

# Testing Alternative Channels for Providing Emergency Contraception to Young Women

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# TABLE OF CONTENTS

## TABLE OF CONTENTS

BACKGROUND	1
STUDY OBJECTIVES	3
STUDY DESIGN AND DESCRIPTION OF ACTIVITIES	4
▪ Selection of Health Care Workers	4
▪ Training of Groups to Provide Information and Services	7
COMPARING THE EFFICACY OF DIFFERENT INTERVENTION STRATEGIES	9
▪ Where Do Young People Go for Information and Services?	10
▪ What Other Variables Influence the Availability of Different Service Delivery Channels?	19
Pharmacists	20
Clinic-Based Health Care Providers	22
Peer Counselors and Community Sales Agents	23
▪ Do Providers Offer Broad Method Choice?	26
CONCLUSIONS AND RECOMMENDATIONS	32
REFERENCES	38

# BACKGROUND

Zambia's population is young, with 26 percent of its nearly 9 million inhabitants aged between 10 and 19 years. In urban areas, which account for almost half of the Zambian population, the proportion of those between 10 and 19 years is even greater.

Like adolescents everywhere, most young Zambians are sexually active by their mid-teens. A recent survey carried out in Lusaka by the USAID-funded project, *FOCUS on Young Adults*, found that nearly 64 percent of boys and 60 percent of girls had already experienced intercourse by the age of 24 (Lemba and Chishimba 1999). The 1996 Zambian Demographic and Health Survey (ZDHS) found that nationwide, a third of all 15 to 19 year old women had already begun child bearing, and by age 19, two-thirds had borne a child. Few adolescents take action to protect themselves from the risks of pregnancy and STIs. According to the same study, less than 5 percent of 15-19 year old girls used a modern method of contraception.

Clearly, young people are at high risk of unwanted pregnancies and sexually transmitted infections (STIs). Moreover, it is a risk they themselves recognize. In a 1997 study by UNICEF and the National AIDS Programme, young people ranked unwanted pregnancy as the greatest of their sexual and reproductive health problems. But they also identified many barriers to adopting safer sexual practices. They report, for example, being "chased away" from clinics by providers who scold them and threaten to tell their parents (Fetters et al., 1998). Adolescents also encounter considerable opposition by teachers and other adults to their use of modern contraceptive methods.

In 1995, *An Assessment of the Need for Contraceptive Introduction* in Zambia found that despite ongoing efforts to strengthen the delivery of family planning services, access still remains severely limited for many potential users. Contributing to this are cultural norms and provider biases that effectively withhold services from unmarried women or those who had not secured the permission of a male partner. The same was true for Zambian youth who, despite risks of unplanned pregnancy and STIs, feel obliged to seek out alternative outlets for reproductive health services and information.

Given the pervasive nature of such barriers, the assessment argued that emergency contraception could play a critical role in limiting unwanted pregnancies, reducing the need for unsafe abortion, and, ultimately, in lowering rates of maternal mortality and morbidity. To this end, it recommended adoption of the Yuzpe method of emergency contraception which involves provision of two high dose oral contraceptive tablets (containing levonorgestrel, 250g plus ethinyl estradiol, 50g ) within 72 hours of intercourse, followed by a further two tablets, 12 hours later.

Though emergency contraception remains largely unknown in most parts of Zambia, there has been growing interest on the part of many providers to introduce the method into ongoing service delivery programs. Unfortunately, introducing emergency contraception entails uncertainties and questions for which the delivery of traditional family planning services provides very few answers. Furthermore, most of what is known about these issues comes

from the delivery of services in *developed* countries, where access to information and the communication media is greater, where contraceptive prevalence overall is higher, and where a large percentage of potential users can be reached through formal institutions such as public health care facilities, universities, youth centers, and the like.

Consequently, in September 1997, the Population Council and Lusaka's University Teaching Hospital (UTH) launched a 15 month study to identify and then explore the range of issues relating to the introduction of emergency contraception within a developing country context. With financial and technical support from USAID, the World Health Organization and the Canadian Public Health Association, the study allowed clinic-based family planning providers to accumulate enough first-hand experience to be able to identify strategies for overcoming difficulties associated with the introduction or delivery of emergency contraception services.

One of the most startling findings to emerge from the UTH study was the relatively small percentage of young people seeking emergency contraception services. Instead of the nulliparous, unmarried, non-family planning users initially believed to have the greatest unmet need for emergency contraception, the mean age of emergency contraception users was just over 29 years, with a range from 19 to 43 years. Emergency contraception users also reported an average of 2.9 previous pregnancies.

While these figures clearly illustrated the breadth of demand for emergency contraception, they also suggested that clinic-based health care facilities may not be the most appropriate channels for reaching out to young people or, for that matter, a host of the other potential target groups. Not only were young women not represented among the users of emergency contraception, they made up a very small percentage of clients at the clinics themselves. Youth aged 19 and below, for example, made up only 14.2 percent of MCH/FP clients at the four participating MOH clinics, and less than 3 percent of clients at clinics of the national IPPF (International Planned Parenthood Federation) affiliate, PPAZ (Planned Parenthood Association of Zambia).

The linkage between age and access to emergency contraception was explored further during focus group discussions with male and female students at the University of Zambia (UNZA). During discussions on preferred sources of family planning services and information, the students insisted that it was the lack of privacy or anonymity that discouraged them from seeking assistance at either the counseling centers or clinics of their respective campuses. Medical students, for example, argued that anyone seeking services on campus would invariably run the risk of their "fellow students knowing their sexual life which is supposed to be confidential. They will be thinking that you have a big sexual problem." Others were even reluctant to go to UTH itself.

On March 10, 1997 a national workshop was held to disseminate the findings of the UTH study. Sponsored by WHO, the workshop was attended by more than 80 participants representing the service delivery, academic, and NGO/international donor communities. One issue on most participant's minds was the need to expand the delivery of emergency contraception services towards young women, especially out-of-school women who are not only more numerous, but also harder to reach. In tackling the problem of youth accessibility, participants recommended that future research activities look beyond school-based health facilities and focus on institutions such as pharmacists, peer counselors, youth clubs, community organizations, or even sports associations.

# STUDY OBJECTIVES

The findings of the 1997 UTH study on emergency contraception indicated fairly clearly the kinds of facilities young people were likely to *reject*. But it provided little indication as to precisely what types of outlets they might *prefer* – either as sources of information about emergency contraception or as supplies of actual emergency contraception pills. The present study, therefore, was designed with that objective in mind. It was designed to gauge – both quantitatively and qualitatively -- youth preferences for sources of emergency contraception information and services.

Coordinated by CARE/Zambia, Lusaka's University Teaching Hospital, and the Zambia Society for Family Health, the study trained four groups of individuals: peer counselors, CBD agents, pharmacists and community sales agents to provide information on emergency contraception as well as, in some cases, actual emergency contraception pills. The study also developed information, education and communication materials in conjunction with each of the service delivery approaches.

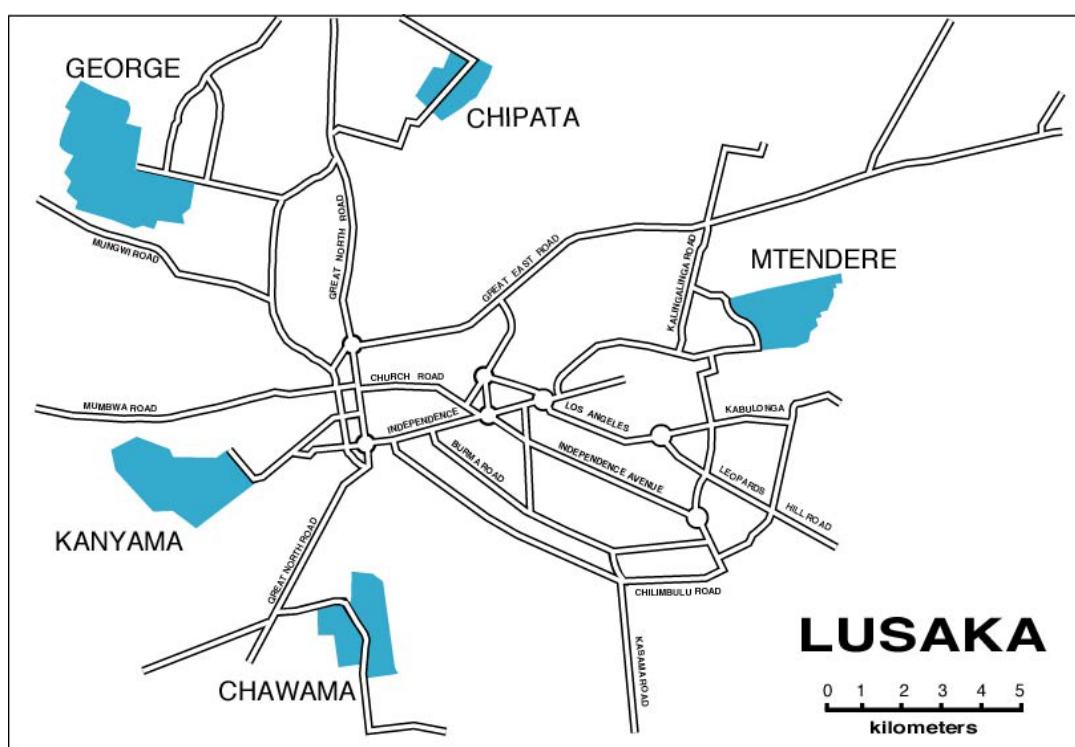
Ultimately, the goal of this project was to provide the Zambia Central Board of Health and the USAID-funded Zambia Integrated Health Program (ZIHP) with quantitative and qualitative data necessary to recommend the most effective channels for providing youth-friendly emergency contraception services within the context of broad method choice. Under this goal, “effectiveness” was defined in terms of the:

1. Absolute frequency with which young people seek out available channels of information and services (where do young people actually go to get emergency contraception?).
2. Feasibility/practicality of training, developing IEC materials, and commodity provision associated with each channel (what are the problems or difficulties associated with equipping each “channel” to provide information and services?).
3. Familiarity of emergency contraception users with alternative contraceptive options (which channels do a better job of providing emergency contraception within the context of broad method choice?).

