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FORMATIVE ASSESSMENT OF EMERGENCY CONTRACEPTION PROVISION AT THE COMMUNITY LEVEL IN UGANDA

SEPTEMBER 2016

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ACRONYMS

CBFP	community-based family planning
ECP	emergency contraceptive pill
FGD	focus group discussion
FP	family planning
HC	health center
IEC	information education communication
KI	key informant
KII	key informant interview
MOFPD	Ministry of Finance, Planning and Economic Development
NMS	National Medical Stores
UBOS	Uganda Bureau of Statistics
UHMG	Uganda Health Marketing Group
VHT	village health team

EXECUTIVE SUMMARY

Advancing Partners & Communities (APC), in collaboration with WellShare International and FHI 360, conducted a formative assessment of emergency contraception provision through community health workers, called village health teams (VHT members), in Uganda. The assessment was designed to identify problems associated with the distribution of emergency contraceptive pills (ECPs) by VHT members to improve the integration of this post-coital contraceptive method into existing community-based family planning (CBFP) programs. Four geographically and socially diverse districts in the Central, Southwest, Eastern, and West Nile Regions of Uganda were selected to participate in the assessment, which included interviews with: VHT members (n=23); family planning (FP) clients who had ever used ECPs (n=20); potential users of ECPs (n=60); key informants (KIs) at the national and district levels (n=37); and focus group discussions (FDGs) (n=16) with men and women from communities in the assessment area.

In general, focus groups participants had little knowledge or awareness of ECPs. After they became more informed about ECPs, their opinions varied on several issues: 1) whether ECP would be accepted by the men and religious leaders of the communities; 2) whether an ECP was an abortifacient; and 3) whether it would be good for VHT members to provide ECPs to community members. Many women in the focus groups felt that the men in their communities would not allow VHT members to provide ECPs, but most of the focus group participants agreed that the approach would increase awareness of and demand for ECPs.

The KIs and the VHT members also believed that the provision of ECPs by VHT members would increase demand for and awareness of the method. More than 85 percent of the VHT members said they felt comfortable with the task of providing ECPs to community members and believed that most community members would accept VHT provision of ECPs. All 23 of the VHT members had been trained in the community-based provision of FP, but only 9 percent said they currently provided ECPs. Seventeen percent had provided counseling on ECPs, and 26 percent had made referrals for ECPs to the health center.

A total of 80 FP clients of VHT members were interviewed in the four assessment districts. Of the 20 women who had ever used ECPs, about 45 percent had used them in the past three months. Of those who had used ECPs in the past 12 months, most had used them between one and three times. The "ever-users" of ECPs identified several challenges to obtaining the pills, including stockouts. Not surprisingly, ever-users of ECPs reported that they would use the method in the future and more than half would prefer to obtain them from VHT members.

Of the 60 potential users (who had never used ECPs), about half had never heard of ECPs before the assessment. The other half first became aware of the method primarily through a health facility provider. In contrast, ever-users were just as likely to identify VHT members or health facility providers in that introductory role. When asked about the best source for obtaining ECPs, the ever-users were more likely than the potential users to mention VHT members. Potential users were also more wary of ECPs than ever-users—22 percent said there were better ways to prevent pregnancy. Nevertheless, 88

percent of the potential users said they would consider using ECPs in the future, and more than 80 percent of ever-users and potential users said they felt comfortable with the provision of ECPs in the community by VHT members.

Key informants from the district were more likely than their national-level counterparts to mention ECP stockouts as a problem. Interestingly, those KIs who did not believe that stockouts were a problem identified a lack of awareness of ECPs as the main problem and the reason for the expiration of more than 200,000 units of ECPs in July 2015. In that regard, the KIs and the focus group participants agreed that merely allowing VHT members to provide ECPs will not increase demand; awareness must also be raised if community-based provision of ECPs is to be feasible.

The KIs (at all levels) expressed concern about the training of VHT members and their ability to provide ECPs effectively. Some focus group participants and potential users also said that a lack of education and ability among VHT members were potential barriers to this approach. The KIs and focus-group participants also expressed concerns about client confidentiality and the potential for overuse or abuse of ECPs if VHT members provided the method. Nevertheless, the KIs acknowledged that there was more to be gained than lost by the community-based provision of ECPs, and that these concerns could be addressed by training and supervising the VHT members.

This assessment indicated a general lack of knowledge about ECPs in the four study districts. After receiving more information about ECPs, most respondents were willing to accept the provision of these pills by VHT members. Most of the respondents also recognized that ECPs could be beneficial and that VHT members could help raise awareness and increase access to ECPs.

Key Findings

- The assessment communities had very little knowledge or awareness of ECPs.
- The majority of respondents believed that the community-based provision of ECPs and community sensitization would increase demand for the method.
- Despite concerns about the training and the abilities of village health team providers, most respondents believed that the provision of ECPs by these community health workers had more advantages than disadvantages.

Based on this assessment, we offer the following recommendations:

- Conduct sensitization activities to increase awareness (and demand) for ECPs. This can be done through VHT members, health facilities, radio, television, community gatherings, and by targeting specific married and unmarried women, men, and couples with customized messages.
- Develop clear strategies—including the incorporation of ECPs into the method mix—to improve the forecasts of the logistics management information system and meet the need for ECPs and other short-acting methods that VHT members can provide.
- Use the provision of ECPs by VHT members as an opportunity to counsel potential family planning clients on the regular use of other contraceptive methods.
- Train VHT members to instruct clients that ECPs are for emergencies only. They are not a substitute for condoms, and they do not protect against HIV or other sexually transmitted infections.

Accordingly, WellShare International and APC will work with the Family Planning/Reproductive Health Commodities and Supplies Working Group (FP/RHCS WG)[1] in a second phase of activities, which will include a strategy document for the integration of ECP into CBFP in Uganda; job aids and training materials; advocacy for partners implementing CBFP to include ECP their VHT trainings; and the assurance that ECPs are provided as a standard part of CBFP services and that VHT members can access ECPs from the health center where they report for resupply.

BACKGROUND

CONTRACEPTIVE USE AND ECP AVAILABILITY IN UGANDA

The Republic of Uganda has one of the world's highest rates of fertility—more than six children per woman—and an estimated population of 39.4 million (Uganda Bureau of Statistics [UBOS], 2014). Fertility is significantly higher among rural women (6.8 children) than it is among urban women (3.8 children). Because less than 20 percent of the population lives in urban areas, reducing urban fertility would have negligible impact on the country's overall fertility rate (Demographic and Health Survey, 2012).

The use of modern contraceptive methods by currently married women increased from 14 percent in 2000–2001 to 26 percent in 2011. About 14 percent of currently married women use injectables, whereas pills, condoms, and female sterilization are each used by less than 3 percent of these women. Approximately 35 percent of currently married women in Uganda have an unmet need for FP: 21 percent for spacing child births and 14 percent for limiting child births. Regional variations show that the unmet need is greatest in the West Nile and North regions (43 percent each), followed by the East Central (42 percent). The Kampala and Karamoja regions have the lowest rates of unmet need, with 17 percent and 21 percent, respectively.

The five-year National Development Plan (2010–2015) recognized that limited access to FP services hinders Uganda's development, especially the progress of women. One of the plan's goals is to reduce the unmet need for FP by ensuring greater access to FP services, especially in rural areas (MOFPD, 2010). Furthermore, the 2010–2012 National Population Policy Action Plan emphasized FP and the security of reproductive commodities, including the use of contraceptives (MOFPD, 2012).

Emergency contraceptive pills (Postinor and Plan B) are available for free in Uganda through the public health sector (government hospitals and health centers (HC) II, III, and IV). Current policy also allows provision by village-level community health workers, organized as village health teams (VHT members) who offer the lowest level of health care services in the country and are referred to as HC I. The National Medical Stores (NMS) supply public health systems facilities with ECPs.

The Uganda Health Marketing Group (UHMG), through the alternative commodities distribution mechanism, supplies free ECPs to private nonprofit providers such as nongovernmental organizations (NGOs), who then distribute them freely through their FP programs and facilities. The UHMG also supplies the private, for-profit sector, such as private clinics that provide their product at cost.

[1] The FP/RHCS WG is led by the MOH and comprises representatives from the FP/RH implementing partners working in Uganda. It was formerly called the FP Technical Working Group.

However, the level of availability of ECPs is not defined and the decision whether to stock ECPs as part of the FP method mix is solely at the discretion of the provider. Commercial pharmacies provide ECPs over the counter and, at 8,000–10,000 Ugandan Shillings ($2.67–$3.33 USD) per dose, charge some of the highest prices for ECPs.

Emergency contraceptive pills are included in the list of 13 essential life-saving commodities by the United Nation's Global Strategy for Women and Children's Health (UN, 2012). A commitment to expand access to these commodities should avert about 2.3 million deaths through the use of FP by the end of 2015. Although ECPs are an integral part of the method mix, they differ from other methods because they are not intended for regular use, and this makes it challenging to forecast demands.

The Ugandan government projected a need to increase the volume of ECPs consecutively in fiscal years 2013-2014, 2014-2015 and 2015-2016 (265,178 units, 273,663 units and 282,420 units, respectively) (Reproductive Health and Pharmacy Divisions, 2013). Stock status reports on January 1, 2015 indicated that 218,799 units of levonorgestrel ECPs were available through the NMS for public-sector consumption and through UHMG for the private sector. However, these units expired and were quarantined at the end of July 2015. The Ministry of Health (MOH) asked donors to procure more ECPs, and the NMS ordered ECPs through UHMG, but they did not arrive until August 2016. As a result, the public sector went without ECPs for more than a year.

DISTRIBUTION OF FAMILY PLANNING METHODS BY VILLAGE HEALTH TEAMS

Village health teams were established by the MOH to link the community with the public health system. The teams typically consist of five members and are required to be at least one-third be female. The VHT members are nominated by their communities. The National Village Health Teams Assessment in Uganda (Pathfinder International, 2015) indicated that there are approximately 179,175 VHT members working to improve the wellbeing of their communities in Uganda. Most were married peasant farmers (18–78 years old) with an average age of 40 years. Nationally, 34 percent of the VHT members surveyed had attained a primary education and 53 percent a secondary education. The VHT activities include home visits, health education, community mobilization, client referrals, nutrition, sanitation, immunization, community-based management of common illnesses (such as malaria), follow-up of pregnant women during pregnancy and after birth, distribution of health commodities (drugs, condoms, mosquito nets, and water purification tablets), community information management and disease surveillance, and FP.

