you now. One week later, you would have had sex. Everything would have been exactly as it was at the time; the *only* difference would be that you would have *known* that there was such a thing as emergency contraception; that it involved taking some contraceptive pills; and that you had only three days to get started doing something about it. Nothing else would be different.

Now I would like to ask you to think back to that time and answer for me a couple questions.

12. Do you think you might have tried to use emergency contraception?

(*Tick only one, and complete section*)

No

Why not? (*tick all reasons mentioned, but do not read out*)

- Never suspected she would get pregnant.
- Not yet familiar to her; she wouldn't have known what to do.
- Concerned it may cause health problems for her.
- Had no access to contraceptive pills.
- Had no access to adequate information about emergency contraception.
- Don't know
- Other: _____.

(*skip to Conclusion, page 12*)

Don't Know

Can you think of any reasons why you might not have wanted to use it
(*tick all reasons mentioned, but do not read out*)

- Never suspected she would get pregnant.
- Not yet familiar to her; she wouldn't have known what to do.
- Concerned it may cause health problems for her.
- Had no access to contraceptive pills.
- Had no access to adequate information about emergency contraception.
- Don't know
- Other: _____.

(*skip to Conclusion, page 12*)

Yes

15. Did you have family planning pills on hand at the time?

No

Where would you have gone to get some?

The friend who told me about emergency contraception.

Health provider (specify: _____)

Would the health provider have been working or available within the 72 hour period after you had sex?

Yes

No

Don't know

Chemist

Would the chemist have been open within the 72 hour period after you had sex?

Yes

No

Don't know

Don't know

Other: _____.

Yes

Would you have known how many pills to take? (*tick one*)

Yes

If yes, where/how did you learn this? _____

No

Don't know

16. Would you have tried to contact someone for more information?

No
If not, why not? _____

(Skip to Conclusion, page 12)

Yes
Who would you have contacted first? *(tick one)*

- The friend who told me about emergency contraception.
- Partner
- Health provider (specify: _____)

Would the health provider have been working or even available within the 72 hour period after you had sex?

- Yes
- No
- Don't know

Pharmacist

Would the health provider have been working or even available within the 72 hour period after you had sex?

- Yes
- No
- Don't know

Don't know

Other: _____

Conclusion

Thank you very much for your time. Before we conclude, would you like to ask me any questions about emergency contraception? *(Note and answer all questions.)* Thank you again.

Questions asked by client:

(Note end time of interview: _____. Also mark time on front page.)

CERTIFICATE OF CONSENT
FOR PARTICIPATION IN STUDY TO
ENHANCE ACCESS TO FAMILY PLANNING
THROUGH THE INTRODUCTION OF EMERGENCY CONTRACEPTION

I have been asked to participate in a study which is designed to provide women with a wide range of options to avoid pregnancy. I understand that the survey will involve answering a number of questions about myself. I also understand that if I participate in this study, I do not have to answer any questions or discuss any issues that I do not wish to. My participation will not affect the services I receive here, nor will it entitle me to any special services, payment or gifts. All information collected from me will remain strictly confidential.

I understand this statement, have no further questions, and wish to participate in this study,

Client's name:.....

Client signature:.....

Date.....

If the client cannot write, he or she should make a cross.

Witness signature

Relation to client.....