# STUDY DESIGN AND DESCRIPTION OF ACTIVITIES

The present study undertook three intervention activities. First, it selected four different groups of health care workers to provide information on emergency contraception and/or actual emergency contraception pills. All providers, except for the pharmacists, were located in one of five residential compounds situated in or around the Zambian capital, Lusaka. These comprised the compounds of George, Chipata, Mtendere, Chawama and Kanyama (see Figure 1). Secondly, the study trained and equipped members of the four groups to provide emergency contraception information and/or services. And thirdly, the study measured and compared the efficacy of the different groups at providing information and services

**FIGURE 1**  
Study Intervention Sites



## SELECTION OF HEALTH CARE WORKERS

Based on data from the 1997 UTH study on emergency contraception (Ahmed et al 1998), young people singled out three groups they felt would be “acceptable” providers of emergency contraception information and services. These included their peers (student counselors, friends, etc); pharmacists and drug vendors; and community-based shopkeepers or other retailers. One other group, clinic-based health care providers, was viewed less favorably, but nonetheless was seen to be a potentially important source of contraceptive commodities in general.

The following four groups, therefore, were selected to provide emergency contraception and/or services under the present study.

**Peer Counselors:** Twenty-five peer counselors were selected and trained by CARE/Zambia to provide information about emergency contraception<sup>1</sup>. The counselors were based at five public sector health facilities located in each of the residential compounds described above. Soon after the initiation of intervention activities, eight of the original peer counselors dropped out of the study. They were, however, quickly replaced and trained with little if any impact on the implementation of project activities. Because of regulatory restrictions on the distribution of oral contraceptives, peer counselors were not authorized to distribute emergency contraception pills. Instead they could only give information on emergency contraception and indicate sources where emergency contraception pills (ECPs) could be obtained.

**Clinic-based outpatient health care providers:** In the 1997 UTH study on emergency contraception, clinic-based health care providers were not seen by young people as an ideal source of either information about emergency contraception or of emergency contraception pills themselves. This rejection derived from what many youth felt was the providers' overly judgmental attitude towards their sexual activities; as well as the general alienation they felt from the "maternal child/health atmosphere" of most clinic-based reproductive health services in general.

Despite such misgivings, many young people recognized that the sources of contraceptive commodities within Zambia were limited, and that apart from pharmacists and health care providers, few other options remained available. For that reason, this study chose to continue exploring the role of traditional clinic-based facilities. But rather than limiting services to MCH/FP nurses<sup>2</sup> – the traditional providers of public sector family planning – the study sought out the participation of outpatient (OPD) nurses. The reason for this decision was to enhance access to services. OPD facilities, open 24 hours a day, seven days a week, offered greater accessibility than MCH/FP Units which typically operated only during office hours. Building on the experience of a 1998 study on the prophylactic distribution of emergency contraception pills (Skbiak et al 1999), the five clinics participating in this study allowed clients to obtain emergency contraception pills (ECPs) at the general OPD dispensary without having to go to the MCH/FP unit for counseling with a health care provider.

**Pharmacists/Chemists:** Based on the results of studies carried out by Ahmed (1998) and Shah et al (1996), young people view pharmacies as ideal sources of contraceptive information and methods. The client-provider relation, by being purely commercial, is perceived to be relatively anonymous; while at the same time pharmacists are viewed by young people as being as both knowledgeable and well-informed. In collaboration with the Zambia Society for Family Health (SFH) and the Pharmaceutical Society of Zambia, ten pharmacies were selected to participate in this study<sup>3</sup>.

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<sup>1</sup> Since 1997, CARE/Zambia has trained more than 250 peer educators in eight communities across Lusaka. Through a variety of approaches, including participatory research, drama, exchanges, sports activities, clinic-based counseling and in-school education, these young people have been promoting safe sex and life skills necessary for the adoption of safe sexual behavior as well as distributing condoms to their peers.

<sup>2</sup> Because the five clinics in this study had already participated in previous OR studies on emergency contraception, all of them had MCH/FP staff trained and equipped to provide ECPs

<sup>3</sup> The ten pharmacies included Katala Pharmacy, Link Pharmacy, Baby Well Pharmacy, Cairo Road Pharmacy, Chachacha Road Pharmacy, Valsons Chemist (3 branches), Southwest Pharmacy, Freedom Way Pharmacy and Mbawame Pharmacy.

The pharmacists were drawn from a pool of professionals already participating in Zambia's contraceptive social marketing program and who had, therefore, already received some training in family planning and reproductive health.

Pharmacists were supplied with stocks of the dedicated emergency contraception product used in this study, PC-4<sup>4</sup>. Because they were donated public sector stocks, however, it was decided that a cap would be set on the price pharmacists could charge for them. Pharmacists and project staff eventually agreed on a cap of 500 Kwacha, the same price as a cycle of the socially marketed oral contraceptive, *SafePlan*. Each box of PC-4 was then stamped to reflect that fact.

***Community sales agents:*** The success of Zambia's social marketing program has largely depended on the active participation of hundreds of shopkeepers and small vendors – individuals who not only sell the socially-marketed brand of condoms, but impart advice to clients on family planning and protection against STDs. Community-based sales agents have also proven to be a favored source of condoms for young people. In a CARE study carried out in Lusaka's Ngombe and Kanyama compounds, over 75 percent of 10-19 year olds obtained condoms through community sales agents.

As a result of these findings and the suggestions of young people themselves, the present study selected and trained<sup>5</sup> 18 community sales agents to disseminate information on emergency contraception. As in the case of peer counselors, regulatory restrictions prohibited their distribution of actual ECPs.

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<sup>4</sup> As anticipated, the project's stock of PC-4 expired in August 2000. All unused packets were retrieved from the participating providers and returned for disposal to Medical Stores Limited, the parastatal agency responsible for the distribution of public sector medical commodities. The retrieved stocks were then immediately replaced with an alternative, progestin-only emergency contraception pill, Postinor-2 (two tablets, each containing 750 micrograms of levonorgestrel)

<sup>5</sup> CSAs were trained using the same curriculum as that used for peer counselors.

## TRAINING OF GROUPS TO PROVIDE INFORMATION AND SERVICES

Every health worker/provider selected by this study had received, at some point in the past, some instruction in family planning and/or reproductive health. Some workers, particularly the outpatient clinic staff, had even received training in emergency contraception. To ensure, however, that everyone shared at least a minimum level of knowledge about emergency contraception, additional training was provided. Instructional materials were drawn from the packet published by the Consortium for Emergency Contraception and were modified to meet the different educational levels and time availabilities of the four provider groups. Each provider received a set of materials for use during the training and to keep as a permanent reference source. Finally, a locally produced pre-test and post-test instrument was used to evaluate technical knowledge.

The training sessions provided a forum for addressing three broad concerns. First, they introduced the participants to the objectives of the study and to their specific role or roles within it. Secondly, they provided basic information on emergency contraception itself -- its mechanism of action, its limitations, its side effects, and the potential consequences of frequent use. To ensure that emergency contraception was made available within the context of broad method choice, the training also included a review of more routine forms of contraception – especially barrier methods.

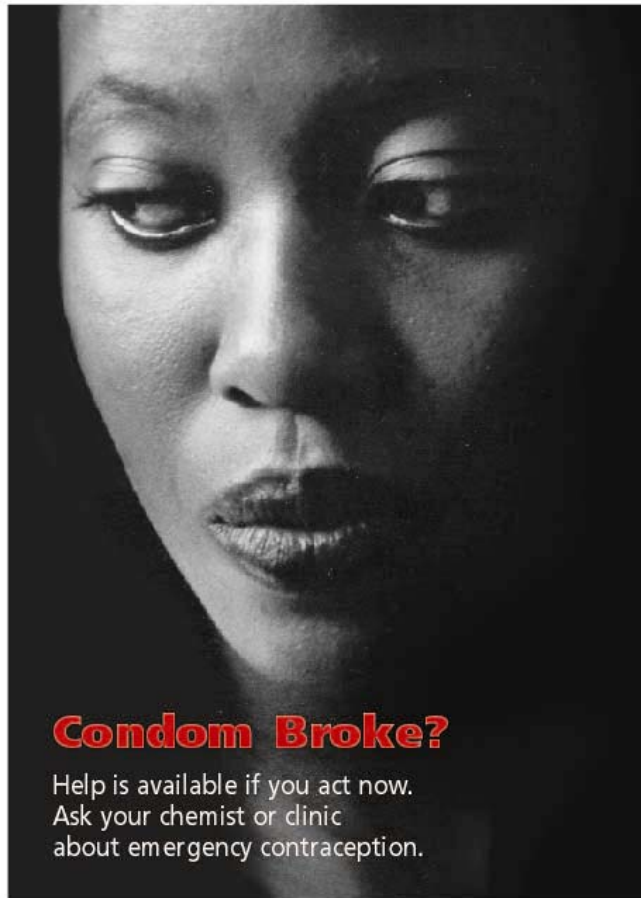
Finally, the training sessions provided an opportunity for each group of health workers to identify and discuss the kinds of materials and strategies they believe would help them communicate accurate information to young people. Based on the results of these discussions, two posters were designed, field-tested and developed for use by all participating providers (see Figure 2). Additional suggestions for material production were also made, though time limitations prevented the study from carrying through with them.