The expansion of community-based FP services has reached 28 of the 112 districts in Uganda. This limited reach is because the current model relies primarily on support from an external partner, such as an NGO, not district/public sector funding.

Emergency contraceptive pills were approved by the Uganda MOH for distribution by VHT members as part of the short-term method mix. The policy change was acknowledged in the 2011 addendum to the 2006 National Policy Guidelines and Service Standards for Reproductive Health Services. The third edition of these guidelines, published in 2012, formally endorses VHT-provision of ECPs (Reproductive Health Division, 2012). However, access to and use of ECPs at the community level has been hampered by several factors: a lack of ECPs in the public sector and communities; limited training of health workers and VHT members on how to educate clients about the use of ECPs and a limited number of VHT members who do have FP training; misinformation among health workers and the community

about the method's mode of action. Thus, government policy has not been translated into institutionalized community-based provision of emergency contraception. Our knowledge of these shortcomings are anecdotal based on conversations at meetings of the MOH FP/RHCS WG (formerly known as the family planning technical working group) and program experience in expanding community-based family planning (CBFP).

As a consequence, WellShare International (WellShare) and Advancing Partners & Communities (APC) have undertaken a formative assessment of existing consumer knowledge and use of ECPs, along with capacity, supply, and barriers to the provision of ECPs by the public sector in four districts across Uganda. The results of the assessment should inform efforts for the community-based provision of ECPs.

GOALS AND OBJECTIVES

The overall goal of this assessment was to understand the dynamics of ECP distribution by VHT members to improve the integration of ECPs into existing community-based FP programs. The specific objective was to assess ECP knowledge, use, supply, and barriers to uptake in districts where community-based programs for ECPs are in operation. This assessment is also expected to generate information for the development of information, education, and communication (IEC) materials.

ASSESSMENT DESIGN

The assessment took place in four districts in Uganda where ECPs are presumably being distributed by VHT members: Arua, Iganga, Kanungu and Mubende. These districts were selected because WellShare has FP projects in Iganga and Arua, and WellShare and FHI 360 had previously implemented FP programs in the Mubende district. In addition, FHI 360 is currently working in Kanungu. Beyond convenience, the selected districts provide a geographically and socially diverse sample of Uganda. Arua is located in the West Nile Region, Mubende in the Central Region, Iganga in the Eastern Region, and Kanungu in the Southwest Region.

Quantitative and qualitative methods were used to collect data from four components: surveys with VHT members, surveys with female clients of VHT members, focus group discussions with men and women in the communities, and key informant interviews (KIIs). Our approach is described below.

1. Surveys of Village Health Team Members

To identify VHT members to participate in the surveys, three health centers (drawn from HCs II and III) were chosen in each district in consultation with the district health office or team. Two VHT members operating in each center's catchment area were then selected. These VHT members were trained in CBFP, provided FP services to clients, and were able to identify potential and past ECP users among their clients. Experience providing ECPs was not required for selection.

The surveys were completed with six VHT members per district—24 in total—with an equal number of male and female VHT members. One female VHT who had not been trained in FP was excluded from the analysis, leaving a total sample of 23 VHT members. The surveys focused on the VHT members'

general experiences with the provision of FP services and their specific knowledge of and experiences with the provision of ECPs. The surveys also explored the community's perceptions about the provision of ECPs by VHT members.

2. Survey with Potential and Past ECP Clients

Female clients between the ages of 15 and 49 were purposively selected as known FP users by VHT members who had participated in the surveys described above. In total, 80 women were surveyed (20 per district), resulting in 20 "ever-users" of ECPs and 60 "potential users."[2] These surveys sought to understand the women's knowledge of ECPs, the sources of information about ECPs and FP, and experiences with ECP use. In addition, the women were asked about the challenges of using ECPs and suggestions for improving ECP awareness and access in their communities.

3. Focus Group Discussions with Community Women and Men

The VHT members who participated in the survey also helped select participants for focus group discussions (FGDs) from their catchment areas, especially women and men of reproductive age, located in rural or peri-urban catchment areas, and who had heard of ECPs or other FP methods. Each focus group included at least one participant who had heard of ECPs. Only 16 FGDs were originally planned, but a total of 32 were conducted, as the data collection team suggested that stratifying focus groups further than originally planned might yield interesting findings. Thus, eight FGDs were conducted in each district, with all-male and all-female groups. However, time and resource constraints held the coding and analysis of FGD transcripts to the original 16. All 32 FGDs were first "mapped" to examine the breakdown by age group, gender, and setting so that the analysis sample would be as representative as possible of all the districts and settings (rural, peri-urban) in which the FGDs were conducted. This resulted in four FGDs from each district, of which two were all-female and two all-male, and two in peri-urban settings and two in rural settings. Three age groups (15–19, 20–24, 25-49) were selected to include younger people of reproductive age and ensure, as much as possible, even distribution according to district, setting, and gender (table 1).

Table 1. Distribution of Focus Group Analysis Sample

		Arua		Iganga		Kanungu		Mubende		Total
Total groups		n=4		n=4		n=4		n=4		**N=16**
Total participants		n=40		n=40		n=33		n=34		**N=147**
Mean group size		(10)		(10)		(8)		(8)		**(9)**
Age range/sex		**Rural**	**Peri-urban**	**Rural**	**Peri-urban**	**Rural**	**Peri-urban**	**Rural**	**Peri-urban**	
15-19	**Female**					1 (8)	1 (8)	1 (8)		**3 (8)**
	Male		1 (10)	1 (10)	1 (10)					**3 (10)**
20-24	**Female**	1 (10)		1 (10)						**2 (10)**
	Male						1 (9)		1 (8)	**2 (9)**
25-49	**Female**		1 (10)		1 (10)				1 (8)	**3 (9)**
	Male	1 (10)				1 (8)		1 (10)		**3 (9)**
Total		**2 (10)**	**2 (10)**	**2 (10)**	**2 (10)**	**2 (8)**	**2 (9)**	**2 (9)**	**2 (8)**	**16 (9)**

[2] Potential users included women who had not heard or had been aware of ECPs before they were interviewed and learned about the method. Expressed interest in using the method may have occurred after they were selected for the assessment.

The focus group guide concentrated on two main themes: 1) knowledge and use of ECPs in the community, and: 2) community-based provision of ECPs. These guides specifically sought to identify participants' misconceptions about ECPs; perceptions on who was likely to use ECPs; challenges to access and obtain ECPs; and community members' thoughts on the best ways to share information about and provide the method in VHT catchment areas.

4. Key Informants

Key informants at the district and national levels were purposively selected by WellShare staff members based on their knowledge and experience with FP, particularly ECPs. These participants were introduced to the WellShare research teams at the district level by the district health officer and at the national level by the MOH's FP focal person. Eight key informant interviews (KIIs) were completed in each of the four districts, plus five at the national level, for a total of 37 KIIs. District-level informants included district health officers, district health educators, the persons in-charge of health centers II–IV, VHT focal persons, providers in private clinics, FP focal persons/assistants, and procurement/stores assistants. National-level informants included staff members from Management Sciences for Health/STRIDES (Senior Technical Manager), the Program for Accessible Health, Communication and Education (PACE; Team Lead, Total Market Approach), and the World Health Organization (WHO; Family Health and Population Advisor), and two MOH staff (Acting Assistant, Commissioner for Reproductive Health and Principal Medical Officer) (table 2).

Table 2. Distribution of key informant interviews

	District level				National level	All levels
	Arua (n=8)	Iganga (n=8)	Kanungu (n=8)	Mubende (n=8)	Kampala (n=5)	**(N=37)**
Job Title						
FP focal person	1	0	1	0	0	**2**
VHT focal person	2	0	0	1	0	**3**
In-charge (HC II)	1	1	1	2	0	**5**
In-charge (HC III)	1	1	1	0	0	**3**
In-charge (HC IV)	0	1	0	1	0	**2**
District health educator	1	1	1	1	0	**4**
District health officer	1	1	1	1	0	**4**
Private provider	1	1	1	1	0	**4**
Procurement	0	2	2	0	0	**4**
*Other	0	0	0	1	0	**1**
National level	0	0	0	0	5	**5**

**Biostatistician.*

The key informant interview guide explored three main themes: awareness and beliefs about ECPs, ECP supply and demand, and ECP provision and support.

TRAINING AND DATA COLLECTION

The assessment team consisted of a lead consultant, an associate consultant, four team leaders, and three research assistants per district, along with a program manager, a country director and an operations manager from WellShare—for a total of 21 people. The training of the team leaders, research assistants, and WellShare staff took place between December 4 and 7, 2014 at the Uganda Museum in Kampala. Training was facilitated by Lead Consultant Gladys Mbabazi, and Associate Consultant Joseph Matovu. Training sessions included presentations on the background of the assessment, a review of the assessment protocol and data collection instruments, a review of the KII guides, and FGD roleplay.

Data collectors were trained to obtain individual verbal consent from participants prior to participating in the assessment. They were also given a prepared script that described the purpose of the assessment and informed the participants that their responses would be confidential and their participation voluntary.

Pre-testing of the data collection instruments took place in Wakiso District (near Kampala) on December 9, 2014. Surveys and FGD data from the districts were collected between December 15 and 19, 2014. The KIIs with the MOH and other implementing partners in Kampala (national level) were collected between January 7 and 12, 2015.

DATA MANAGEMENT AND ANALYSIS

The analysis of client survey data was descriptive only and the data are presented in the aggregate. The summary statistics include percentages for categorized or categorical variables, and the mean (or if more appropriate, median) and range for continuous variables. Because of the small sample size of the datasets, data may be presented as *n* instead of *percentage*, using a cut-off of *n* less than 20 in any one cell. The ECP client data are presented in the aggregate and stratified by *user* and *potential user* status. District-based analyses were not feasible because the sample sizes were too small.

