Providing Emergency Contraception through Community Health Workers in Uganda: A Formative Assessment

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Community-based family planning is recognized as a high-impact practice for extending reproductive services to women, especially those who live in hard-to-reach places.[1] Condoms, oral contraceptive pills, and even injectable contraceptives are provided by community health workers through family planning programs. Yet many of these programs do not include emergency contraceptive pills (ECPs). Globally, only a third of social marketing programs distribute ECPs,[2] and the proportion is even smaller among community-based family planning programs. This absence is significant because the method occupies a unique position in the method mix as a post-coital contraceptive—offering women a second chance to prevent an unwanted pregnancy in the event of contraceptive failure, rape, or failure to use a contraceptive method.

KEY FINDINGS

- **The communities that participated in the assessment 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.**

So why is such an invaluable method with no medical contraindications not more common in community-based family planning programs? Funding priorities and misconceptions about ECPs may be factors in some places. Some countries prohibit the provision of ECPs by community health workers. But in other countries, such as Uganda, where the policies are favorable, community-based family planning programs have yet to fully embrace emergency contraception. Some other factors must be preventing the use of this approach.

Between 2014 and 2015, we conducted a formative assessment to explore possible factors with key stakeholders in certain parts of Uganda. Do the individuals in these communities know about emergency contraception? If so, what do they think about it? Are ECPs available? Would community health workers be accepted as distributors of emergency contraception? The answers to these questions can inform future attempts to integrate ECPs into existing family planning programs. Our results should also provide direction for the development of information, education, and communication materials related to community-based provision of ECPs.

Background: Uganda and Emergency Contraception

The Ugandan Ministry of Health approved the use of ECPs in 1998, and the method was introduced three years later as a socially marketed product to increase the public's awareness of emergency contraception. Soon after, the method was deemed illegal under the country's abortion laws.[3] The tide changed in 2007 when ECPs became available again, largely through the commercial sector. Advocates of emergency contraception now recognize the delicate balance between raising awareness and increasing access to emergency contraceptive pills in any country where some stakeholders characterize emergency contraception as an abortifacient.

Emergency contraceptive pills 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 the provision of ECPs by village-level community health workers, organized as village health teams (VHTs), who offer the lowest level of health care services (called HC I) in the country. National Medical Stores typically supply public health system facilities with ECPs.

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"It is good for VHTs 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)*

In 2012, the Ugandan government included levonorgestrel in the dose required for emergency contraception in its Essential Medicines List.[1] The government also projected a need to increase the volume of ECPs over three fiscal years, from 265,178 units in 2013/14 to 282,420 units in 2015/16.[4] Stock status reports on January 1, 2015 indicated that 218,799 units of levonorgestrel ECPs were available through the National Medical Stores for public-sector consumption and through the Uganda Health Marketing Group for the private sector. However, these units expired and were quarantined at the end of July 2015. Low levels of awareness and knowledge of emergency contraception very likely played a role in this event.[5] Donors subsequently ordered ECPs for distribution through the Uganda Health Marketing Group Alternative Distribution System (ADS), but supplies did not arrive until August 2016. As a result, the public sector was essentially without ECPs for over a year and is now sourcing ECPs from Uganda Health Marketing Group, which typically supplies the non-profit private sector with the product, Revoke 1.5.

Our Assessment Methods

We assessed ECP knowledge, use, supply, and barriers to uptake in the four districts in which community-based programs for ECPs were ostensibly in operation (Arua, Iganga, Kanungu, and Mubende). These districts were selected for convenience based on past and present programs in these areas by WellShare and FHI 360. These districts also provided 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.

We used quantitative and qualitative methods to collect the data. This included interviews with VHT providers (n=23); family planning clients who had ever used ECPs (n=20); or who were potential users of ECPs (n=60); and key informants at the national and district levels (n=37). We held 16 focus group discussions (FGDs) with men and women from communities in the assessment area.

The VHT providers who participated in the interviews helped us to select participants for the FGDs from their catchment areas, targeting women and men of reproductive age, located in rural or peri-urban catchment areas, and who had heard of ECPs or other family planning methods. To enrich the discussions, the focus groups included at least one participant who had heard of ECPs. This resulted in four FGDs from each district, two of which were all female and two all male; two were conducted 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 to ensure, as much as possible, an even distribution according to district, setting, and gender (Table 1).

Table 1. Characteristics of Focus Group Participants

		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)

*Numbers in parentheses are group size or mean group size of focus groups

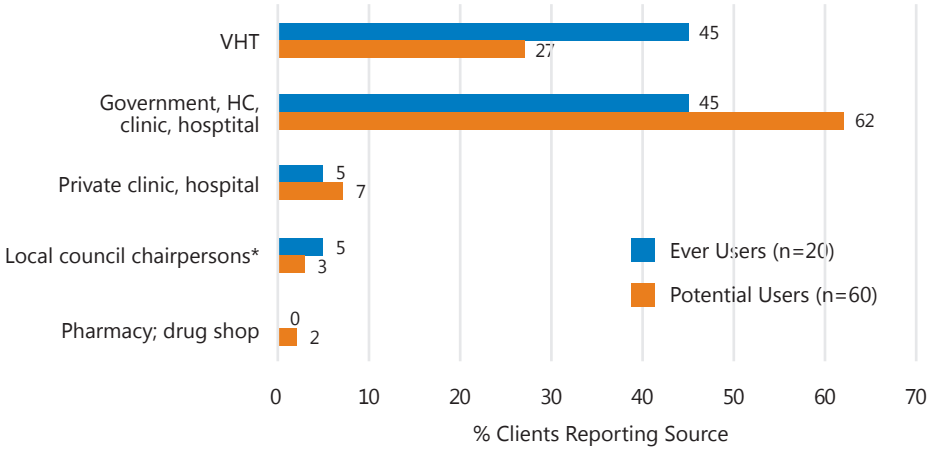
What We Found

The FGDs revealed very low levels of awareness of ECPs in the assessment communities. Once the communities were informed of this post-coital contraceptive method, opinions varied on whether it was an abortifacient, whether it would be accepted by men and religious leaders, and whether it would

