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Strengthening Reproductive Health through Emergency Contraception



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PLANNED PARENTHOOD.



Margaret Sanger
Center International

Strengthening Reproductive Health through Emergency Contraception

**Margaret Sanger Center International
of Planned Parenthood of New York City, Inc.**

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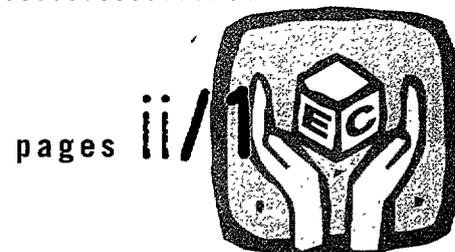
“Strengthening Reproductive Health through Emergency Contraception” was hosted by Margaret Sanger Center International in collaboration with the Malawian government.

The conference was sponsored by the Wallace Global Trust, United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID). UNFPA-Malawi, World Health Organization (WHO) and Department for International Development (Dfid) contributed additional support for local coordination and expanded local participation. The Population Council and UNFPA country offices within SADC and East Africa also provided considerable assistance.

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Executive Summary

Margaret Sanger Center International (MSCI), in collaboration with the Malawian government, hosted “Strengthening Reproductive Health through Emergency Contraception” from November 15 through November 18, 1998. The conference was held in Lilongwe, Malawi for representatives from the Southern Africa Development Community (SADC).

The objectives of the conference were:

1. to identify where and how emergency contraception (EC) might be incorporated in reproductive health services within SADC, and
2. to share information related to needs, public opinion and delivery of EC services between Southern and Eastern Africa and countries with significant experience in this field.

The conference was sponsored by the Wallace Global Trust, United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID). UNFPA-Malawi, World Health Organization (WHO) and Department for International Development (DfID) contributed additional support for local coordination and expanded local participation. The Population Council and UNFPA country offices within SADC and East Africa also provided considerable assistance.

Conference activities were designed to maximize opportunities for participants to exchange knowledge and experiences through a combination of focused plenary and small group activities.

The conference targeted policymakers within SADC’s Ministries of Health and national family planning associations. A total of 96 delegates representing Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Ethiopia, Kenya, Uganda, Ghana,

United Kingdom and the United States attended the conference. Eleven of the 14 SADC member-states were represented.

Prior to the conference, a brief questionnaire on knowledge and attitudes relevant to emergency contraception and the status of EC integration in national reproductive health services was circulated to managers within health ministries and family planning associations within SADC. The East African community was not included in this survey.

Survey results from 10 of the 14 SADC member-states indicated a high level of knowledge of EC within the provider community; a general lack of attendant policy or guidelines for the administration of EC; and a low level of knowledge regarding community attitudes toward EC.

All respondents demonstrated knowledge of EC, its purpose and mode of action. Forty-one percent stated that EC worked by preventing implantation, 37% stated EC prevented ovulation and 22% indicated interference with ovulation as EC's mode of action. Ninety-four percent stated that EC should be used within two to three days of unprotected sex.

Eighty percent of those surveyed reported that there were no laws or policies in their country regulating the use of EC. Only 13% indicated there were regulations. Most respondents (56%) indicated that EC was not referenced in their country's family planning policy or guidelines; 38% reported that EC was referenced.

There was a wide range of responses to the question asking where women could get EC. Thirty-five percent of respondents indicated the Ministry of Health, 30% listed private providers, 22% reported chemists and 4% indicated community based distribution networks as women's source for EC. Forty percent of respondents reported that EC was routinely provided as part of family planning counseling, another 40% reported this was not the case in their country and 20% did not know.

Sixty-seven percent of respondents reported not knowing if their community believed EC encouraged irresponsible sexual behavior, 20% reported that their community felt it did and 13% reported the opposite. Half reported there were no publicly expressed sentiments against EC in their country, but 48% did not know where their community stood on the issue.

EMERGENCY CONTRACEPTION AT A GLANCE

Emergency contraception can prevent pregnancy after unprotected intercourse. Emergency contraceptives include hormonal pills and the copper-T intrauterine device (IUD). The pills, which are specific doses of combined oral contraceptives, are the most common method. EC pills are 75% effective. The IUD is 99% effective.

EC prevents pregnancy. It is not an abortifacient. EC works in one of three ways. It can delay ovulation; it can prevent fertilization of an egg; and it can prevent a fertilized egg from attaching itself to the uterine wall. If the woman is already pregnant from a previous act of intercourse, emergency contraception will not work.

EC pills (including minipills—oral contraceptives containing only progestin) are taken in two equal doses. The first dose should be initiated within 72 hours of intercourse and the second dose should be taken 12 hours after the first dose. If an IUD is used as EC, it should be inserted within seven days of intercourse. Studies are currently underway to determine whether EC pills taken more than 72 hours after unprotected intercourse are as effective as those taken within three days.