District-level KIIs and the stratified sample of 16 FGDs were transcribed and then analyzed with the aid of QSR Nvivo 10.0. The content of the national-level KIIs were recorded in field notes. Transcripts and field notes were read in their entirety and structurally coded in NVivo based on their respective interview guides. Once initial coding was complete, primary structural coding reports were reviewed for salient content areas that emerged. Content codes were then applied to text where applicable and, on completion, secondary content coding reports were reviewed to identify and solidify salient themes. Responses from KIIs and focus group participants are provided to substantiate qualitative findings, but in the case of KIIs, no additional information is provided on the source because the number of KIs was small and potentially identifiable.

RESULTS

Results are divided into three sections. The first describes the results of the VHT surveys and the second section presents data from the client survey. Qualitative data from the focus group discussions with community members are integrated into the relevant sub-sections of VHT client surveys. The third section presents the results from the KIIs with district- and national-level officials.

PART 1. SURVEYS OF VILLAGE HEALTH TEAMS

Sociodemographic Characteristics

The VHT members were nearly evenly divided in terms of gender: 11 respondents were female and 12 were male (table 3). The mean age was 37.5 years (with a range of 27–57 years) and the majority (almost two-thirds) were married. Only 4 percent were single and never married. As a group, they were not highly educated and nearly two-thirds indicated that their highest level of education was primary or less than primary school. About one-fourth had been to secondary school; none had a university education. Nearly all the VHT members had children (96 percent) and, of those who did, the mean number of living children was 4.8.

Table 3. Sociodemographic Characteristics of VHT Members

	VHT members (n=23)	
	%	n
Sex of VHT		
Female	48	11
Male	52	12
Age of VHT		
Mean years	37.5	23
Have living children	96	22
Living children (among those with children)		
Mean number	4.8	22
Range	2-8	
Marital status		
Single/never married	4	1
Married	65	15
Living with partner, not married	9	
Separated/divorced	9	2
Widowed	13	3
Highest level of education completed		
Less than primary	13	3
Primary	48	11
Secondary	26	6
Vocational	13	3

Work Characteristics

On average, assessment participants had worked as VHT members for 7.7 years with a range of 2–29 years of service to the community (Table 4). They had been providing FP services for an average of 5.0 years. All VHT members reported that they mobilize clients for FP services; conduct FP talks; provide and counsel on FP methods; and provide referrals for methods. All offered condoms (male and female) and most (83 percent) provided injectables. More than half (61 percent) provided oral contraceptive pills. Only 9 percent said they currently provide ECPs. The VHT members offered counseling on a range of methods, with most counseling on condoms and injectables, and to a lesser extent on oral contraceptive pills, implants, the IUD, and sterilization methods (data not shown). Only 17 percent reported that they provided counseling on ECPs. The VHT members made the most referrals for implants, tubal ligation, and the IUD. Although few had provided ECPs, 26 percent of VHT members had made referrals for ECPs to the health center.

Table 4. VHT work experience

	VHT members (n=23)	
	%	n
Time working as VHT		
Mean years	7.7	23
Range	2-29	
Time providing FP services		
Mean years	5.0	23
Range	0.4-28	
Methods currently provide		
Condoms (male & female)	100	23
Injectables	83	19
Oral contraceptive pills	61	14
ECPs	9	2

ECP Knowledge and Use

All but one VHT member (96 percent) reported that they had heard of ECPs. More than half of the VHT members knew that ECPs can be used after unprotected sex to prevent pregnancy (78 percent) and that they are effective (57 percent) (figure 2). About 30 percent of the VHT members knew that ECPs are easy to use and an equal proportion knew that ECPs can be used after coerced sex to prevent pregnancy. The most-oft cited disadvantages of ECPs were side effects (35 percent), no protection from HIV/STIs (26 percent), and poor availability (22 percent). Many (39 percent) reported that they did not know any disadvantages (figure 3). Four VHT members reported that they had personally used ECPs.

Figure 2. Benefits of Using ECPs, as Reported by VHT members

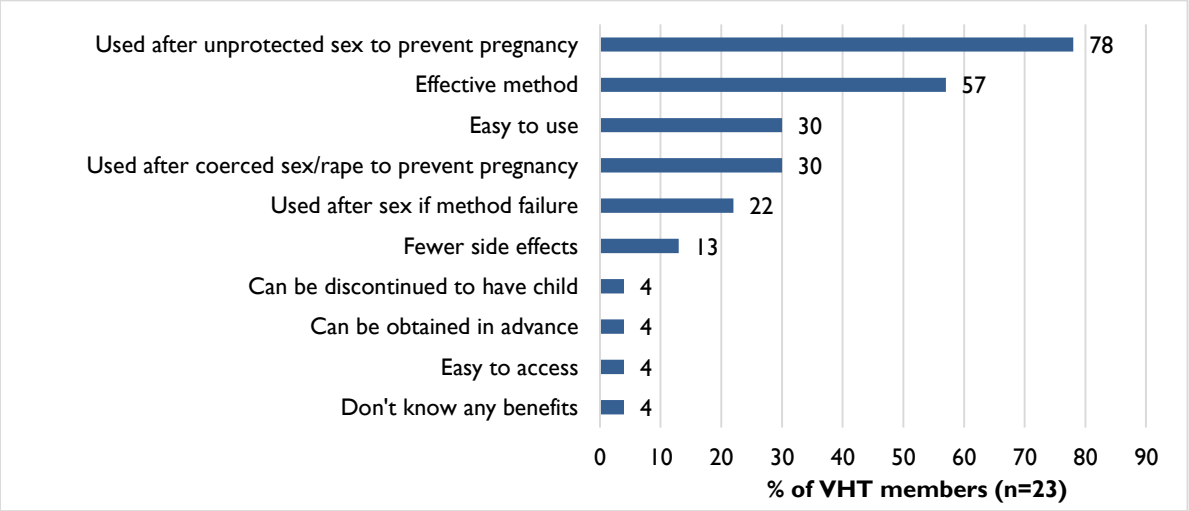
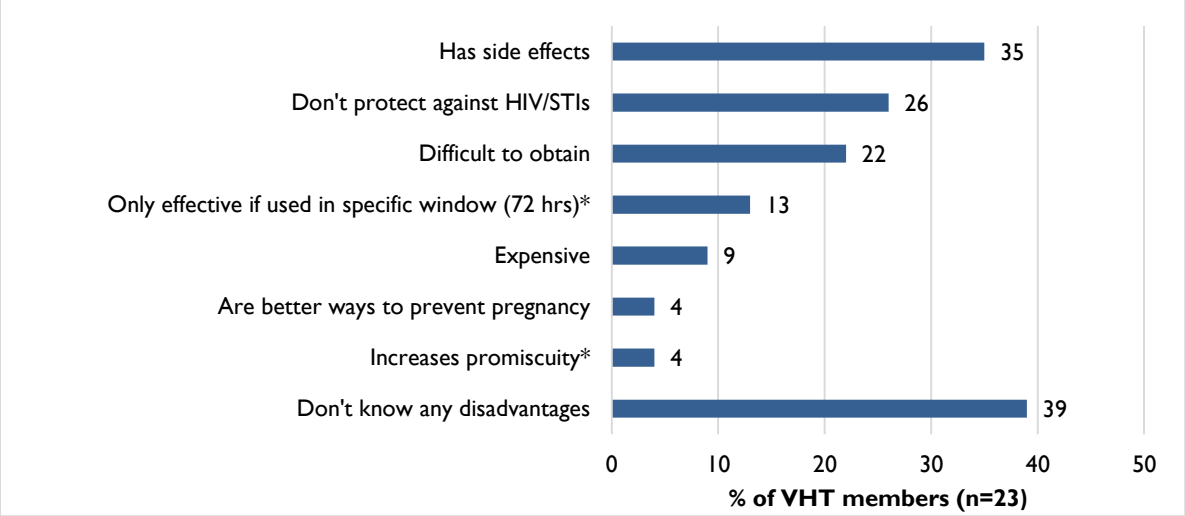


Figure 3. Disadvantages of Using ECPs, as Reported by VHT members



*From 'other' responses.

Perceptions of ECP Provision

Most VHT members (87 percent) felt comfortable providing ECPs to women in the community. These VHT members said that ECPs engender a close patient-provider relationship that could increase uptake (65 percent); that the provision of ECPS by VHT members would increase women's access and reduce their transport costs to clinics (60 percent); and that the provision of ECPs increases the actual availability of ECPs in the community (55 percent). Nonetheless, a little more than half of the VHT members thought there could be problems with the community-based provision of ECPs. A variety of reasons were suggested, but no single reason was mentioned by more than three of the 23 VHT members. For example, three participants said that VHT members are not well-accepted in the community, and three said that VHT members are not adequately trained to provide ECP services.

The VHT members overwhelmingly believed the community would be happy to receive ECPs from them; all but one (96 percent) said the community would be satisfied with VHT-provision of ECPs. About two-thirds (68 percent) of the respondents said that VHT members would provide easy access to ECPs, and 45 percent said VHT members would provide more information to the community. The lone VHT who said that the community women would not be satisfied believed that VHT members were not accepted by the community.

A little more than half (57 percent) of the VHT members reported that they had been asked directly by a community member about ECPs and a similar percentage believed there was a great need for ECPs in the community. All believed that the provision of ECPs by VHT members will increase the demand and use of the method. A lack of knowledge about ECPs was cited as the main barrier (78 percent) to the use of ECPs in the community. Other commonly mentioned barriers included a fear of side effects (30 percent), religious beliefs that prohibit FP (30 percent), and difficulty accessing ECPs in health facilities (22 percent). In addition, 13 percent said that men (or husbands) do not approve of ECP use.

About 96 percent of the VHT members suggested that ECP uptake would correspond to increased community awareness of ECP services. In addition, 70 percent thought that awareness could be increased by supporting the provision of ECPs by VHT members and by making ECPs available in the community (38 percent). Finally, 17 percent stated that men should be involved in all related reproductive health programs.