be a good method for VHTs to provide to community members. Although many women in the focus groups felt that men would not allow it, most FGD participants agreed that the demand for ECPs would increase if VHTs were allowed to provide the method.

Key informants and VHT providers believed that provision by VHTs would increase demand for and awareness of the method. More than 85 percent of VHT providers said they felt comfortable with the task of providing ECPs to community members and that, in turn, most community members would accept VHT provision of ECPs. Although all VHT providers had been trained in the community-based provision of family planning, only 9 percent said they currently provided ECPs; 17 percent provided counseling on ECPs; and 26 percent made referrals for ECPs to the health center.

Figure 1. Best Source for Obtaining ECPs According to Ever-users and Potential Users



* Local council chairpersons (LC) are elected leaders from village level up to district level; LC 1 represents the village

A total of 80 family-planning clients of VHT providers 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 them in the past 12 months, most used them between one and three times. Ever-users named several challenges to obtaining ECPs, 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 VHTs. Of the 60 potential users (never used ECPs), about 50 percent had never heard of ECPs before the assessment. The other half, which was aware of the method, reported that the predominant source of introduction to ECPs was through a health facility provider. Ever-users were just as likely to identify VHT providers as health facility providers in that introductory role. When asked about the best source for obtaining ECPs, ever-users were more likely to mention VHTs than were the potential users (Figure 1).

Potential users were also more hesitant about ECPs than ever-users, as 22 percent reported that there were better ways to prevent pregnancy. Nevertheless, 88 percent of 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 about the provision of ECPs by VHTs in the community.

Key informants from the district level were more likely to mention stockouts of ECPs as a problem than were their national counterparts. Interestingly, the key informants who did not believe stockouts were a problem saw 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 this regard, the key informant interviews concurred with the FGD participants in that merely allowing VHTs to provide ECPs will not increase demand; community awareness must also be raised.

Key informants (national and district) expressed concern about the training and the abilities of VHT providers to deliver ECPs effectively. Some FGD participants and potential users also said that a lack of education and ability were potential barriers to the provision of ECPs by VHTs. Other concerns expressed by key informants were also mentioned by FGD participants, such as the loss of confidentiality if ECPs were to be provided by someone in the community and the overuse or abuse of ECPs if the method were to become easily available. Nevertheless, the key informants acknowledged that there was more to be gained than lost by the community-based provision of ECPs, and that these concerns could be mitigated by training and supervising VHT providers.

What It Means

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 aware that emergency contraception existed. And general knowledge about ECPs was also very low among people who were familiar with the method. 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 VHTs, but respondents generally agreed that training and supervision could overcome any perceived deficiencies of VHTs as ECP providers. We also believe that such concerns are misplaced because ECPs have been approved for over-the-counter use in many countries, including Uganda.[6] Respondents also recognized that ECPs could be beneficial and that VHTs could play an important role by raising awareness and increasing access to ECPs.

The lack of knowledge about emergency contraception indicated the need for information, education, and communication materials to inform communities. We also recognized a need to provide resources and train VHT providers to counsel clients when they provide ECPs as part of the family planning 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 VHTs, health facilities, radio, television, and community gatherings.
- Develop clear strategies for including ECPs in the method mix. Make sure that logistical and medical information systems forecast and meet the need for ECPs and other short-acting methods that VHTs can provide.
- Use the provision of ECPs by VHTs as an opportunity to counsel family planning clients on the regular use of other contraceptive methods.
- Train VHTs 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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Reference List

[1] USAID. Community health workers: Bringing family planning services to where people live and work. 2015. https://www.fphighimpactpractices.org/sites/fphips/files/hip_chw_brief/pdf.

[2] ICEC. Introduction to Emergency Contraception and the Status of Global Access. 2013. http://www.cecinfo.org/custom-content/uploads/2013/12/Westley-ICEC-Addis-2013-FORUM.pdf

[3] http://www.cecinfo.org/custom-content/uploads/2015/01/ICEC_Uganda-factsheet_2015.pdf

[4] *Quantification for Family Planning and Selected Reproductive Health Commodities FY2013/14 - FY2015/16.* December 2013. Uganda Ministry of Health, prepared by Reproductive Health Division and Pharmacy Division.

[5] Byamugisha, J. K., Mirembe, F. M., Faxelid, E., & Gemzell-Danielsson, K. (2006). Emergency contraception and fertility awareness among university students in Kampala, Uganda. *African Health Sciences, 6(4).*

[6] Chin-Quee DS, Stanback J, Graham V. (2016) In support of community-based emergency contraception. Contraception 94(1), 1–5.

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