Throughout the project, providers met on a monthly basis (by group) to review ongoing activities and to identify any problems or issues requiring attention. In the intervals between such meetings, providers were routinely monitored and supervised by project staff. It was during such on-site visits that supplementary training was offered to new recruits.<sup>6</sup>

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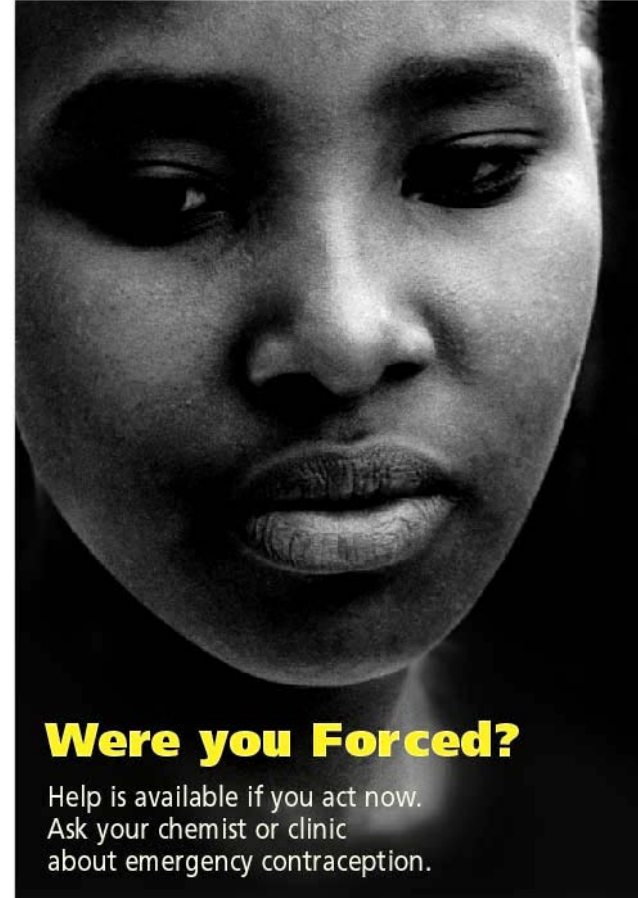
<sup>6</sup> As described in the following chapters, all provider groups experienced at least some level of attrition. To compensate for the loss of participants, project staff provided on-site training in emergency contraception, using the same materials employed during the initial training sessions.

**FIGURE 2**  
Posters produced and disseminated during study



**Condom Broke?**

Help is available if you act now.  
Ask your chemist or clinic  
about emergency contraception.



**Were you Forced?**

Help is available if you act now.  
Ask your chemist or clinic  
about emergency contraception.

# EFFICACY OF DIFFERENT INTERVENTION STRATEGIES

The primary goal of this project was to provide the Zambia Central Board of Health and the USAID-funded Zambia Integrated Health Program (ZIHP) with quantitative and qualitative data necessary to recommend the most effective channels for providing youth-friendly emergency contraception services within the context of broad method choice. Under this goal, the project defined “effectiveness” in terms of the following three criteria:

- Absolute frequency with which young people seek out available channels of information and services (where do young people actually go to get emergency contraception?).
- Feasibility/practicality of training, developing IEC materials, and commodity provision associated with each channel (what are the problems or difficulties associated with equipping each “channel” to provide information and services?).
- Familiarity of emergency contraception users with alternative contraceptive options (which channels do a better job of providing emergency contraception within the context of broad method choice?).

Each of the above criteria was measured using a different data collection activity. The first, for example, employed a system of prescription cards that enabled project staff to track the frequency with which young people sought out different sources of emergency contraception information and services. The second criterion was assessed using observation and descriptive accounts of key project activities. Finally, the third criterion was evaluated using mystery client interviews of providers of emergency contraception information and services.

The following three chapters take an in-depth look at the three effectiveness criteria. After describing the rationale for selecting each criterion and the indicators used to define it, the chapters then document the research methodology employed to collect the data and the actual research results themselves.

## WHERE DO YOUNG PEOPLE GO FOR INFORMATION AND SERVICES?

Given the cost and other operational constraints facing national reproductive health programs, the need to focus on interventions with a proven track record is essential. This is particularly true with respect to so-called “youth-friendly” services since the possibilities for non-clinic outlets – which comprise the bulk of such youth friendly services -- are so broad and diverse. For that reason, the present study wanted to know whether project participants would actually use the different information and service delivery outlets they had suggested.

The approach adopted by the study entailed giving providers of emergency contraception information and services, a stock of printed “prescription” cards containing basic information on the use of the emergency contraception pill (see Figure 3). The exact number of cards given to each category of provider was recorded to keep track of the number of contacts made over the course of the study.

When potential emergency contraception users were given information about emergency contraception by any participating health worker, they were given a card, which could then be redeemed for a pack of ECPs, either by the same health worker or by any one of the project’s other participating providers (except for peer counselors or community-based sales agents who, because of regulatory restrictions, were forbidden from distributing ECPs). On each card, the information provider indicated the age of the client and whether the client was in-school or out-of-school. The card also had space for the health worker to indicate the category of provider to which he or she belonged (peer counselor, CBD agent; chemist, etc.).

Once the card was redeemed for a pack of pills, the supplier of emergency contraception pills also noted on the back of each card, the “category” of supplier (pharmacist, OPD providers) to which he or she belonged. Clients who came to a service delivery outlet without a card were asked where they had originally received their information about emergency contraception and the card was filled out for them on the spot. In cases where the “pill supplier” was also the initial source of information, then the supplier completed both sections of the card to reflect that fact. No names or unique identifiers of any emergency contraception clients were recorded.

Throughout the study, redeemed cards were collected on a monthly basis from each of the ECP suppliers (since they were the only ones to end up with redeemed cards). The data were then entered into a data base, thereby allowing the project to track over time, the frequency and patterns by which the cards were issued and redeemed.

**FIGURE 3**  
 Prescription Card for ECPs  
 (Obverse and reverse)

**Remember:**

- Take the first dose as soon as possible after unprotected sex but not later than 72 hours (3 days).
- Take the next dose 12 hours later.
- Take tablets with food.
- If you vomit within two hours of taking a dose, immediately return with this card to a participating chemist or clinic to ask for another dose.
- Emergency Contraception does not protect you against STDs or HIV/AIDS: only condoms and abstinence can do that.

**Age** \_\_\_\_\_ **School** (circle one) **in** **out**

**Source of information** (indicate provider number in box)  
 Date \_\_\_\_\_

Peer       Chemist       CSA  
 MCH/Nurse       Other       OPD Nurse

**Supplier** (indicate provider number in box)  
 Date \_\_\_\_\_

Chemist       OPD Dispensary  
 Other

Once this coupon has been redeemed, supplier should detach this stub and hold for collection

**If you need emergency contraception**  
 take this card to a participating chemist or clinic for your packet of pills.

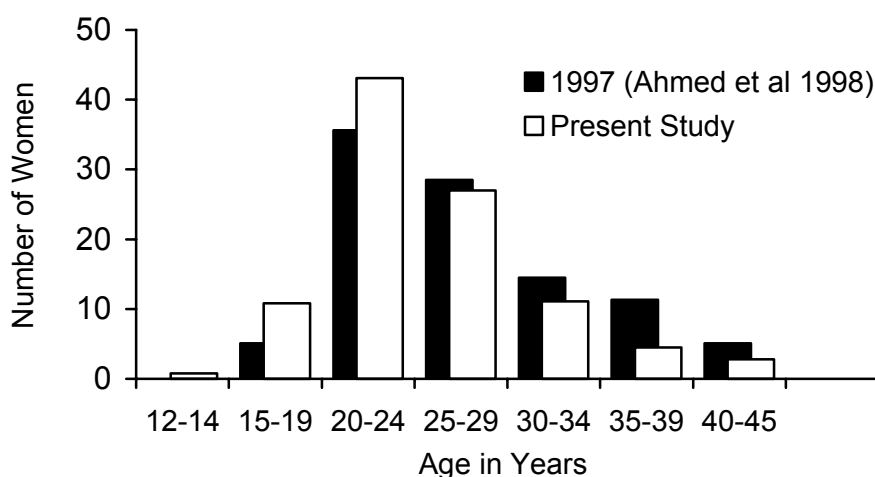
Between February 26 and September 30, 2000, 3,517 prescription cards were delivered to the four groups of health care workers. These individuals included:

- The staff of ten pharmacies located in and around the city of Lusaka;
- Twenty-five clinic-based peer counselors in five of Lusaka’s periurban compounds;
- Ten OPD and MCH/FP nurses, based at the same clinics as the peer counselors;
- Eighteen community sales agents located in the same five periurban compounds.

On March 15<sup>th</sup>, the providers began distributing prescription cards and requesting signed consent forms, following the protocol described above. No prior selection was made on the basis of age and any woman requesting ECPs, or information about them, was issued a prescription card. By September 30 approximately half (N=1,798) of all the prescription cards delivered to the providers had been distributed to potential emergency contraception users. Of these, approximately a quarter (N= 421) were later redeemed for a packet of ECPs.

As indicated below in Figure 4, the mean age of ECP users in this study was just 25 years – four years younger than that of emergency contraception clients in the 1997 UTH study. The age range of clients was also wider than in 1997 -- with 11 percent of all clients falling below the age of 20, and over half (51.5 percent) falling within the WHO definition of “young people” (15-24 years).

**FIGURE 4**  
Age of Study Participants



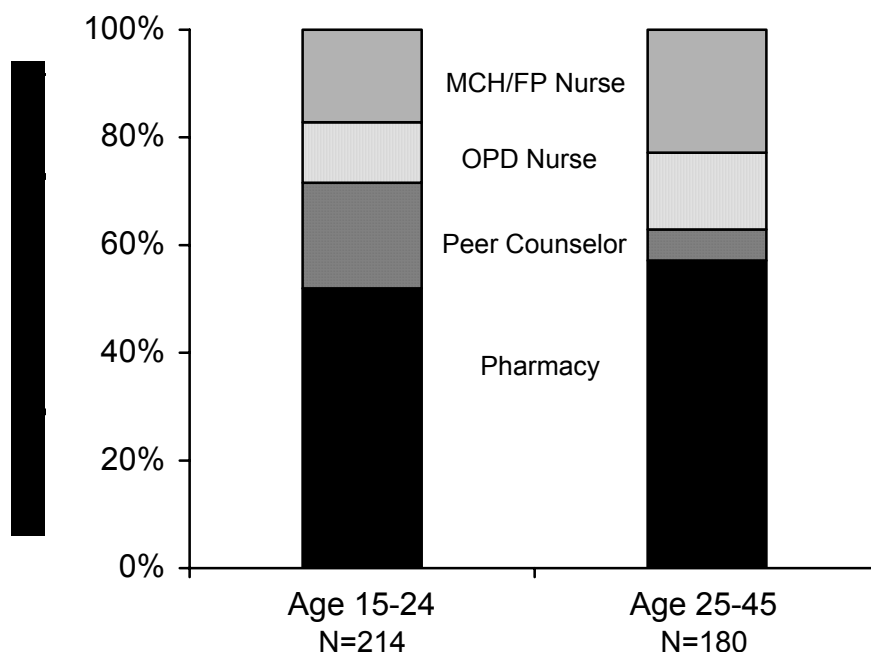
The following discussion highlights some of the key findings to emerge from the analysis of returned prescription cards.