Strengthening Reproductive Health through Emergency Contraception: Report on Conference Proceedings

WELCOME AND OPENING REMARKS

To open the conference, Chrissie Mwiyeriwa, Principal Secretary for Malawi's National Research Council and Chairperson for the Local Coordinating Task Force, welcomed delegates to Malawi and said it was an honor for Malawi to play a leading role in a conference on emergency contraception for the Southern African Development Community.

In his opening remarks, Peter Purdy, Director of Margaret Sanger Center International, linked Africa's high rate of clandestine abortions and related deaths to the overall worsening of family health and economic well being. According to Mr. Purdy, the loss of women threatens community survival because women play a pivotal role within the family and community. Mr. Purdy also called attention to the relationship between gender inequality and women's mortality rates.

KEYNOTE ADDRESS:

POPULATION STUDIES, GENDER RELATIONS AND EMERGENCY CONTRACEPTION

Khama Rogo, Chairperson, Centre for the Study of Adolescence, delivered the keynote address entitled "Population Studies, Gender Relations and Emergency Contraception." Dr. Rogo placed the discussion of emergency contraception within the context of the developing world's experience of unsafe abortions, unwanted pregnancies among adults and adolescents, child abandonment, street kids, sustainable development and worsening of human suffering. Rapid population growth and high fertility, he asserted, perpetuate poverty and make it impossible for governments to focus on the future. These conditions retard development as future resources are consumed by the overwhelming crises of the present.

“Men and women . . . given the choice, will have fewer children than their parents did. Thus smaller families and slower population growth depends not on control but on choice,” Dr. Rogo stated, reiterating key tenets of the International Conference on Population and Development (ICPD). He lamented the developing world’s failure to honor these commitments, warning that failure to respond adequately to reproductive health needs will lead to more:

- ➔ potential family planning users without contraception;
- ➔ unwanted pregnancies;
- ➔ pregnancy related morbidity and deaths;
- ➔ unsafe abortions;
- ➔ unwanted births;
- ➔ infant and child mortality;
- ➔ devastating shortfalls in social services;
- ➔ civilian movements, unrest and upheavals; and
- ➔ irreparable injury to our environment.

“Contraception is a key strategy in the protection of women’s health,” Rogo argued, characterizing gender disparities as “the altar” on which women’s health is sacrificed. The number of women using contraceptives has risen in most developing countries, despite men’s objection to family planning and women’s use of contraception. In the absence of male support, female controlled family planning like emergency contraception offers women another chance.

A lack of respect for women, women’s intelligence and women’s ability to decide in their own best interest have made EC “one of the best-kept secrets.” Claiming inadequate information, potential for women’s abuse and the potential for EC to reduce women’s reliance on longer-term methods, EC is kept hidden from general knowledge. “There is an important role for EC in women’s reproductive lives,” Rogo offered, as he provided new ways of viewing EC. He posed the following provocative questions:

- ➔ Why should EC not be considered the primary method of family planning in conjunction with fertility awareness?
- ➔ Why do we need a dedicated product for EC?
- ➔ Why use nausea as a deterrent for promoting EC?
- ➔ Why is EC not advertised in mass media – like malariaquin and Coca-Cola?
- ➔ Could inertia around EC promotion be tied to provider insecurity and/or the over-medicalization of family planning?
- ➔ Are providers ready to trust women?

“It is incumbent on us to ensure that family planning, including EC, is available to [all women],” urged Dr. Rogo. “Rather than withhold EC until we complete our research, let us make the services available and construct our research to answer those questions that are truly critical.”

OFFICIAL CONFERENCE OPENING

In his opening address, the Honorable Harry Thompson, MP, Minister of Health and Population of Malawi, reaffirmed Malawi’s commitment to promoting reproductive health despite the difficulties encountered in implementing family planning programs. Family planning methods are viewed with suspicion, he explained, appealing for “adequate and scientifically proven data to guide the health sector.” Minister Thompson reviewed Malawi’s experience with unintended pregnancy and its consequences. “The need to expand the range of contraceptives [currently available] is indisputable,” he concluded.

EMERGENCY CONTRACEPTION: MODE OF ACTION, EFFICACY AND SAFETY

Valerie Koscelnik, Biomedical Research Fellow with the USAID’s Office of Population, reviewed the mode of action and efficacy of EC. She discussed key distinctions between fertilization and pregnancy, underscoring the fact that EC prevents pregnancy and is not an abortifacient. She went on

to explain that EC is a class of family planning methods used after intercourse to prevent pregnancy. They include oral contraceptives (Yuzpe regimen and progestin-only pills), copper-T IUD and other hormonal preparations like Danizal and mifepristone. Oral contraceptive pills are the most common type of EC.