PART 2. CLIENT SURVEYS AND COMMUNITY FOCUS GROUPS

Sociodemographic Characteristics

VHT clients were, on average, 23.8 years old. One-third of the women were single and more than half were in union (married or not married but living with a partner). Three-fourths had ever-been pregnant; the average number of pregnancies was 2.7 among those who had ever been pregnant; and the average number of living children was 2.4 among those with living children (table 5). The sociodemographic profiles of ever-users of ECPs and potential users were similar, although, on average, ever-users were seven months older than potential users.

Table 5. Socio-demographic Characteristics of VHT Clients by Ever-users of ECPs

	All clients (n=80)		Ever-users (n=20)		Potential users (n=60)	
	%	n	%	n	%	n
Age of client						
15–19 years	33	26	20	4	37	22
20–24 years	26	21	35	7	23	14
25–29 years	19	15	20	4	18	11
30 years or older	23	18	25	5	22	13
Marital status						
Single/never married	33	26	30	6	33	20
Married	31	25	40	8	28	17
Living with partner, not married	23	18	15	3	25	15
Separated/divorced	10	8	15	3	8	5
Widowed	4	3	0	0	5	3
Ever pregnant	75	60	85	17	72	43
Pregnancies (among ever pregnant)		(n=60)		(n=17)		(n=43)
Mean number	2.7	60	2.4	17	2.8	43
Range	1-9		1-7		1-9	
Have living children	70	56	70	14	70	42
Living children (among those with child)		(n=56)		(n=14)		(n=42)
Mean number	2.4	56	2.4	14	2.4	42
Range	1-7		1-6		1-7	

General Trends among FGD Participants

As shown above in table 1, focus group participants were evenly divided between male and female, peri-urban and rural groups (eight each), with four of the 16 groups comprising 20–24-year-olds, and six groups each of 15–19 and 25–49-year-olds. We examined key responses among these groups to determine whether there were any trends or interesting patterns associated with gender, location, or age group. Male and female participants both reported that ECPs were not a popular (widely used) method in their communities. The three age groups did not differ on this issue either. All eight peri-urban groups reported that ECPs were not popular, while five of eight from rural communities did so. However, in all groups that discussed the lack of popularity or low use of ECPs, it was with consensus of all participants.

Participants were probed on whether ECPs "were viewed as an abortifacient" in their community. The responses demonstrated that there were no distinctions between gender and location, as both men and women and participants from peri-urban and rural communities were just as likely to express beliefs that ECPs cause or do not cause abortion. However, in only four focus groups (one all-male, one all-female, one rural, and one peri-urban) did all participants believe that ECPs cause abortion. Participants in the oldest group (25–49) were more likely to bring up the topic of abortion than the two younger age groups; so all discussants in the two focus groups of 25–49 –year-olds reported that ECPs were abortifacients, whereas no focus groups of the two younger groups expressed that opinion.

The majority of groups reported that it was not "OK to replace condoms with ECPs." In only three focus groups did all participants agree that the substitution of condoms for ECPs was "OK." Participants in eight focus groups explicitly mentioned specific drawbacks of condom use: condoms could burst, tear, or get lost in the woman's body; condoms make a woman's vagina dry; married couples don't need condoms; and ECPs would be better because their use is controlled by the woman (as opposed to male condoms, which are controlled by men).

Many groups expressed mixed views about the provision of ECPs by VHT members. Male groups were more likely than female groups to express concerns; some males said that ECPs would allow women to hide their use of FP from their husbands. The youngest participants and rural participants were also more likely than their counterparts to simultaneously express support and opposition. Young participants were concerned about the VHT members' ability to maintain confidentiality and the general lack of youth-friendly services. An overwhelming majority of male, rural, and peri-urban group members believed that the demand for ECPs would increase if they were provided by VHT members, whereas female participants in six of the eight FGDs felt that men would not allow it.[3]

> *Men want [to continue] having children. Women go to family planning in hiding without their husband's knowledge, because they don't allow them to use family planning. We still have that problem in our community.* **(Peri-urban female, 25–49)**
>
> *Very few men would be happy about that [VHT ECP provision], most men are not good at family planning issues ….* **(Rural female, 15–19)**
>
> *It is good for VHT members to give out these pills, but while some men might find no problem with this, some will not be amused. A man might blame his wife for not giving birth when he wants a child, because she uses this pill. He can end up chasing her [out of the house/marriage]* **(Peri-urban female, 25–49)**

This issue could not be examined with respect to the age of the participants because some groups did not address the provision of ECPs by VHT members.

The subsequent descriptions of our findings from the FGDs provide context to the survey results and offer an overall perspective beyond these stratifying characteristics.

Family Planning Knowledge and Use

Almost all survey respondents had heard of FP; only one woman (a potential user) said that she had not. The main source of information about FP for both groups are government medical providers (from health centers, clinics, or hospitals) and, to a much lesser extent, VHT members and the radio. Women who had ever used ECPs were more likely to report that they had received information about FP from

[3] In the remaining two female FGDs, one group felt men would accept VHT provision of ECPs; in the other, the issue was not addressed.

VHT members than were potential users (30 percent and 10 percent, respectively). Most of the ever-users of ECPs were currently using a method, whereas less than half of the potential users were. For both groups, injectables were the method most commonly used, followed by implants. Among the ever-user group, two respondents said that they were currently using ECPs as a contraceptive method (table 6).

Table 6. Family Planning Knowledge and use among VHT Clients by Ever-used ECPs

	All clients (n=80)		Ever-users (n=20)		Potential users (n=60)	
	%	n	%	n	%	n
Main community source FP information						
Govt medical provider at HC, clinic, hospital	63	50	55	11	65	39
VHT members	15	12	30	6	10	6
Radio	14	11	10	2	15	9
Friends	6	5	0	0	8	5
Outreach*	1	1	5	1	0	0
Other (school)	1	1	0	0	2	1
Currently using FP method	56	45	90	18	45	27
Method using (among current users)		(n=45)		(n=18)		(n=27)
Injectables	40	18	-	7	41	11
Implant	24	11	-	4	26	7
Condoms	13	6	-	3	11	3
Oral contraceptive pills	11	5	-	2	11	3
ECPs	4	2	-	2	0	0
Natural FP: rhythm; safe days; calendar	4	2	-	0	7	2
LAM	2	1	-	0	4	1

* Mobile services outreaches are done either through public or private sector clinic or NGO

ECP Knowledge and Attitudes

As expected, all ever-users in the survey had heard of ECPs, but only about one-half of the potential users had heard of them. The survey responses to a query about the ever-user's first main source of information about ECPs were friends, VHT members, or public-sector health providers; each was cited by 30 percent of the respondents. The main source of first information for potential users was from a government medical provider (45 percent), followed by friends (16 percent) and the radio (10 percent). Only 6 percent (two potential users) said that they first heard about ECPs from VHT members.

Because a concerted effort was made to recruit participants for FGDs who had ever-heard of ECPs, nearly all groups (n=15) had *at least one* participant who had heard of ECPs before participating in the discussion. One participant mentioned having heard of ECPs just prior to participating in the group from the VHT who recruited him/her for the discussion. However, the groups were just as likely to contain participants who (of those who responded), had *never* heard of ECPs prior to their participation (13 FGD participants). Furthermore, all groups had *at least one* participant for whom it was unclear whether or not s/he had previously heard of ECPs (16 FGD participants). The lack of clarity is due, mainly, to the lack of individual responses or the ambiguity of the response(s). The lack of a response may also be interpreted as reluctance by some participants to acknowledge that they had never heard of ECPs. Some groups also had current or former VHT members as participants, which skewed the discussion of this

topic to these more knowledgeable participants: two male groups had former or current VHT members and one female group had a current VHT.

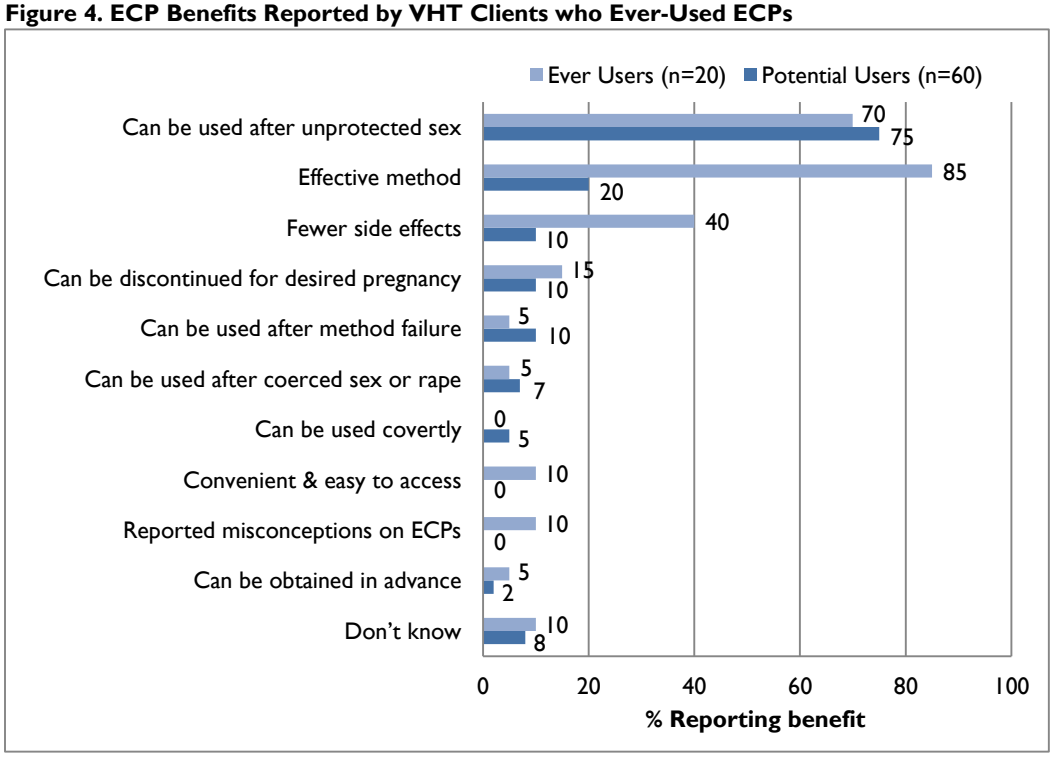
Focus group discussions confirm that public health centers or clinics and health workers are among the most-cited sources for people first learning about ECPs, followed by other health outlets, such as private clinics, hospitals, and pharmacies.