***For young and old alike, pharmacists lead in the provision of both information and services.***

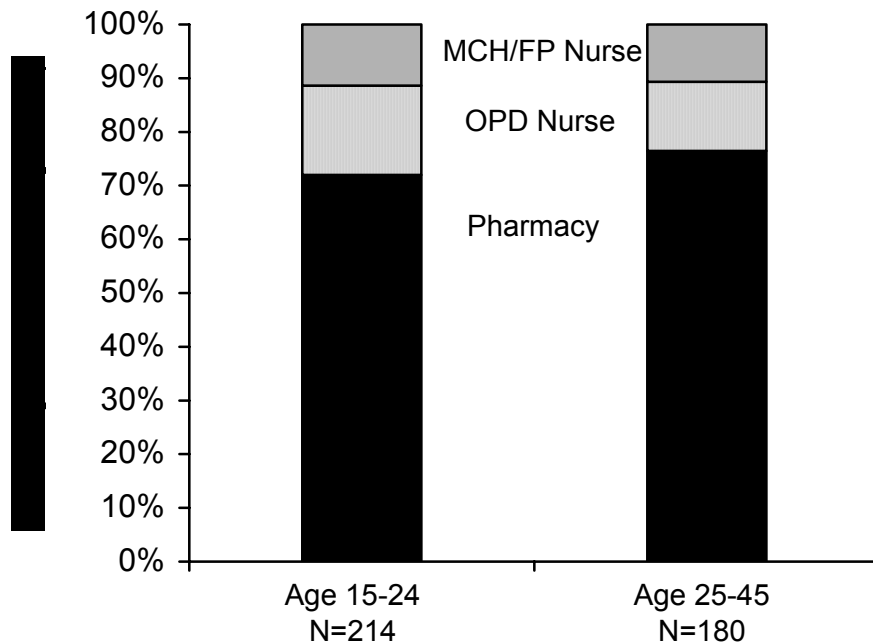
Between March 31 and September 30, 2000, 421 women between the ages of 12 and 45 redeemed their prescription cards for a packet of ECPs. Of these women, the vast majority turned to pharmacists, both as sources of information about emergency contraception and ultimately as suppliers of the pills themselves. Fifty-four percent of all ECP users first learned of emergency contraception from a pharmacist; and 74 percent of users turned to pharmacists as suppliers of ECPs. MCH/FP nurses and OPD dispensaries followed far behind, with only 14 and 10 percent of ECP users, respectively, obtaining pills from them.

Even when classified by age, pharmacists remain the preferred source of information and supplies. Figure 5, for example, compares the frequency with which younger (15-24 years) and older (>24 years) women sought out different suppliers of *information*. For both groups, pharmacists were the first choice. The same was also true with respect to the *provision of ECPs* (Figure 6).

**FIGURE 5**  
To Whom do Women Turn for Information about Emergency Contraception?  
Young vs. Older Women



**FIGURE 6**  
 To Whom do Women Turn to Obtain Emergency Contraception Pills?  
 Young vs. Older Women

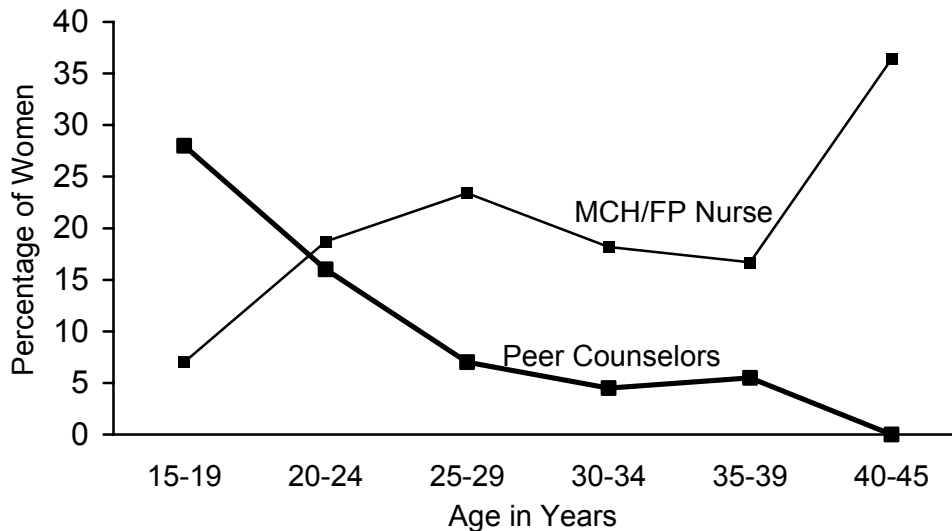


***Young people remain suspicious of traditional service delivery outlets.***

In earlier studies on the delivery of emergency contraception services in Zambia (Ahmed 1998), young people were often critical of static health care facilities, especially MCH/FP staff who – as traditional providers of family planning services -- were seen to be unwelcoming and judgmental towards younger clients. Indeed, it was this rejection of traditional health care facilities that led to calls for the identification of more “youth-friendly” outlets.

The results of this study do indeed confirm young people’s mistrust of traditional, clinic-based family planning providers. While pharmacists constituted everyone’s number one choice for information; the “number two” choice varied with the age of the client herself. As shown below in Figure 7, for example, the utilization of MCH/FP nurses as suppliers of information about emergency contraception was low among younger people, and increased only with the age of the client population . The utilization of peer counselors, by contrast, was high at first and declined as MCH/FP nurses became “more acceptable”.

**FIGURE 7**  
 After Pharmacists, To Whom do Women Turn  
 for Information about Emergency Contraception?



***Community sales agents had virtually no impact whatsoever in distributing cards that would later lead to actual use of ECPs***

One finding of particular – perhaps even surprising – interest was the negligible role played by community sales agents at communicating information about emergency contraception. In focus group discussions (FGDs) carried out in 1998, young people were asked to identify places and persons that might serve as acceptable “youth friendly” outlets for emergency contraception services. One of the most widely heard suggestions was shopkeepers, kiosk operators and other vendors of items typically purchased by students and other young people.

As a result of input from these FGDs, a number of such retail outlets were included under the rubric of community sales agents (CSA) – typically small vendors who also sell a range of socially marketed contraceptives such as *Maximum* condoms or *SafePlan* contraceptive pills. Insofar as the suggestion to include CSAs actually came from the young people, themselves, one might have expected them, like peer counselors, to have become a favored source of information about emergency contraception. And judging from the number of prescription cards actually handed out by CSAs (they ended up distributing 64 percent (N=366) of all the 572 cards they were given by CARE), one might have expected many of them to eventually be redeemed. Yet by the end of the intervention period, CSAs had virtually no impact whatsoever in distributing cards that would later lead to actual use of ECPs. Indeed, of all 421 women who redeemed their prescription cards, only 6 (1.4 percent) learned about emergency contraception from a community sales agent. Moreover, there was no consistent pattern whatsoever in the age of the clients who received information from them. Three clients were below the age of 25 year and three were above.

***Young people will use public sector facilities if they are treated with privacy, respect and understanding.***

In contrast to the fairly wide choice of information suppliers, the choice of ECP providers in this study was fairly limited: pharmacists, MCH/FP nurses, or the OPD dispensaries of traditional health care facilities. As noted earlier, pharmacists were the number one ECP provider, accounting for 71 percent of all ECP users below the age of 25 and 76 percent of all users 25 years and above. But when one looks more closely at the returns for young people, an interesting pattern starts to emerge. What it shows is that OPD dispensaries supplied a disproportionately large percentage (almost 35 percent) of people under the age of 20. Among no other age group was the percentage of cards redeemed by OPD dispensaries so high. What, then, could be the explanation for this?

The most likely explanation is that clinic-based peer counselors, who also supplied information to a disproportionately large percentage of this age group, simply referred clients to the OPD dispensary located in the same health facility. This connection is even more evident when 15-19 year olds are differentiated by school status (in-school or out-of-school). Out-of-school youth, perhaps because of their greater economic and/or social independence, tend to behave more like their elders than their in-school age mates. Like the former group, close to half (43 percent) of out-of school youth learned about emergency contraception from a pharmacy, while in-school youth turned to peer counselors (many of whom actually visit schools) as the single largest source of information (39 percent).

With respect to redeeming prescription cards, out-of-school youth also behaved more like their elders than like their in-school age-mates. Sixty-two percent of out-of-school youth, for example, redeemed their card with a pharmacist, compared to only 39 percent of in-school youth did so. The latter, most of whom actually received the card from a peer promoter, turned to the OPD dispensary for the actual product.

These findings are significant, because they illustrate the importance of making emergency contraception services accessible, even within the confines of a traditional public-sector health-care facility. By taking contraceptive commodities outside the exclusive domain of the MCH/FP unit, this study has shown that young people will use public sector facilities if they can be assured a modicum of privacy, respect and understanding. While there is no question that pharmacies represent the number one supply choice for most potential users of emergency contraception, OPD dispensaries can also play a critical role – particularly among in-school youth who are most likely to learn about emergency contraception from a peer counselor, and who may not have the resources necessary to purchase ECPs from a private pharmacy.

*Because the supplier of ECPs also typically served as the initial source of information about it, the probability of any single prescription card being redeemed is likely to depend on the suppliers' direct access to actual stocks of ECPs*

Although there was some variation in the total number of prescription cards distributed to each category of provider, the percentage actually given away to potential clients remained fairly constant. The most prolific distributor of cards, for example were the CSAs who distributed 64 percent of the cards they were given (366 out of 572). But even the least prolific – OPD nurses – still managed to distribute almost 45 percent, or 330 of the 740 cards they were given.

And yet, as the previous discussion has shown, when it actually came to redeeming the cards for ECPs, no group could match the success of the pharmacists. Indeed, over half of all the cards they handed out eventually got redeemed; compared to only 15 percent of the cards distributed by OPD nurses; and less than 2 percent of those distributed by CSAs.