EC works by inhibiting or delaying ovulation. These are probably not the only mechanisms of action. EC may also interfere with implantation. Studies show that EC decreases the risk of pregnancy by 75% when taken within 72 hours of unprotected sex. A World Health Organization (WHO) study on EC in 1998 showed that progestin-only oral contraceptives were more effective in preventing pregnancy than the Yuzpe method and that the efficacy of both decreased the longer the period between intercourse and taking EC. The study also showed that women experienced less vomiting and nausea with progestin-only pills than they did with the Yuzpe method.

Participants in this presentation discussed concerns about the high prevalence of HIV infections and EC promotion. The impact of EC marketing on condom use and long term methods of contraception were also explored.

DEVELOPING A RATIONALE FOR EMERGENCY CONTRACEPTION

John Chipangwi, Principal of Malawi's College of Medicine, articulated a rationale for EC in Malawi. Dr. Chipangwi reported that EC was not widely utilized in Malawi. The issue of EC use, he suggested, is more complex than lack of access or ignorance. The "will" of the couple needs to be examined. Providing a summary of Malawi's experience with pregnancy and maternal mortality—no fewer than 27,000 women lose their life as a result of a pregnancy—Chipangwi concluded that education and access to contraception could have prevented some of these deaths. Family planning counselors do not routinely educate patients about EC and when asked, confuse RU-486, an abortifacient, with EC. It is important that Malawi begins to discuss EC openly. Chipangwi recommended that Malawi:

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- ➔ accept EC as a part of the family planning options offered nationally so that education and access can be provided;
- ➔ re-examine weekend closure of clinics in light of the WHO study on the lapse between exposure and treatment and EC's efficacy;
- ➔ not restrict EC distribution to medical providers; and
- ➔ link EC marketing with condom promotion in light of high HIV prevalence in Malawi.

Josephat Byamugisha of the Makerere School of Medicine articulated another rationale for EC—women's empowerment. Thirty years of contraceptive availability in Africa have not resulted in high rates of use. In Uganda, contraceptive prevalence rate hovers around 15% and the rate of unmet need is estimated to be 29%. Availability is not access, Dr. Byamugisha contends, as having to walk long distances for supplies and widespread shortages of one's method of choice present serious barriers to access.

“Limited involvement of men in family planning is an essential problem in gender relations,” Byamugisha suggests. Limitations placed on women in deciding when and how many children to bear and whether or not to contracept are also reflections of inequities in gender relations. Further, laws restricting family planning options — many of which are formulated by men — severely curtail women's reproductive freedoms and health. Women's status remains low; their marginalization is seen in their relatively low access to education and economic resources. Men also provide the transport and money necessary for access to contraception. Broadening contraceptive choice requires:

- ➔ granting women a say in family planning options;
- ➔ educating providers not only about EC but about how to effectively support women's decision-making; and
- ➔ broadening awareness and availability of EC.

For reproductive health goals to be achieved, women and men must be encouraged to discuss family planning and couples must be assisted in gaining access to family planning through education about all possible options.

Discussion during this presentation revolved around the role that counselors' discomfort with sexuality plays in miscommunications around family planning. Confusion over RU-486 and EC and the need for cost-benefit analysis in promoting EC were also discussed. Suggestions for those seeking to encourage national support included:

- highlighting EC as a viable option for family planning;
- emphasizing that EC is not an abortion pill;
- advocating for more open communication about sexuality, particularly among medical providers;
- identifying barriers to family planning care and ways to remove them; and
- introducing a wider definition of "provider."

INCORPORATING EMERGENCY CONTRACEPTION IN ROUTINE REPRODUCTIVE HEALTH CARE: CASE STUDIES

ZAMBIA

Yusuf Ahmed, Principal Investigator in Zambia's Emergency Contraception Project, highlighted significant features in Zambia's introduction of EC. Termination of pregnancy is legal in Zambia, making it atypical and possibly more liberal in its reproductive health policies. All methods of family planning are available though not universally accessible. A needs assessment conducted in 1995 documented the need and the desire for EC and assisted in galvanizing support of several relevant ministries and USAID.

Introduction of EC was preceded by efforts to broaden access to family planning, the selection of a

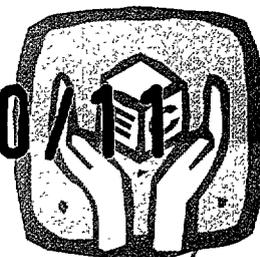
dedicated product, the development of guidelines on administration and dispensing of EC and protocols for management of side effects. Preparatory steps also included the development of a plan for encouraging transition to routine family planning methods and training of relevant providers.