> *I heard about this pill from the health center as the health workers were educating women about family planning. After hearing about it, I went back to the nurse and asked her to explain for me further. She then told me that this pill is not just used by anybody, but only during emergency.* **(Peri-urban female, 25–49)**

In survey data, 60 percent of ever-users did not think that a woman should use ECPs as often as she wants. A smaller proportion of potential users (50 percent) shared that belief. There were noteworthy proportions of both ever- (10 percent) and potential (17 percent) users who reported that they did not know.

The two main benefits of ECPs that ever-users cited were that they are an effective method and can be used after unprotected sex. The most-cited disadvantage (45 percent) is that they have many side effects. A large proportion of potential users (75 percent) also cited the use of ECPs after unprotected sex as a benefit. Other benefits cited by fewer potential users were that they are an effective method, can be discontinued for desired pregnancy, have fewer side effects, and can be used after method failure (figure 4).

Figure 4. ECP Benefits Reported by VHT Clients who Ever-Used ECPs



The FGDs about ECP knowledge were divided into three topics: how ECPs are used, the purpose of ECPs, and how ECPs work. When asked "What are ECPs?" or "What have you heard about ECPs?" most respondents referenced the timing of when the pills were to be taken. Many participants said *after*

unprotected intercourse, though some indicated that ECPs could be taken beforehand. Some mentioned specific timeframes in which ECPs could or should be taken. Many participants said that ECPs should be taken in as little as 24 hours before or after unprotected intercourse, whereas others indicated they could or should be taken one-to-two months before or after unprotected sex. Responses regarding ECP use also included the manner in which ECPs could or should be taken, with most respondents indicating that ECPs were to be swallowed, although some expressed the belief that they should be inserted vaginally. The frequency of use was also discussed by some participants; a few indicated that ECPs could be taken daily, perhaps confusing them with oral contraceptives.

> *I have heard about them that when you take them every day, you might not get pregnant and should have a particular time to swallow them may [be] like at 7[pm].* **(Rural female, age 20–24)**

Participants of focus groups also discussed the purpose of ECPs and provided circumstances in which ECPs could be used. They generally indicated that ECPs were used to prevent pregnancy, with some emphasizing that ECPs were for emergency use only. Specific circumstances mentioned were contraceptive-method failure, rape (being attacked "abruptly"), and unprotected ("live") sex.

> *Okay what I know about that ECP is that sometimes when on family planning and your days expire for that particular family planning–you fail to return to the health facility for the renewal of that family planning and you happen to have live sex with a man, you can use it and you don't conceive.* **(Peri-urban female, 25–49)**

> *According to what the nurse told me, these are pills you take to prevent pregnancy after having sex with a man or when a man attacks you abruptly. They are of very great help during emergency, and that is why I decide to use them.* **(Peri-urban female, 25–49)**

> *I was told that just in case you engage in sexual intercourse with a man but you were not prepared, you had not used any other family planning method and you were not ready to get pregnant, you can go to a health worker and tell him/her, he/she gives them to you, they work within 72 hours. The sperms of the man die and so you cannot get pregnant.* **(Peri-urban female, 15–19)**

Most FGD participants reiterated that ECPs work by *preventing* pregnancy. Some participants provided details on how ECPs work (the mechanism of action) to prevent pregnancy, whether correct or incorrect. These responses included beliefs or having heard that ECPs kill sperm, kill the ovum ("kill eggs"), or by prevent "an egg" from developing. The predominant view of the focus group participants was that ECPs are not an abortifacient, but even within those groups, there were participants who believed that ECPs caused an abortion or loss of pregnancy (which highlights the mixed views reported earlier). Those who did not view ECPs as an abortifacient simply said that ECPs are just contraceptives. A few participants indicated that ECPs could not be considered an abortifacient because ECPs are ineffective after conception.

> *For me, one time, I had unprotected sex and I was worried that I could have gotten pregnant, but when I went to see a health worker and explained my dilemma, the health worker asked me how much time had elapsed since I was involved in sex, I told the health worker two days. The health worker told me that the ECPs can still work effectively within three days. I was so much worried because I thought that I had conceived, but I found out that I was not, which means that ECPs stop the sperms from fertilizing the ova but do not cause abortion.* **(Rural female, 15–19)**

For men and women who believed ECPs *are* an abortifacient, most reasoned that this was due to their belief that conception occurs instantly. Therefore, anything that prevents pregnancy post-unprotected sex is considered an abortifacient. Still others pointed to religious beliefs or physical effects of ECP use (i.e., bleeding) as indicators that ECPs cause abortion.

> *There is something you have asked us for so long, but I am not sure of the angle you want us to respond it from. From the religious angle, when a man's sperm meets a woman's egg and fertilization takes place, whatever type of medicine that you take means that it causes an abortion. I do not know if that is the question you are asking? However, to sum it up, these ECPs can cause an abortion.* **(Rural male, 25–49)**

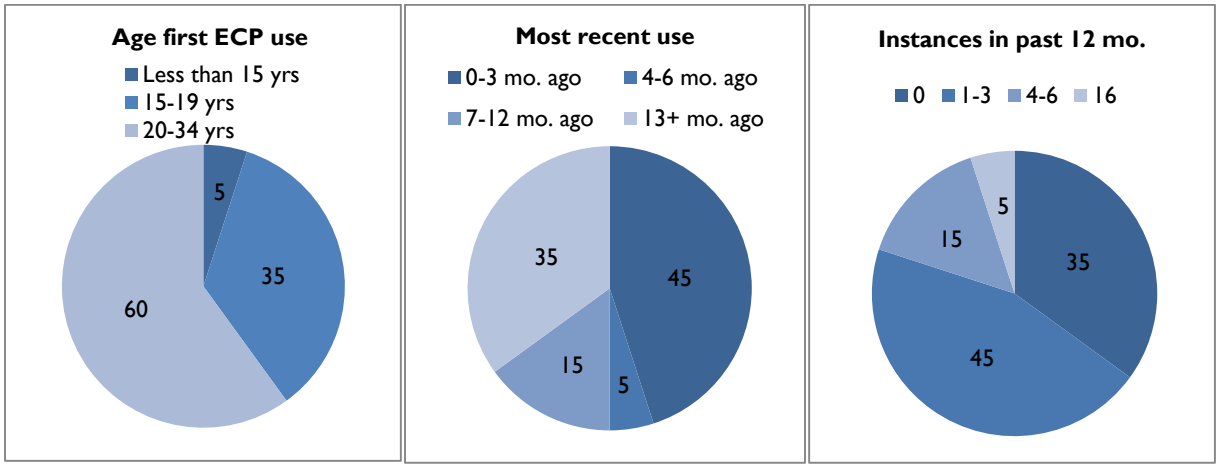
> *I have not been told that these pills cause abortion, but since they are for emergency, according to me, this shows that they can be used for abortion.* **(Peri-urban female, 25–49)**

Frequency and Reasons for Use and Non-use among Ever- and Potential Users of ECPs

Survey: ECP ever-users

For ever-users of ECPs, most of the survey respondents were between the ages of 20 and 34-years-old. The rest were under younger than 20 when first used ECPs. Of the 20 women who had used ECPs, 13 (83 percent) had used them at least once in the past 12 months and nearly half (45 percent) had used them in the past three months. For those who had used them in the past 12 months, most used them between one and three times. Three women used them between four and six times and one more than six times (figure 5).

Figure 5. Use of ECPs among Ever-users (n=20)



At the most-recent use, 90 percent took an ECP within 72 hours after unprotected sex. One respondent took an ECP after 72 hours (though the time was not specified), and one took an ECP six hours before sex. One woman experienced a pregnancy despite ECP use; she reported taking an ECP between 48 and 72 hours after sex. Nevertheless, all ever-users would consider using them again.

Survey participants were also asked, "What was the reason you obtained ECPs as a method the last time you obtained them?" Half reported that it was because they had unprotected sex. About one-third used them because they considered ECPs effective or easy to use. Survey participants were also asked who

was involved in their decision to use ECPs the last time. Ever-users predominantly reported the involvement of a provider at a health facility in their decision (45 percent), and a little more than one-third involved their spouse or sexual partner in the decision. Three ever-users (15 percent) involved a VHT member in the decision.

Although most ever-users did not involve their male partners in their decision to use ECPs, male participants in four FGDs acknowledged the value of ECPs to avoid unwanted pregnancies, while male participants in three FGDs generally supported women's ECP use as an emergency FP method. Men who acknowledged the value of ECP use mentioned that men could encourage their partners to use ECPs or could purchase them for their partners.

> *I think that after getting information on how ECPs work, how I can get involved is by buying the ECPs and I can tell my woman that you see these pills, if we are not ready to have other children, in case of unprotected sex you immediately take it.* **(Rural male, 25–49)**

In contrast, participants in seven of the eight FGDs with women indicated that men do not accept FP use in general, and specifically because men desire children (mentioned in five of eight FGDs).

Three-fourths of the 20 ever-users who were surveyed reported challenges to seeking or using ECPs. The main challenges (each mentioned by four respondents) were stockouts, distance to a service provider, stigma (or fear of public image), side effects, and resistance from a husband or partner. Two mentioned that the high cost of buying ECPs is a challenge and another said that she did not know sources of ECPs. As mentioned earlier, however, cost is an issue only in the for-profit private sector because ECPs provided by VHT members and at health centers are supposed to be free of charge.

Focus group participants also mentioned the costs associated with ECPs at public-sector health centers. Participants in three FGDs mentioned that ECPs were sold at high prices in health centers. As one noted:

> *…..in the clinics they are expensive, and with these clinics, I will be far in the village with no transport money or money to buy it, but if [they are] given to the VHT members, we will go there, explain to them, and they [will] give them to us, because I think they give them to us [for] free* **(Peri-urban female, 15–19)**

For ever-users in the survey, the main source of ECPs for their most recent use was a government health center, clinic or hospital (55 percent). Fifteen percent received them from a VHT and a similar percentage received them from a pharmacy. Nearly all women were comfortable receiving ECPs from the source where they obtained them; the one who said she was not comfortable obtained them from a government hospital or clinic. More than half of the ever-users reported that, in the future, they would prefer to obtain ECPs from a VHT, primarily because the method would be easily available from them.