Clearly, many factors could have contributed to these differences. One might be variations in the clients' own reproductive intentions. The fact someone received a prescription card, for example, was no guarantee that they were committed to avoiding an unwanted pregnancy; or even to engaging in unprotected sex. And while there is no indication to suggest that such variations might have coalesced among provider lines, the possibility certainly cannot be dismissed.

Another factor may have been the immediate circumstances surrounding the choice of provider. Those who received information from a pharmacist or health care provider, for example, may have done so precisely because they felt they already were at risk of pregnancy. Under such circumstances, one would expect a higher percentage of them to actually redeem the prescription card. Those who received information from a CSA on the other hand (or perhaps even peer counselor), could very well have done so unintentionally (ie. especially in those cases where it was the provider who sought the client out).

But there is a third factor strongly associated with the redemption of prescription cards; namely, the provider's ability to inform a client about ECPs and then, if necessary, immediately give them the product. Of all the provider groups involved in this study, only three could offer such service: pharmacists, MCH/FP nurses, and occasionally clinic-based peer counselors (with direct access to OPD dispensaries). Not surprisingly, these three groups saw the highest levels of prescription cards being redeemed.

The importance of linking information and services was also borne out in the actual "channels" by which clients obtained and redeemed their prescription cards. Whether young or old, clients did not typically switch from one provider (of information) to another (of the product). Indeed, of the 313 ECP users who ended up obtaining their ECPs from a pharmacist, 71 percent actually learned about emergency contraception from the same person.. The same was true with MCH/FP and OPD nurses; the former having introduced emergency contraception to 81 percent of its ECP takers;

the latter to almost 60 percent of its takers.<sup>7</sup>

Though there are still questions remaining as to why some prescription cards were redeemed more readily and rapidly than others, one fact is clear: any effort to expand access to emergency contraception must, in some way, build upon or reinforce links between sources of information and the actual supply of ECPs.

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<sup>7</sup> Of those who obtained ECPs from OPD nurses, 83 percent learned of the product right at the health center – either from the OPD nurse or peer counselor.

# WHAT OTHER VARIABLES INFLUENCE THE FEASIBILITY OF DIFFERENT SERVICE DELIVERY CHANNELS?

In the previous chapter, the “efficiency” of different information and service delivery providers was assessed in terms of the absolute frequency with which emergency contraception users actually sought the providers out. The results of that assessment clearly demonstrated the appeal of pharmacists to young and older people alike. But the notion of “efficacy”, as was conceptualized in this study, entailed more than simply numbers. It also encompassed some notion of the investment required to equip providers with the skills and materials they needed to provide quality services. In terms of education, mobility, and economic independence, for example, members of the five service delivery channels differed markedly. It was, therefore, reasonable to expect that such differences would manifest themselves in a variety of ways: in what they perceived to be the benefits of providing emergency contraception and therefore, in the providers’ inclinations to invest the time and resources needed to do so. The different environments in which the providers operated could also be expected to exert some influence on the kind of strategies needed to deliver services in an appropriate manner.

Given such diverse contexts in which the providers found themselves, the second broad criteria for gauging the effectiveness of the different service delivery channels, was the feasibility and practicality of training, developing IEC materials, and commodity provision associated with each channel. Under the present study, three factors were used to gauge the feasibility of employing the different delivery channels. The first was the practicality of training members of the different groups. Did the different groups, for example, routinely attend all the required sessions? Did certain groups require information above and beyond what was covered during routine training? Were some groups better than others at retaining and using the information and skills they learned? Was the training of some groups more labor intensive than others? Did some groups have more difficulty than others in capturing certain concepts or ideas? All of these questions were felt likely to influence what has been defined as the “feasibility” of each channel.

The second factor influencing the concept of “feasibility” was the need, if any, for supplementary materials to assist health workers in accessing or communicating with young people. Though the project had anticipated developing at least some IEC and other didactic materials from the start, it was not clear whether these needs would be the same for all. Did certain groups, for example, require additional supplies -- materials that implied greater “cost” per client?

And, of course, the third factor to influence feasibility were the requirements of sustaining each groups’ activities. Did certain groups need more support than others, and if so, what kind? Similarly, did some groups remain more motivated over time than others?

While client-loads and other service delivery-related variables were adequately gauged using prescription cards, most factors related to feasibility were assessed qualitatively, through direct observation by project staff. Project staff maintained written records of all activities associated with the setting-up (selection, training, etc.) and support of each group of health providers. Furthermore, routine monitoring visits were made throughout the life of the project to collect and distribute prescription cards; and to ensure that each health worker had adequate stocks of ECPs or any other required materials. During these visits, project staff solicited general information from the providers regarding difficulties encountered or simply observations. The contents of these discussions were noted and kept in a general log book.

This chapter consolidates and summarizes the most salient observations made by project staff on the participation of the different service delivery providers. Structured by provider category, the discussion focuses on the key issues of training, IEC requirements, support, and commitment.

## PHARMACISTS

The challenges associated with using pharmacists as channels of services and information reflected, more than anything else, the conflicts they face in reconciling the demands of, on the one hand, operating a business establishment and, on the other, complying with what are traditionally perceived to be the prerequisites of quality health care services. For pharmacists, time is money and the opportunity costs of attending training sessions or of devoting time to client counseling can be quite high.

At the conclusion of the study, project staff reviewed quarterly project reports; field notes and written accounts of intervention activities to draw on what they felt were the challenges of using pharmacists to provide emergency contraception and the implications of such challenges for future work with them. The findings are described below:

### ***Competing pressures make it difficult to offer individualized attention***

Appropriate counseling is universally recognized as an indispensable component of quality service provision. But it is an activity that many pharmacists find difficult to carry out with the degree of intensity or depth expected by traditional health care providers. Rarely is there adequate space for any level of privacy, and the need to attend to multiple customers often makes it difficult for pharmacists to maintain any consistent level of quality in their counseling efforts. Such weaknesses are illustrated in more detail in the following chapter, where service delivery providers are compared in terms of the degree to which they mentioned such issues as STI risk and alternative contraceptive choices.

In interviews with pharmacists and pharmacy technicians, many were quite open in saying they would prefer a situation in which emergency contraception clients come to them only after getting information from other providers such as CSAs and peer counselors.

### ***Coordination is difficult***

From the beginning of this study, it was expected that pharmacists would require a different training curriculum and schedule than clinic-based providers, peer counselors or community sales agents. Aware of the conflicting demands on their time, special provisions were made so that the training of pharmacists could be carried out in the evenings after work, and for a shorter periods of time.

But even with these allowances, physician turnout was low. During the initial training session, for example, only two of the 12 invited physicians turned up. The study was then forced to compensate by adding additional sessions as well as offering individualized training in some cases. Obviously, from a programmatic perspective, the costs of tailoring curricula and training programs can be significant. For NGOs, it involve greater staff time, and additional costs for the rental of meeting facilities that, during the day, could have been available without cost.

### ***In business, financial considerations must prevail***

As energetic and enthusiastic as the pharmacists were to participate in this study, financial concerns were never far from their mind. Their primary goal, after all, was to run a business -- so business considerations always played an important role in the determining how the physicians' would collaborate with the project.

One of the primary financial concerns over emergency contraception was the longer-term impact of pricing supplies of ECPs. Because the pills used in the study consisted of donated public sector stocks, it was decided early on that a cap would be set on the price pharmacists could charge for ECPs. Eventually the cap was set at 500 Kwacha (US\$ 0.13), the same price as a cycle of the socially marketed oral contraceptive, *SafePlan*. Though the price had been agreed to by all participating pharmacists, in the end, many felt it was too low. What is more, some pharmacists felt that it would eventually hurt them because it had been rumored that before the study began, some pharmacies were already selling ECPs for as much as 15,000 Kwacha (US\$3.75). According to a number of pharmacists, offering customers such a low price now would make it more difficult after the study to sell stocks at a more "reasonable price". Others simply argued that the selling price of 500 Kwacha yielded too small a return to justify spending the kind of time needed to provide adequate information and counseling on emergency contraception.

### ***Pharmacy staff are not all alike***

At the beginning of this study it was assumed that involving pharmacies meant working with pharmacists. It was with them, for example, that CARE, UTH and the Zambia Society for Family Health first broached the possibility of collaborating on the project. And it was with the pharmacists' skills and educational levels in mind that project's "pharmacy-specific" training materials were developed.

It was not until the start-up of routine monitoring activities, however, that project staff began realizing that emergency contraception clients could just as likely be seen by an untrained dispensing technician as by the trained pharmacist. In fact, at one participating pharmacy, the trained provider had left his job, leaving only untrained

sales staff to dispense ECPs. Once again, the project was once forced to intervene by offering individualized training.

High staff turnover has often been viewed as a problem within the public sector health care system; the experience of this project suggests that it is also a very much private sector issue. The implications of this for the distribution of ECPs by pharmacists is clear: provisions for training must be ongoing; and they must reflect the fact that the educational levels of those dispensing ECPs may be quite varied. What was perceived at first to be the easiest group to train (because of pharmacist's university education), eventually turned out to be the most operationally complex.

#### CLINIC-BASED HEALTH CARE PROVIDERS (OPD and MCH/FP NURSES)

The decision to explore the feasibility of using Outpatient Department (OPD) staff arose out of concerns over limited access to the MCH/FP Unit – the traditional home of family planning. Because MCH/FP Units typically operate only during office hours; and only from Monday to Friday, they are not always able to provide ECPs within 72 hours of unprotected sex. OPD facilities (and dispensaries), by contrast, operate every day, 24 hours a day.

A second barrier to access was what young people felt to be the over-bearing and paternalistic attitudes of MCH/FP nurses. Previous studies on emergency contraception in Zambia revealed that the average age of MCH/FP clients in the five participating clinics was 27; and that almost 96 percent of clients had already given birth at least once. It is not surprising, therefore that the nursing staff devoted to this population would be less empathetic with the needs of young, unmarried, sexually active youth. It is also understandable that young women would feel uneasy seeking services at a facility where they have little, if anything, in common with the other clients.

The challenges associated with introducing ECPs into the OPD, however, had less to do with the capabilities of any single group of providers, than it did with the reluctance of clinic staff in general to adopt the procedural changes that such an activity implied. It meant adding a new medical commodity to the list of OPD dispensed products, which meant increasing OPD staff responsibilities for stocking supplies, maintaining inventories, and recording product provision. It also meant increasing the counseling workload of OPD staff who, for the first time would be expected to provide information on family planning, albeit emergency contraception. For many clinic staff, the delivery of emergency contraception services, however different from other contraceptive services, was still a family planning issue. For them, its logical home should have remained the MCH/FP Unit.

Compounding the situation was the ongoing implementation of Zambia's Health Reforms, a process that saw increasing numbers of nursing staff taking early retirement, or "voluntary separation", as the process became known in Zambia. At a number of participating health centers, this trend decimated the ranks of OPD departments with the result that responsibility for the distribution of ECPs devolved almost by default back to the MCH/FP Units.

***Knowing about emergency contraception is only half the battle; the other half is knowing where to go to get it.***

Introducing ECPs into the OPD dispensaries was an adjustment for both OPD and MCH/FP staff. But it was also an adjustment for the many clients who had grown accustomed over the years to seeking out family planning information and services from MCH/FP units. All of the health facilities involved in this study, for example, had been involved in earlier operations research studies on emergency contraception, so it was natural that clients should continue turning to the MCH/FP facilities for ECPs.

One lesson to be learned from this experience is that in the future greater efforts must be made to enhance awareness of the availability of ECPs at OPD dispensaries. IEC efforts under this project focused largely on creating awareness about emergency contraception, not on identifying all the places they could go for it. How might this be achieved? Clinic-based posters and signs are one option; introducing the issue into health talks are yet another. One other possibility is the introduction at health care facilities of ECP corners, just as is currently done for ORT.

#### PEER COUNSELORS AND COMMUNITY SALES AGENTS

Between the start-up of service delivery activities in February and the conclusion of data collection activities in September, over 33 peer counselors were recruited to participate in this study. Some were trained, then left. Others entered the project and were trained to replace them. And some were never replaced. The same period saw the participation of 18 community sales agents (CSAs); only 15 of whom were able to continue throughout the study.

Peer counselors and community sales agents were the two groups only authorized to provide information about emergency contraception, not the actual ECPs themselves. As a result, the likelihood that anyone receiving information from them would eventually avail themselves of ECPs, depended very much on the degree to which CSAs and peer counselors could link their clients to an actual ECP supplier. CSA's, as noted earlier, proved unable to forge workable linkages and as a result, only six of the 650 cards distributed by them were eventually redeemed.

For peer counselors, the story was somewhat different. Operating out of the five participating health centers, they had direct access to OPD and MCH/FP nurses, both of whom were authorized to dispense ECPS. And it was probably as a result of these linkages, that the redemption rate for PC-supplied prescription cards was comparable to that of the clinic-based providers, themselves. But the advantages peer counselors enjoyed from the support of others, could also work against them. Indeed, they were perhaps the only group whose success at distributing information on emergency contraception depended as much on outside support as on their own efforts.

***Inadequate space and limited recognition hindered the effectiveness of peer counselors***

Peer counselors enjoy limited influence in the clinics where they work. As a result, their ability to provide quality counseling depended very much on the opportunities provided to them by the clinics themselves. At two participating clinics, for example, peer counselors reported not having adequate space to discuss sensitive issues of any kind. Sometimes they got around this by taking clients aside to a more isolated corner and speaking in a low voice; at other times they ask clients to meet off the clinic premises. Neither solution was adequate, and the frustrations experienced by providers and clients was made evidently clear during the mystery client interviews.

A first step to solving the problem of adequate space would be for the relevant clinics to begin providing it. But even in facilities where space was available, peer counselors claimed that not enough clients knew they could come to them to talk about emergency contraception. Once again, project IEC efforts underestimated the need to indicate which clinic staff women could turn to for information and services. Interestingly, peer counselors detected this weakness early on and recommended that the project produce T-shirts, with messages implying that person wearing it (a peer counselor) could offer advice on emergency contraception. Several designs were actually developed and field-tested. Unfortunately, because of time constraints, none of the designs were ever produced.

### ***Constant supervision can reduce the sense of powerlessness facing peer counselors***

For reasons not entirely clear, there was a strong sense among project staff that of all the four categories of providers, peer counselors felt the least empowered and most marginalized from the operation of the study. Attrition among them was extremely high (nearly one-third of the original 25 dropped out of the study within the first months of the study); they were slow to begin distributing cards; many were not entirely convinced that emergency contraception was not an abortifacient; and quite a few reported their reluctance to discuss emergency contraception outside the clinic setting.<sup>8</sup> Perhaps because they could not actually distribute ECPs; or perhaps because of they lacked authority within the clinic, peer counselors faced many uncertainties they often felt ill-equipped to address. Rarely were these uncertainties insurmountable, but they did often require the intervention of project staff.

One of the important lessons to be learned from working with peer counselors, therefore, is the need for constant supervision – especially during the start-up of intervention activities. Apart from simply enhancing motivation, regular visits gave peer counselors the confidence to undertake activities that to some degree, took them outside their regular scope of work.

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<sup>8</sup> Though peer counselors regularly visited local schools to discuss reproductive health issues; initially they were reluctant to mention emergency contraception during those visits because they felt they were only authorized to discuss those methods covered during their initial peer counseling training sessions with CARE. Emergency contraception was not one of them.

# DO PROVIDERS OFFER BROAD METHOD CHOICE AND DELIVER SERVICES WITHIN A REPRODUCTIVE HEALTH CONTEXT?

A fundamental premise of WHO's *Strategy for Contraceptive Introduction and Technology Transfer* is that any new method must be provided within the context of broad contraceptive choice so that the focus of the introductory effort is not on one single method, but on the strengthened delivery of all methods (Spicehandler et al 1994). In keeping with this premise, the present study chose to provide emergency contraception only through groups who were already familiar with the basic concept of reproductive health and were knowledgeable about alternative contraceptive technologies. Obviously, the level and depth of that knowledge varied from group to group. But at the very least, this project expected any client or potential client of emergency contraception to be aware of other contraceptive options; that emergency contraception does not in any way protect against sexually transmitted infections (STIs) or HIV/AIDS; and finally, that the availability of emergency contraception should not serve as a pretext for abandoning condoms or more effective methods of contraception. The third criterion for comparing the effectiveness of the different information and service delivery channels, therefore, was the ability to provide emergency contraception within the context of broad method choice.

Since the prescription card system did not track clients in such a way that they could be contacted and interviewed at a later date, the content and quality of information they received from providers could only be assessed indirectly, using a mystery client approach. Consequently, six months after the start-up of service delivery, 30 project-trained health care providers were observed by mystery clients posing to be potential or actual users of emergency contraception.

The four clients, all high school students, presented providers with one of six hypothetical scenarios. Described below in Table 1, the different scenarios made it possible to gauge providers' ability to recognize and respond to factors determining the appropriateness of EC as a contraceptive method. They also made it possible to know whether (and, if so, which) providers really were providing emergency contraception within a broad reproductive health context.

From August 23 to September 7, 37 interviews were conducted among a randomly selected group of 6 pharmacists, 7 clinic-based health care providers (MCH/FP or OPD nurses), 10 peer counselors, and 7 community sales agents. At the end of every interview, each mystery client completed one of six scenario-specific questionnaires.

In the discussion that follows, mystery client interviews are used to compare the overall strengths and weaknesses of each group, and for linking those comparisons with the findings described in previous sections of this report. In broad terms, the present discussion examines whether there are any appreciable or meaningful differences among the provider groups in terms of their ability to provide emergency contraception within the context of broad method choice. Three key issues are addressed: the risks of STI

transmission and the inability of emergency contraception alone to reduce them; the breadth and availability of contraceptive options other than emergency contraception; and the adequacy of technical information about emergency contraception.

**TABLE 1**  
Different Scenarios for Mystery Client Interviews

Theme	Scenario
General Inquiry about Contraception	1. Mystery client tells a community sales agent or peer counselor (those who can only give information, not actual ECPs) that she has a boyfriend who is pressuring her to have sex. Mystery client is worried that she will be unable to continue refusing him.
ECPs would be an appropriate contraceptive choice	2. Mystery client tells a community sales agent or peer counselor that she had unprotected sex the night before, and that her last menstruation was 10 days ago.
	3. Mystery client presents an EC prescription card to a pharmacist or clinic-based provider. She tells the provider that she had unprotected sex the night before, and that her last menstruation was 10 days ago.
ECPs would not be an appropriate contraceptive choice	4. Mystery client tells a community sales agent or peer counselor that she is worried she may be pregnant because she has been routinely having unprotected sex and her last menstruation was 6 weeks ago.
	5. Mystery client presents an EC prescription card to a pharmacist or clinic-based provider. She tells the provider she is worried she may be pregnant because she has been routinely having unprotected sex and her last menstruation was 6 weeks ago.
	6. Mystery client presents an EC prescription card to a pharmacist or clinic-based provider. She tells the provider that she had unprotected sex 4 days ago (more than 72 hours earlier), and that her last menstruation was 10 days ago.

***Providers do not routinely inform EC users of alternative contraceptive options***

A common concern among many in the reproductive health community is that the more convenient or accessible emergency contraception becomes, the more likely it will be used in lieu of routine family planning methods – particularly barrier methods that offer protection against STI transmission. Though research carried out in Zambia suggest that such concerns are often misplaced (Ahmed 1998: 29), it is nonetheless true that the delivery of emergency contraception services offers providers an ideal opportunity to 1) find out why the client was not using regular contraception; and 2) offer information on other methods that the client may find more acceptable.

During the mystery client interviews, the following three indicators were used to assess the adequacy with which providers informed clients of the broad array of contraceptive options available to them:

- Whether the provider counseled the mystery client about using abstinence or family planning methods other than emergency contraception to avoid pregnancy and/or STI transmission.
- Whether the provider offered the mystery client information and/or services on other methods of family planning.
- Whether the provider offered condoms to the mystery client.

In some cases, up to 39 interviews were carried out in which providers could have responded positively to each indicator. Unfortunately, the results fell far short of what had had been desired. Out of the 27 interviews in which providers could have offered the mystery client information and/or services on other methods of family planning, only a third (N=8) did so. One group, clinic-based MCH/FP and OPD nurses, alone comprised half of the total; but not even they were consistent in that respect.