Potential ECP users

About 40 percent of potential users in the survey had never used ECPs because they had never heard of them (table 7). Another 22 percent said that there were better ways to prevent pregnancy. Thirteen percent said that ECPs were not available in the area, and 13 percent said that they were not or had never been sexually active. The majority of potential users (88 percent) said that they would consider ECPs in the future. Only seven women said they would not; three of these said they would not because they wanted more children. Only one or two women said they lacked knowledge of ECPs or had problems with access.

Table 7. ECP Use among Potential Users

	Potential users (n=60)	
	n	
Reason why never used ECPs		
Never heard of them	40	24
There are better ways to prevent pregnancy	22	13
Not available at facility/shop in area	13	8
Not/never sexually active	13	8
It has many side effects	10	6
Difficult to obtain in area	7	4
Not accepted by husband/partner	5	3
No need; no interest	5	3
Other	5	3
Not effective	3	2
Expensive	3	2
Don't know	2	1
Would consider ECP use in future		
Yes	88	53
No	12	7
Reason would not consider future use*		(n=7)
Want more children	-	3
Unsure of effectiveness	-	2
Fear of side effects	-	2
Does not protect against HIV/STIs	-	2
Other (expensive, better FP, difficult to obtain)	-	3

*Multiple responses possible

The assertion that ECPs were not a popular (i.e., well-known or used) form of contraceptive was expressed by 13 FGD participants. They confirm the survey results where most of the respondents said that the lack of popularity was due to a lack of information about ECPs. Participants in the FGDs also said many women may be using other FP methods. Despite a general lack of awareness by the public,

the participants indicated that women would probably use ECPs if they were accessible, affordable, and came with proper education and information on their use.

> *Their usage is not bad [i.e., fair], except that they are very few people who are using them; people mostly use other family planning methods.* **(Rural female, 15–19)**

> *[W]e could easily use them if we knew which health facilities have them at what price they cost, so that if you want it, you know where to find it and its cost so that you are prepared with the cost.* **(Peri-urban female, 15–19)**

The focus group participants could envision several circumstances where people would benefit from the use of ECPs. Married and unmarried women, school girls and students, rape victims, women who engage in casual sex, female sex workers, or women who have had too much alcohol (the latter two were mentioned much less frequently than the others).

> *Other people using them are girls and women that have been raped, and are rushed to hospital so that the hospital can immediately give her that ECP so that whoever raped her might not [impregnate] her.* **(Rural male, 25–49)**

> *Yes it is true. They are used by unmarried women because for us who are married, we mostly use the long term family planning method. We don't use those ones.* **(Peri-urban female, 25–49)**

Sources of Information, Sensitization, and Attitudes about the Provision of ECPs by VHT Members

In the surveys, ever-users and potential users expressed different opinions on the best ways to increase education about and access to ECPs. Ever-users were more likely to believe that VHT members were the best channel for communications, whereas potential users were more likely to suggest providers at health centers or other health care sites (figure 6). Radio was also cited as a good source of information by about 20 percent of both groups, and about 10 percent of both groups suggested outreach activities. Ever-users were evenly divided about the best place to obtain ECPs; health centers and VHT members were each mentioned by about 45 percent of the ever-users (figure 7). Conversely, the majority of potential users (62 percent) believed the best source was a health center, though 27 percent thought that VHT members would be better.

Figure 6. Best Channels for Communicating ECPs

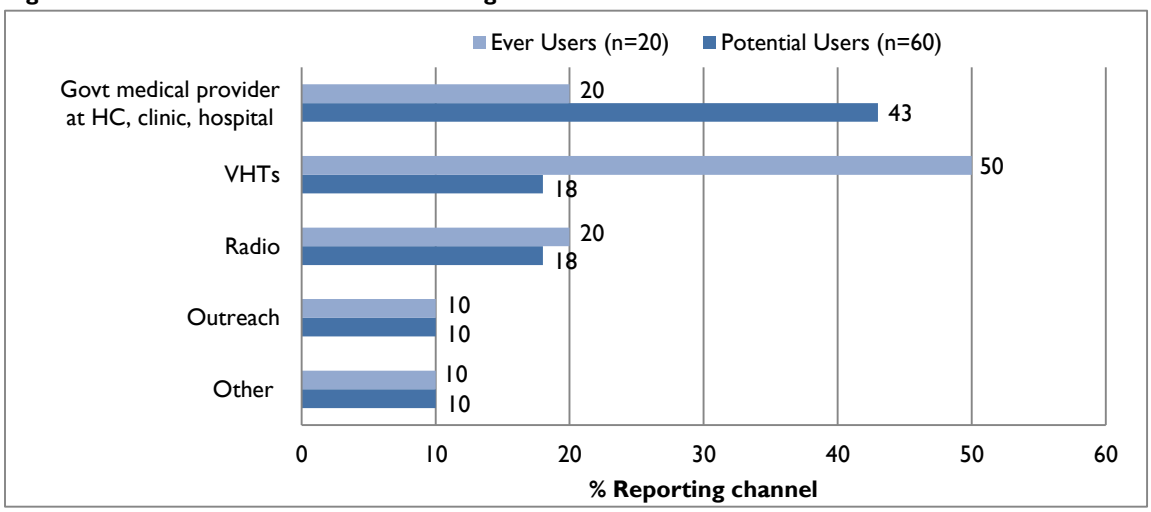
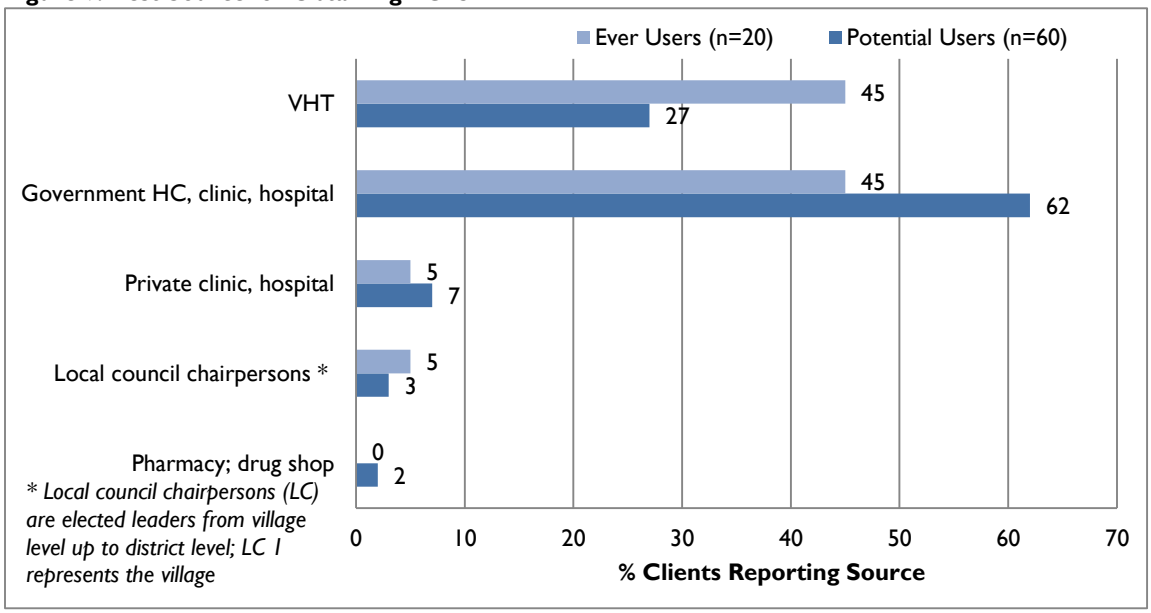


Figure 7. Best Source for Obtaining ECPs



Despite some disagreement on the best source for ECPs, more than 80 percent of ever-users and potential users were comfortable with ECP provision by VHT members (table 8). These respondents indicated that VHT members were more approachable and available and that transport costs and travel distances would be reduced because clients/users would not have to go to health centers. Of the 11 survey participants who did not feel comfortable with this approach, six indicated potential loss of confidentiality because VHT members were members of their own (the clients') community. Three women said that they did not trust or respect VHT members.

Table 8. Client Perceptions of ECP Provision by VHT Members

	All clients (n=80)		Ever-users (n=20)		Potential users (n=60)	
	%	n	%	n	%	n
How feel about VHT members providing ECPs in community						
Comfortable	83	66	85	17	82	49
Not comfortable	14	11	15	3	13	8
Don't know	4	3	0	0	5	3
Reason why comfortable		(n=66)		(n=17)		(n=49)
VHT members more approachable	58	38	65	11	55	27
Reduced distance & cost of transport	58	38	47	8	61	30
VHT members more available	35	23	24	4	39	19
VHT members trusted by community	8	5	6	7	8	4
VHT members well trained	6	4	6	1	6	3
Reduced stockouts	5	3	0	0	6	3
Reason why uncomfortable		(n=11)		(n=3)		(n=8)
Loss of confidentiality since VHT members are community members	-	6	-	2	-	4
Don't trust/respect VHT members	-	3	-	1	-	2
Other	-	3	-	0	-	3

Supporting the views of survey clients, focus group participants cited the accessibility of VHT members, their greater proximity (compared to local health facilities), and potential cost savings because of reduced travel expenses and because VHT members could not charge users for ECPs.

Although focus group participants were less likely to cite VHT members as their or other people's first source of information about ECPs, many considered VHT members and health centers as the best way for others to learn about ECPs in the future. Interestingly, although several groups cited radio or TV advertisements as sources for learning about ECPs, these media were less likely to be considered sources of future information. One teacher suggested that the information should be presented to students in schools.