While one could argue that in the case of clients whose needs could be met by emergency contraception, a broader discussion on routine methods was unnecessary, the reverse certainly did not hold true. Among the six mystery clients who reported having had unprotected sex more than 72 hours earlier, condoms would have been the most appropriate response (since, apart from the need for STI protection, hormonal methods would not have been immediately effective). Yet not one of them was provided or even offered condoms.

***Do providers adequately inform EC users about the risks of STI transmission and the inability of ECPs to protect them against it?***

Given the soaring rates of STI and particularly HIV/AIDS transmission in Zambia, an important goal of this study was to ensure client awareness that emergency contraception, for all its advantages, offered no protection whatsoever against STIs. IEC messages were designed in such a way that emergency contraception was never presented as an alternative to condom use; but rather as an adjunct to it. Posters, for example, presented emergency contraception as an emergency response, either to condom breakage (the implicit message being that non-use was unacceptable) or rape (where non-use was beyond anyone's control). Consent forms and prescription cards were even more explicit, with both containing the message that "*Emergency Contraception does not protect you against STDs or HIV/AIDS: only condoms and abstinence can do that*". On the training front, all providers were instructed to advise potential ECP users on the need to ensure adequate protection from STIs – something that emergency contraception itself could not do.

What, then, was the effect of such precautionary advice? Did providers emphasize the fact that emergency contraception offered no STI protection? And did they do so in equal numbers or with equal vigor or diligence?

During the mystery client interviews, the following three indicators were used to address the issue of provider awareness and/or support for STI protection:

- Whether the provider counseled the mystery client about HIV specifically, or STIs in general

- Whether the provider told the mystery client that emergency contraception would not prevent transmission of HIV specifically, or STIs in general
- Whether the provider offered condoms to the mystery client.

What the results show is that, regardless of scenario, providers were not doing an adequate job of reminding clients that emergency contraception does not protect them from STIs. They were doing an equally poor job at counseling clients about the risks of STIs. And they were doing an even poorer job at providing clients with condoms.

Mystery clients for whom emergency contraception would *not* have been appropriate could have provided an ideal opportunity to breach the subject of other methods, or at the very least, STI protection. And yet, when the first two indicators listed above were used to gauge the content of such encounters, those opportunities clearly remained under-utilized. Of the 18 mystery clients for whom emergency contraception would *not* have been appropriate, only four were eventually counseled about HIV/STIs or told that emergency contraception would not offer any protection against them. Of those who were informed, three were told by a clinic-based provider and one by a peer counselor. Only one of the women was given condoms – again by a clinic-based health care provider.

The situation was even worse in those cases where emergency contraception did represent an appropriate response (where clients reported unprotected sex within 72 hours). Under those circumstances, only 3 out of 14 clients were told that EC offered no protection against STIs; and not even one was offered a condom.

What, then, can be concluded from these observations? First of all, while there is need for improvement among all provider groups, it is clinic-based health care providers (OPD, MCH/FP nurses) who appear to be the most inclined to situate emergency contraception within a broader reproductive health context. Not only were they more inclined than any other provider group to breach the subject of STI transmission, they were also the only ones where a *majority* of providers volunteered information and/or services about alternative contraceptive methods. Obviously, such openness is commendable. But as we have seen in a previous section, it also comes at a price. Such readiness to engage clients in a broader discussion of sexuality and reproductive health can be off-putting to many, especially younger, users of emergency contraception.

Pharmacists clearly emerged as the ones least likely to raise or discuss issues not-directly related to the nature of the business transaction (purchasing ECPs). In fact, no pharmacy client – regardless of scenario – received information about STIs, were told that emergency contraception did not prevent STI transmission, or were sold a condom. Such silence is very likely to raise some concerns among the health community. But it is also worth keeping in mind that it may be precisely the pharmacists' silence that makes them so popular a source of emergency contraception information and services. To use the words of one mystery client, “they mind their own business”.

The business orientation of pharmacy operators, and the appeal of that orientation to many potential ECP users does not diminish the importance of making them aware that emergency contraception offers no protection against STIs. The solution,

however, need not necessarily entail making counselors of pharmacists, but rather developing and exploiting more non-interactive channels of information.

***Do providers have adequate technical knowledge about emergency contraception?***

At the conclusion of the initial service delivery training in February, all providers were required to demonstrate competence by passing an exam on the basic elements of emergency contraception. They were expected to know what forms emergency contraception could take; what its contraindications were; and what its potential role was within the broad range of contraceptive methods. Although routine monitoring visits by project staff served as a conduit for providing health workers with ongoing technical support, the growing lapse in time did represent a potential threat to adequate provider skills and knowledge. Consequently, to gauge the providers' retention of what they learned, a series of "technical" questions was included in the mystery client interviews. The objective of these questions was not so much to test technical knowledge per se, but rather to assess how well providers were putting their knowledge to use; whether they were asking the right questions; and whether they were responding to answers in an appropriate manner. Once again, the study wanted to know whether there were any appreciable differences among providers in the quality of the services they were providing.

Following the interviews, mystery clients were asked questions dealing with three broad issues: whether the providers' had demonstrated an awareness of the timeframe within which emergency contraception can be effective; whether they had indicated the correct regimen for taking ECPs; and whether they had identified and informed clients of effective strategies for managing side effects. The results were somewhat mixed.

First of all, in contrast to the providers' generally poor acknowledgement of STI risks, familiarity with correct ECP regimens was universally high. Every mystery client who received ECPs was correctly advised to take the first dose within 72 hours of unprotected sex, followed by the second dose, 12 hours later. Every client was also asked how long ago the act of unprotected sex took place. In terms of technical knowledge, therefore, both pharmacists and clinic-based providers (the only two authorized to provide ECPs) performed equally well.

Where discrepancies began to appear, however, was in the attention given by providers to the potential side effects of ECPs: how to minimize them and what to do should vomiting occur within two hours<sup>9</sup>. Based on 26 interviews with all five groups of providers, only one group consistently informed users to take ECPs with food and to return for another dose should vomiting occur within 2 hours. That group was the clinic-based OPD and MCH/FP nurses. Peer counselors and community sales agents also scored poorly on this indicator, though the importance of such an omission was probably less, given the fact that neither group was authorized to actually distribute

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<sup>9</sup> All hormonally-based emergency contraception regimens entail some side effects. Those associated with the Yuzpe method (including PC-4, the method initially used in this study), for example, include the same range of effects commonly experienced with short-term use of combined oral contraceptives, though with higher frequency. Research carried out in Zambia in 1997 indicated that the range and severity of side effects associated with PC-4 were comparable to those described in the existing literature. Vomiting occurred in approximately 16 percent of users; and nausea in about 65 percent (Ahmed et al 1998: 20).

ECPs. It was, however, the pharmacists that surprised most observers by failing to mention possible side effects. In fact, they failed to do so in up to 50 percent of all cases in which ECPs were administered.

# CONCLUSIONS AND RECOMMENDATIONS

The primary objective of this study was to provide the Zambia Central Board of Health and the USAID-funded Zambia Integrated Health Program (ZIHP) with quantitative and qualitative data necessary to recommend the most effective channels for providing youth-friendly emergency contraception services within the context of broad method choice.

To achieve this goal, three criteria were used to compare the effectiveness of different health care providers: the frequency with which young people actually sought providers out; the feasibility of supporting them with training, materials, and commodities; and the quality and breadth of information they provided.

In the previous chapters, research findings were presented within the context of the specific variable or criterion being examined. Except for illustrative purposes, little effort was made to link criteria or to assess the implications of one on the other. In one chapter, for example, pharmacists clearly emerged as the most frequently used provider of ECPs, but they also emerged in the following chapter as one of the most difficult to coordinate and organize for training purposes. What then, does this say about pharmacists or about the relative importance of supporting pharmacists as supplies of emergency contraception information and services?

This chapter highlights what the authors believe to be the most critical conclusions and recommendations to come from this study. Before doing so, however, it is important to return to one of the key assumptions of this study: namely, that the concerns and constraints affecting young people were so different from those of adults, that meeting their needs called for nothing less than testing efficacy of new, non-traditional sets of service delivery arrangements.

In the end, the findings of this study did not really support such an assumption. Because this study encompassed women of all ages, it became possible to view the behavior of women aged 15-24 within a broader context. Perhaps predictably, what emerged was not a homogeneous or even well-defined age-specific behavioral pattern, but rather multiple patterns that, in many cases, were more similar than different across the various ages groups. Perhaps the most clear cut example of this was the universal preference for pharmacists as providers of both information and services. Except for certain clearly defined categories (out-of-school under age 20), among no age group did pharmacists ever represent less than half of the total emergency contraception services delivered. Another example was the universal rejection of CSAs. Though the suggestion to use them as emergency contraception providers actually originated from young people, in the end they proved no more willing than their elders to turn to them for information.

Equally interesting was the finding that behavioral differences, where they did occur, did not coincide with any well-defined age parameters, but rather evolved along a continuum. The shifting preferences for peer counselors and MCH/FP staff showed

how difficult it was to single out young people as a discrete unit of analysis. Even among women aged 25-39, peer counselors still represented an important, albeit decreasing, source of information about emergency contraception.

And finally, the results showed that even within a single age group, behavioral differences could exceed those between groups. The most obvious example of this was the degree to which out-of-school youth, by seeking services from pharmacists, had more in common with adults, than they did with their in-school age mates.

What all of this suggests is that the lessons to be learned from this study speak less to the needs of young people, per se, than they do to the multitude of factors that impede the delivery of emergency contraception services across all age groups.

***Official registration of a dedicated emergency contraception pill is essential if pharmacists are ever able to respond to the public demand for emergency contraception***

Without a doubt, pharmacists represent a popular and highly valued source of emergency contraception services. Their “don’t ask, don’t tell” approach, though perhaps less than ideal from an informational perspective, does not seem to diminish the public’s demand for their services, and in fact could partially explain why so many clients prefer them over the more “thorough”, but less anonymous clinic-based nurses.

Given pharmacists’ popularity and accessibility as a source of ECPs, Zambia’s policy makers and public health officials should ensure that the national policy environment maximizes the pharmacists’ potential to meet public demand for such products. In this respect, it is critically important that a dedicated emergency contraception product be identified and registered for use in Zambia by the national Drug and Poisons Board. There are, today a number of effective, safe ECPs products on the market, including both combined and progestin-only formulations. The fact that no such product is registered in the country severely limits access to emergency contraception, because it precludes pharmacists – who are only permitted to sell registered drugs and medicines -- from distributing them. In fact, pharmacists’ authorization to sell the product will end at the conclusion of the present study<sup>10</sup>.

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<sup>10</sup> The participation of pharmacists in this study was made possible through the special authorization of the Central Board of Health and the Zambia Drug and Poisons Board.

***Advanced prescription of ECPs does not represent an effective approach to the wider distribution of emergency contraception information and services.***

The rationale underlying the use of prescription cards is twofold: first, it reduces the risk of product wastage by limiting product distribution only to those who really intend to use it; and secondly, it enhances access to a product by removing the barriers (such as the need for additional counseling) that might otherwise precluding immediate access to it. But the concept of advanced prescription is also predicated on the assumption that the product, when needed, will actually be available – or that it will be readily given with no strings attached. Unfortunately, in developing countries, where shortages are commonplace, the delayed gratification associated with a prescription card implies a huge leap of faith on the client's part. Perhaps for that reason, almost everyone who learned about emergency contraception from someone authorized to actually provide it (pharmacists and MCH/FP or OPD nurses), chose to redeem the card immediately.

While it is important that peer counselors and CSAs be encouraged to discuss emergency contraception with their clients, it is unlikely that the distribution of prescription cards will have any appreciable effect on their success at doing so. Indeed, the fact that most pharmacy and clinic clients chose to redeem their prescription cards immediately, only highlighted the degree to which the cards were not used as originally intended. An important recommendation of this study, therefore, is that the use of prescription cards be abandoned in favor of more traditional, method-specific brochures or hand-outs, but whose contents reflect more accurately the needs and unique circumstances surrounding each provider group.

***The quality of care provided by pharmacists could be enhanced by the development of new materials for distribution to prospective or actual clients of ECPs***

Of all four provider groups, pharmacists were the ones least likely to engage clients in any discussion beyond what was required to complete the business transaction at hand. They did not raise the issue of STIs; they did not offer condoms when ECPs were not an appropriate contraceptive choice; and they were just as likely not to mention the potential side effects of emergency contraception as they were to do so. And yet, despite these shortfalls (or perhaps even because of them), the appeal of pharmacy operators to potential ECP users remains exceptionally high.

The reluctance of pharmacists to engage clients in broader discussions of their personal health increases the risk of dispensing ineffective treatment; it also gives rise to lost opportunities for addressing broader public health issues such as STI transmission. But the greatest challenge in improving the information pharmacists provide, however, is doing so without sacrificing what it is about them that clients value most. In other words, rather than trying to make counselors out of pharmacists, the challenge is to identify and make better use of information channels that pharmacists will actually use. Two channels immediately come to mind.

The first is a more user-friendly package insert for whichever brand of ECPs is finally registered for use in Zambia. To date, neither PC-4 nor Postinor-2 has such an insert

and, as a result, any information contained in them is unlikely to be read by a client<sup>11</sup>. One insert that could serve as a model for Zambia is the one developed in South Africa for the local equivalent of PC-4, marketed under the name-brand E-GEN-C. It is a colorful booklet with simple instructions on when and how the product should be taken, as well as on strategies for managing side-effects.

The second informational tool would be a printed brochure<sup>12</sup> on emergency contraception, designed specifically for distribution to pharmacy clients. Using simple language and an attractive user-friendly format, the brochure would provide general information about the method, with particular emphasis on those issues pharmacists have shown a reluctance to discuss in public. The brochure would describe, for example, not only the circumstances under which ECPs *would* be an appropriate contraceptive option, but also those under which it would not. In the latter case, the brochure would inform women about the risks of possible pregnancy and the various courses of action they should take, depending on the outcome (the importance proper antenatal care in the case of pregnancy; or more effective contraceptive options if not). It would certainly discuss the inability of emergency contraception to protect against STIs, and it would recommend strategies as to how one might go about doing so in the future. Finally, so as to serve as a marketing tool, the brochure could include space for the name and address of the dispensing chemist.

***OPD facilities have a critical role to play in assisting public sector health care facilities to broaden their client base and in meeting the needs of young people.***

By taking contraceptive commodities outside the exclusive domain of the MCH/FP unit, this study has shown that young people will use public sector facilities if they can be assured a modicum of privacy, respect and understanding. While there is no question that pharmacies represent the number one supply choice for most potential users of emergency contraception, OPD dispensaries can also play a critical role – particularly among in-school youth who are most likely to learn about emergency contraception from a peer counselor, and who may not have the resources necessary to purchase ECPs from a pharmacy.

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<sup>11</sup> The inserts currently available with PC-4 and Postinor-2 are highly medicalized and readable only by someone with at least a secondary-level education.

<sup>12</sup>In contrast to traditional health care facilities, where posters of all shapes and sizes typically run from floor to ceiling, pharmacists are often reluctant to display them so prominently. In some cases, it is their size that limits their use. In others, it is their content. In the case of the posters prepared under this project (see Figure 2), for example, some pharmacists refused to display them out of respect for religious edicts that prohibit representations of the human form.

***Moving emergency contraception outside the confines of MCH/FP Units requires a re-education of clients as well as re-training of providers.***

Introducing emergency contraception into OPD dispensaries was an adjustment for both OPD and MCH/FP staff. But it was also an adjustment for the many clients – young and old -- who had grown accustomed over the years to seeking out family planning information and services from the MCH/FP unit only. If the strategy of clinic-wide distribution is to continue into the future, then greater efforts must be made to enhance clients' awareness of the breadth of clinic-based ECP outlets; including OPD dispensaries and peer counselors.

One strategy would be to develop signs or banners (items that stand out from the multitude of posters that adorn most health care facilities) that identify the different clinic-based distribution points clients have to choose from. In the case of peer counselors, IEC efforts could focus on more youth-friendly items such as t-shirts, key rings, pens, and postcards. There are enough examples of such materials from developed countries that a preliminary field-testing of some of them could be carried out almost immediately.

***High staff turnover has implications for the training and supervision of all provider groups, whether public or private sector.***

High staff turnover has often been viewed as a problem within the public sector health care system; the experience obtained from pharmacists suggests that it is also a very much private sector issue. The implications of this for the distribution of ECPs is clear: among all provider groups, provisions for training must be ongoing; among pharmacists, training curricula must reflect the fact that the educational levels of those dispensing ECPs from chemists may be quite varied.

***Social marketing of a dedicated emergency contraception product could enhance access dramatically if it were to succeed in expanding the number of potential ECP providers***

One of the key objectives of this study was to determine whether there was any empirical basis for justifying the social marketing of an emergency contraception product. While the ultimate answer to this question is a "yes", it is a yes predicated not so much on the establishment of "alternative" pricing mechanisms, but rather on the distribution of ECPs by a wider range of providers than is currently the case (ie. just pharmacists and clinic-based providers).

Two sets of questions informed the decision to support the introduction of a socially marketed ECP. The first related to the impact of having set an ECP price comparable to that of the socially marketed oral contraceptive, *SafePlan*. Was there any evidence from the study, for example, that demand for ECPs increased as a result of having reduced the price from that at which pharmacists reportedly sold it prior to this study? Or alternatively, was there any evidence that ECPs were being purchased by individuals who would not otherwise have done so if the price had not been set at this new amount?

The second set of questions related to the impact of broadening the range of persons eligible to distribute ECPs. Were there, for example, any potential distributors who would only distribute if they received some remuneration for the product? And, equally as important, was there any indication that consumers would respond favorably to the distribution of ECPs by such persons?

With regards to the first set of questions, it is unclear whether pharmacists ever saw any increase in the sale of ECPs during the life of the study<sup>13</sup>. Anecdotal information from them suggested not and there were no service statistics collected prior to the study to suggest otherwise. Consequently, from an economic perspective, one could argue that at least among those clients who frequented pharmacists, emergency contraception remained reasonably price inelastic – in other words, its demand did not appear to vary with price. One could conclude, therefore, that from the perspective of pharmacists, the introduction of a socially marketed ECP would offer few monetary advantages.

But there was at least one group of women for whom price may very well have played an important role: namely, in-school women below the age of 20. As noted earlier, one possible reason they sought services from OPD facilities was the fact that ECPs at such facilities remained free compared to a widespread (but essentially incorrect) perception that the pharmacy price would be too high<sup>14</sup>. Since younger women typically shun traditional health care facilities, it is quite possible that in the trade-off between cost and using an otherwise undesirable provider, many women ended up doing without emergency contraception altogether. It is for these women, that a socially marketed ECP would enhance access dramatically.

And to whom would these women turn? To peer counselors and CSA's, both of whom were extremely effective at distributing information (ie. prescription cards) about emergency contraception, but who were only marginally successful in bridging the gap between information and services. If such individuals were able to sell ECPs directly, then once again, access to emergency contraception could be enhanced dramatically<sup>15</sup>.

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<sup>13</sup> As noted previously, there were rumors circulating that before the study began, some pharmacies were already selling ECPs for as much as 15,000 Kwacha per packet. Since doing so would have been technically illegal, it is not known to what extent, if any, the pharmacists participating in this study were ever part of this group. What is clear, however, is that many pharmacists perceived the 500 Kwacha cap on the price of ECPs to represent a 66 percent price cut in what they could theoretically make – even if that perception had no basis in fact. The claim that they saw no increase in ECP sales, therefore, may be based more on comparisons with hypothetical scenarios than on any actual increases or decreases in the number of emergency contraception users.

<sup>14</sup> In the mystery client interviews, peer counselors often highlighted to clients the fact that whereas pharmacists charged for ECPs, in health care facilities they were available for free.

<sup>15</sup> There are, of course, other groups who could serve as providers of a socially marketed product – drug vendors and community based distributors to mention but a few. Neither group, however, participated in this study, so their potential role, compared to those who did, remains unclear.

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