Focus group participants indicated that VHT members would be easy to mobilize (door-to-door or health education events), or suggested that VHT members could be "branded" with special T-shirts to make it clear that they provided ECPs. However, a few participants explicitly stated that VHT members would not be the best source for raising awareness. This was because they believed that some people did not put much "stock" in what VHT members had to say, that there were few (if any) VHT members in their community, or they knew potential clients who were turned away by VHT members.

Some focus group participants suggested that VHT members would be a good first source of information about ECPs because they tended to turn to VHT members for other FP or health information, and because VHT members were already knowledgeable about other FP options.

> We *have VHT members in our village so we at times get information about the family planning from them and about the ECPs, it is important to pass the information through the VHT members to the people.* **(Rural male, 25–49)**

Many focus group participants also felt that radio (a few mentioned TV) would be the best way to raise awareness about the provision of ECPs by VHT members. Some participants identified specific radio stations within their community that were the most popular and therefore most likely to reach a wider audience. Radio was thought to be the best medium because nearly everyone owned and listened to the radio for a variety of reasons, including for health-related news. Some participants did, however, note that not everyone owned a radio or TV. They also expressed concern about message content because radio reaches such a broad audience. This was especially true for descriptions of the relative advantages and disadvantages of ECPs; too much information might scare people, whereas a lack of information might make people leery.

> *I do not believe that you should talk of its disadvantages over media when everyone is listening.* **(Peri-urban female, 15–19)**

Health facilities (health centers, clinics, hospitals) and health professionals (nurses, health workers) were also considered to be effective channels of communication because the community members expect them to be well-informed and many (mostly women) already visit the facilities for other services. Other participants suggested that health facilities and VHT members should work together to inform communities about the provision of ECPs by VHT members.

Some respondents mentioned word-of-mouth and community organizations and events (churches, trading centers/markets, local leaders, local councils, political rallies) because they draw large crowds/are led by influential people. Fewer people mentioned posters, schools (for youth or young girls), the MOH, the newspaper, or community men as channels of information. Social gatherings—burial ceremonies, drinking places, community meetings, or informal gathering places—were also mentioned because relatively large groups of people would be located in one place.

Among participants who believed the community would be opposed to the provision of ECPs by VHT members, the primary concern was with ECPs (not VHT members). They feared that the method could be used for population control or "immoral" purposes (such as adultery and promiscuity) and so cause marital discord and sexually transmitted infections. As illustrated below, religious opposition was also mentioned.

> *Provision of these pills within the community would cause trouble for the VHT members because certain churches do not completely want family planning (talks with emphasis), that is why you find that certain women are afraid of coming openly for family planning; they do not want others to know. Some churches do not encourage family planning.* **(Peri-urban female, 25–49)**

Participants in four FGDs (two male, two female; from peri-urban and rural settings, representing ages 15–19 and 25–49 years) were opposed to the provision of ECPs by VHT members, who are generally considered to be uneducated, lacking in training and skill, unable to answer questions or unwittingly provide incorrect information or advice that would result in the misuse of ECPs.

> *I think they should bring such medicine and keep it in the hospital. In case they do give, should do it from the hospital. And people should get adequate teaching about it from health workers because there are people here who have missed these things because they come to ask questions and VHT members*

cannot answer as required, so they will say, 'they brought inactive or bad medicine again.' **(Rural female, 20–24)**

Participants in three FGDs (with all-male participants) expressed concerns about the potential for corruption among VHT members. They suggested that VHT members may illegally demand payment for ECPs, knowing that clients are in an "emergency" situation.

What information should be communicated about ECPs?

Focus group participants frequently mentioned that the proper use and side effects of ECPs should be conveyed to potential users: How are ECPs used? Single or regular use? Oral or vaginal delivery? Before or after sex? How long before or after sex? Is long-term use safe? Participants also suggested that the capacity of ECPs—prevention of pregnancy but not disease—should be included in awareness raising. Participants felt that this warning should be directed toward young girls especially.

The focus group participants said that the side effects of ECPs should be made known, so that potential users could make an informed decision. Certain side effects raised the greatest concern: the potential effects on future (desired) pregnancy; the potential for causing birth defects; and potential for causing uterine disorders (such as fibroids).

The participants also suggested that ECP awareness messages should mention the advantages and disadvantages as well as where to find the product. Other ideas mentioned less often were the inclusion of information on dosage, effectiveness, how ECPs work, who should use them, promotion of other FP methods, and negotiating use of ECPs.

PART 3. KEY INFORMANT INTERVIEWS

ECP Provision in Health Care Facilities

Most KIs believed that health care workers supported the distribution of ECPs at health care facilities (mentioned by 24 of the 37 respondents, including two from the national level). Many respondents said that health care workers support ECPs because they recognize the consequences of abortion and the long-term consequences of unintended or unwanted pregnancy on the mother and child. The KII respondents said that any negative perceptions of ECPs—such as their use as a primary contraceptive method—are outweighed by their benefits. As one HC in-charge stated, "The health workers feel very comfortable and safe since they are knowledgeable and trained on family planning services…The health workers feel it is very necessary to provide the emergency contraceptive pills to clients because the clients are saved the burden of unwanted pregnancies."

The majority of KIs said that their clinics provide ECPs to eligible clients after an assessment by a health worker, or to clients who specifically request ECPs. Three KIs said their clinics provided ECPs to clients on request, but with the exception of rape, they did not freely offer ECP as an option to eligible clients. One respondent said that her site provides ECPs only when directly requested by a client; even women who were raped would not be offered ECPs unless they requested the product.

Nineteen of 37 KIs (two national-level informants) explicitly stated that they do not place any restrictions (client's age, marital status, or occupation) on the provision of ECPs beyond the basic requirement of taking the medicine within a certain timeframe following unprotected sex. Two respondents said that even though there were no restrictions on who could receive the medication,

they thought that health care workers were not consistent, and that the workers' biases about who should be having sex would affect their decisions. As one respondent explained, "These health workers are very funny. Some clients go there and they do not get, and others, they go there and they get [ECPs]."

Stockouts were a common concern, particularly among those who work more closely with clients or health care providers. Twenty-two KIs said that stockouts were a problem; but 10 did not think they were a problem. As one in-charge noted, "We get constant stockouts because we are given very few doses and by the time we get them, everyone wants a dose. So in no time, they get finished; for example, the last time of replenishment we were given about five doses but in two days they were all finished. In fact, since September 2014, we have not received any ECPs."

Among those who said that stocks were not a problem, a lack of demand (due to a lack of awareness) was the most-commonly cited reason. One health educator noted that, "Yes they are available but the problem is low demand for emergency contraceptive pills."

The respondents provided several reasons for the occurrence of stockouts; these varied somewhat according to the respondent's job category. Across all job categories, participants most frequently mentioned communication errors, requisition office errors, or not ordering more ECPs until the existing stock was already gone (n=12). Not receiving adequate EPC supplies to begin with and running out before the next distribution cycle was mentioned by 10 KIs, eight of whom were in-charge at health centers. The expiration of ECPs (because of low demand n=4) and the NMS and requisition delays or unfilled requests (n=3) were also mentioned.

Respondents overwhelmingly thought ECPs should be provided at health care facilities, where clients could get appropriately assessed for ECP need, counseling, and treatment. They also believed that facilities were the most common source of ECPs. Only a few concerns were mentioned about the provision of ECPs at health care facilities, including requests by clients who did not need the product, and requests by clients who came in too late after having unprotected sex.

Attitudes Toward the Provision of ECPs by VHT members

Although the KIs supported the provision of ECPs in health care facilities, most also supported the provision of ECPs by VHT members (26 of the 37 KIs, including two from the national level). Only four people did not favor the provision of ECPs by VHT members (none from national level), citing the lack of VHT member training (leading to potential safety concerns). It is worth noting that two of the four individuals who did not support ECP provision by VHT members were private care-providers.

Nearly all participants mentioned at least one benefit related to the increased availability of ECPs if VHT members were to provide them (n=34). The most commonly mentioned benefit was increased access to ECPs (n= 26), but faster provision of ECPs (because of the proximity or accessibility of VHT members) and lower costs were also mentioned. The participants also mentioned the general role of VHT members in the community. Because VHT members understand their community's health needs, they are better able to meet these needs.

In the words of one health educator, "…because it is VHT members who are serving people with health services at the grass roots and at the roots that is where there are people with need and problems that require emergency contraceptive pills. These VHT members are easily accessible to the women in the community at any time and it doesn't require the women who are in need of emergency contraceptive pills to incur any transport, she just goes to the VHT members. Since the emergency contraceptive pills have a time limit which is within 5 days so the woman will not say that I have missed accessing

emergency contraceptive pills because I did not have transport to go to the health facility; she will just walk to the VHT's home."

Although respondents generally supported the provision of ECPs by VHT members, most expressed some doubts, too. The suspicion that VHT members might not have sufficient training to provide ECPs safely was the most common concern. Participants felt that the proper assessment of a client and the administration of ECPs required training that VHT members do not currently receive. As one district officer noted, "You see the VHT members are not technical and doing certain technical things needs technical expertise. My feeling is that VHT members may not have knowledge to assess whether someone really needed emergency contraceptives at the time they came….."

A number of KIs (n=15) also believed that community members might abuse ECPs if the method was easily accessible. Many of these informants expressed concerns that emergency contraception might replace other FP methods for primary prevention. Some respondents worried that the provision of ECPs might engender a backlash in the community against VHT members, who might not have the support or expertise to handle such a situation. Seven respondents were also concerned about the loss of confidentiality—because VHT members and clients were members of the same community or because clients had raised this issue at a health care facility. As one in-charge HC mentioned, "The VHT is your neighbor, the VHT knows your husband so I think some people may not feel comfortable, they may not trust the VHT." Participants were also concerned about poor storage of ECPs, including the increased likelihood of theft, but most believed that this issue could be addressed through training and proper storage facilities. In general, the respondents believed that the challenges they mentioned could be mitigated by training and supervising VHT members.

VHT Training and Support Needs

The training of VHT members for the provision of ECPs raised four themes:

- Who should conduct the training?
- How long should the training last?
- What content should be covered in the training?
- What are the qualifications of a successful VHT?

The majority of KIs said that individuals who work at health facilities (including midwives) would be best suited to train VHT members on the provision of ECPs. Respondents believed that the workers at these facilities know their communities, and would provide unique insight for the training. Although the respondents had various suggestions on the ideal duration of the training, the most common suggestion was two-to-three days.

The basics of ECP provision—how to assess a client, how to administer ECP, how the medication works, and possible side effects—were the most frequently mentioned topics for training (n=26). The participants said that ECP training would refresh VHT members' knowledge of other FP methods (n=13). In combination with training on counseling skills (n=8), VHT members could help clients adopt an FP method, and reduce their need for ECPs in the future. Community mobilization was also perceived to be an important skill to learn during training, especially in light of the concern that the community might express a backlash against VHT members and ECPs.

The participants identified several qualities of a successful VHT member, including specific skills such as literacy (n=17) and English proficiency (n=7), and simply being a member of the community (n=6). Many respondents said that VHT members should be selected and trusted by community members (n=12). Respondents said that VHT members would be more motivated to volunteer their time and increase their availability if they have been individually selected by the community they serve.

The respondents provided several suggestions for the types of support and supplies required by VHT members to provide ECPs. The most commonly mentioned supplies included stationery (for notes), T-shirts (for recognition), ID badges, pill-storage cupboards, bags to carry supplies, gumshoes or boots, flashlights, raincoats and umbrellas, and brochures and other handouts.

Transportation support was mentioned by 23 of 37 KIs, including bicycles for travel within the community and travel reimbursements to attend meetings or bring clients to health care clinics. Twenty-one of the 37 participant said that financial support would dissuade VHT members from demanding money for ECPs.

Supervision and Ongoing Support of VHT Members

KIs believed that VHT members should receive ongoing training, supervision, support, and links to health care clinics. As one private provider said, "Keep supervising the VHT members either monthly or weekly to monitor how they are progressing. Should also listen to their problems and their worries. You see one might not master all that was taught during the training. Therefore, they should keep training them, since they meet many clients in the field, asking the most questions that a VHT can't reply." One in-charge acknowledged his/her role in supervision: "Our role is to ensure that we help VHT members understand the whole concept of ECP use. We should supervise them to make sure that they are doing the right thing and during the health talks that we give mothers, we can also mention that VHT members are providing ECP services..."

District health educators, district health officers, and in-charge HCs mentioned the use of a monthly reporting system to track the distribution of ECPs by VHT members. The VHT members would report the number of pills distributed and the number remaining in their stocks. Respondents supported a monitoring and evaluation system that could be incorporated into the existing M&E systems at health facilities. The importance of supervision and technical support was mentioned by all district health educators, three of four district health officers, and half of the in-charge HCs.

Finally, many KIs mentioned that the community's support and awareness of ECPs and their provision by VHT members was critical to the success of this initiative. Five individuals highlighted the importance of community dialogues and other outreach methods. Respondents noted that raising community awareness of ECP benefits and the VHT members' work in the community would probably increase support for ECP provision by VHT members and reduce stigma associated with the use of ECPs. One in-charge highlighted this idea: "If it is only giving ECPs to the VHT members, that will not increase the demand but if sensitizing the community is involved, I think it will increase. People may know that the VHT has got FP methods but they may not know that this ECP does this and that. So if VHT members are given ECPs and the community sensitized, they will increase definitely."

DISCUSSION

This assessment suggests a general lack of knowledge about ECPs in the four study districts. This result is consistent with observations that the knowledge and use of ECPs is especially low in rural settings across the globe (Westley et al., 2013)—where community health workers generally provide services. Even so, our results indicate an overall acceptance of the provision of ECPs by VHT members. Furthermore, it appears that VHT members can help raise awareness and increase access to ECPs.

Moreover, the respondents generally recognized that ECPs can be beneficial. The VHT members, key informants, and community members cited many advantages of ECPs, notably the prevention of pregnancy after unprotected sex, the effectiveness of the method, and the use of the method after forced or coerced sex.

Of the VHT clients in the survey who had never used ECPs, only half had ever heard of them—and this was the main reason these women had never used the product. The community focus groups confirmed the widespread lack of knowledge about ECPs, including misconceptions such as the mode of action, and when and how they should be taken. For instance, some believed that ECPs are an abortifacient, are inserted vaginally, and can be taken prior to sex.

Despite this lack of knowledge, there may be a large unmet demand for ECP use in these districts. The finding that all of the ever-users would use them again indicates an overall satisfaction with the method. The majority of potential users also said they would consider using them. It should be made clear in sensitization events, however, that ECPs are not meant to replace condoms or more effective contraceptive methods. Unlike ECPs obtained in the private sector, the provision of ECPs by VHT members offers the perfect opportunity to counsel clients on more effective, ongoing contraceptive methods and the possible need for dual-method use. Most focus group participants agreed that it would not be acceptable to use ECPs in place of condoms. At the same time, many focus group discussants (particularly men) mentioned that ECPs would facilitate the prospects of having "live" (unprotected) sex. This underscores the importance of emphasizing that ECPs are to be used in emergencies only to avoid misuse and backlash from the community.

Community sensitization should also make clear that ECPs issued by clinic-based providers and VHT members are free-of-charge. Many focus group discussants seemed concerned about costs and dishonest providers, but they did not make the distinction between the private sector (where ECPs are sold) and the public sector, which they identified as their preferred source of ECPs.

The findings of this assessment point to several strategies that could increase community knowledge and appropriate use of ECPs. The primary strategy is education to increase demand. The results indicated that VHT members, health care providers, and radio announcements could be effective ways to reach people with health messages. Messaging should include information about ECPs and about FP in general. A more comprehensive approach to messaging would provide information on the range of available methods and the place of ECPs in the method mix. The results also indicated the possibility of religious opposition to FP and the general desire of men to have many children. These issues should be addressed in any strategy to increase FP and explain the post-coital function of ECPs. These issues also indicate the need to target specific (sex and age) groups with different messages.

Coupled with increasing demand is the need to improve access to ECPs. Many agree that the provision of ECPs by VHT members will improve access by making it easier and less costly to obtain the pills. Many respondents accepted the prospect of ECP provision by VHT members, but ever-users were more likely than potential users to recommend VHT members as a source. This may be because they were more likely to have received FP or information about ECPs from VHT members. The results suggest that few VHT members are actually providing or counseling community members on the use of ECPs. In addition, many more VHT members made ECP referrals than provided them. These areas are worthy of further exploration.

Several suggestions to improve the skills of VHT members were made. Some suggestions were specific to the provision of ECPs; others were aimed at improving their work in general. The KIs mentioned the need to train VHT members to assess clients, to explain the drug's mechanism, and to discuss possible

side effects. They also suggested further training on counseling skills and refresher training on other methods. The KIs also mentioned a need for continuous supervision and training of the VHT members, which is necessary for most methods they provide, but not necessarily ECPs. Emergency contraceptive pills are approved for over-the-counter provision, which means it is considered safe to use without a health professional's intervention and that the potential user herself can determine if and when she needs it. This suggestion by KIs as well as other findings in this assessment helped inform to a commentary that was recently published in Contraception (Chin-Quee et al., 2016). In support of community-based provision of ECPs, the commentary challenges some of the beliefs and attitudes that create barriers for CBEC such as the belief that easier access to ECPs will encourage promiscuity and the overuse of ECPs, and increase STI rates--especially among adolescents.

Beyond training on ECPs, informants also suggested ways to facilitate the work of VHT members, including support for transportation and material goods. They also mentioned challenges such as stockouts, stigma, partner resistance, and side effects. Although the last three could be resolved through education, reducing stockouts will require systematic improvements to the health care system, including a clear strategy to incorporate ECPs into the method mix. Such actions could prevent loss of stock through expiration.

This assessment also indicates a need for job aids and IEC materials to help VHT members provide ECPs to the community. As indicated by surveys, KIIs and FGDs, these materials should be in print, audio, and electronic formats (if feasible).

LIMITATIONS OF THE ANALYSIS

The selection of participating districts, health facilities, and participants for this assessment was purposive, and the sample sizes determined through convenience and feasibility. We were only able to analyze half of the 32 FGDs conducted in the four assessment districts, though they were chosen with as much care as possible to be representative. Our analytical approaches allowed us to observe recurring themes on the awareness, use, supply, and barriers to ECP uptake, but these findings cannot be generalized beyond the participants and the locations where data was collected.

CONCLUSIONS AND NEXT STEPS

Our assessment revealed several factors that might be contributing to the exclusion of emergency contraception from community-based family programs in Uganda. In our sample, half of the potential users of ECPs were not even aware that emergency contraception existed. The general knowledge about ECPs was also very low among those who were familiar with the method (i.e., how and when to take ECPs, how they work, that they don't protect against HIV/STIs). Lack of availability and stockouts were also identified as possible contributors to the low use of ECPs in community programs.

On the whole, our results indicated that members of the public generally accepted ECPs, but that certain sectors of the population—religious leaders and some men—might not welcome the method. There were also apprehensions about the provision of emergency contraception by VHT members, but respondents generally agreed that training and supervision could overcome any perceived deficiencies of VHT members as ECP providers. We also believe that such concerns are misplaced: ECPs have been approved for over-the-counter use in many countries, including Uganda.[i] Respondents also recognized

that ECPs could be beneficial and that VHT members can play an important role by raising awareness and increasing access to ECPs.

The lack of knowledge indicated a need to inform communities through information, education, and communication materials. We also recognized a need to provide resources and train VHT members to counsel clients as they provide ECPs as part of the FP method mix. In this regard, we offer the following recommendations:

- Conduct sensitization activities to increase awareness and demand for ECPs by targeting married and unmarried women, men, and couples with customized messages.
- Deliver messages through VHT members, health facilities, radio, television, and community gatherings.
- Develop clear strategies for including ECPs into the FP method mix. Make sure that logistical and medical information systems are able to forecast and meet the need for ECPs and other short-acting methods that VHT members can provide.
- Use the provision of ECPs by VHT members as an opportunity to counsel FP clients on the regular use of other contraceptive methods.
- Train VHT members to instruct clients that ECPs are for emergencies only. They are not a substitute for condoms, and they do not protect against HIV or other sexually transmitted infections.

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