Lessons Learned

- The average woman who used EC was in her late 20s, married and already using a family planning method.
- Young people had difficulty accessing EC because they have difficulty accessing family planning clinics in general.
- If women did not perceive a risk of pregnancy, broadened access to EC and information on EC had no effect on use; however, 25% of EC users did not have prior knowledge of EC.
- Contraceptive users were more likely to know when they were at risk for pregnancy.
- Women given information and EC prophylactically were more likely to use it and use it earlier.
- EC use seemed positively correlated with subsequent use of routine family planning methods; however, after using EC, many went from using a barrier method (condom) to a non-barrier method.

UNITED KINGDOM

Anne Webb of the Women's Health Directorate presented the United Kingdom's experience. The UK began unregulated use of EC in the 1960s. The first licensed product was introduced in 1984; a national campaign was launched in 1995. About one million women seek EC in the UK annually. Access to EC remains exclusively within the domain of medical providers. Discomfort in communicating around issues of sexuality, prejudices about who should and should not have sex, anti-choice sentiments, limited funds and professional fears have presented formidable challenges to broadening access to EC. Although 75% women knew about EC in 1990, women didn't know how to use it or where to get it.



Lessons Learned

- Learn from countries with experience in EC.
- Clarify laws about EC to reduce professional fears.
- Educate and inform people including health workers, influential people and women with clear, concise and correct information.
- Start educating before myths set in; early education saves money in the long run.

SOUTH AFRICA

Helen Rees, Executive Director of the Reproductive Health Unit, described South Africa's experience with EC as "unknown, unused, unpopular and possibly unwanted." South Africa has a 50% contraceptive prevalence rate (CPR) with a preference for injectables. It has one of the highest incidence of HIV in the world and a similarly high incidence of rapes and violence against women. One in three women experience rape.

South Africa utilized WHO's strategic approach to expanding contraceptive choice — baseline assessment, research, and using research for policy and planning. Baseline assessment carried out in 1994 revealed that few barrier methods were being used and that programs for HIV/STD prevention, detection and treatment were poor. A rationale for hormonal EC was formulated around the need to avoid and reduce the number of unwanted pregnancies and the termination of those pregnancies. EC is seen as a backup for contraceptive failure within an overall strategy promoting dual method use. E-Gen-C has been introduced as the dedicated product for EC. South Africa is in the process of developing a national contraceptive policy supportive of EC, retraining providers and introducing the female condom.

Lessons Learned

- ➔ Policy is needed to incorporate EC as part of a method mix.
- ➔ An EC product with acceptable side effects profile is needed.
- ➔ Operations and behavioral research is needed to inform implementation strategies.
- ➔ Cost benefit analysis of mortality/morbidity vs. EC provision is a good advocacy strategy for EC.
- ➔ Focusing on a single method is unrealistic in the developing world.
- ➔ EC should be available over the counter but in conjunction with aggressive promotion of barrier methods.

Discussion included mass media involvement in promoting EC, particularly after the adoption of South Africa's national contraceptive policy. Rees explained the preference for injectables as a function of propaganda, past practice, comfort and privacy. Dr. Rees explained that the Termination of Pregnancy Act should not be considered a deterrent to EC use because of women's restricted access to abortion services and the newness of this right. She suggested that the high incidence of rape does provide an opportunity to talk about EC; however, most women do not present within 72 hours.

NEW YORK CITY, USA

Jacqueline Johnson, Associate Vice President for Clinical Services, Planned Parenthood of New York City (PPNYC), described PPNYC's EC initiative. Only hormonal contraceptive is used in PPNYC's EC initiative, which aims at broadening access, enhancing public awareness and encouraging physicians' participation in providing EC. EC service provision started in 1995 with extensive protocols in place. These include a comprehensive clinic visit and follow-up exam. The Yuzpe method and Lo-Ovral are administered. Initially, very little advertising was done.

An acceptability study conducted a year later showed that 40% of EC patients found out about EC from a friend and 40% from the media. Ninety percent reported that they would use it again but not regularly because of the nausea. Most felt EC should be more readily available but with a prescription, while 26% felt EC should be available over the counter.

In 1998, PPNYC expanded the number of EC appointments, eliminated the pelvic exam requirement, lowered the fee for EC and expanded advertising. In addition, PPNYC launched a subway campaign, engaged local print and broadcast media and included EC as a topic in its automated telephone information line. PPNYC also convened a conference for providers. Future steps in promoting EC include relaying prescriptions to a pharmacy by telephone for existing PPNYC clients.

KENYA

Stella Abwao, Program Officer, PATH, presented Kenya's experience for review. Kenya introduced EC in 1996 through a two-year pilot program in 12 service delivery sites using a dedicated product. The initiative was a collaborative effort involving Pathfinder International, Population Council, the Ministry of Health, the Global Consortium on Health and the University of Nairobi. The foci of the initiative were to ensure that information on EC reached all women of childbearing age, that EC counseling was provided in routine family planning visits and that training for health care providers incorporated EC.

Population Council, using focus group discussions and in-depth interviews, conducted a baseline assessment. It identified information gaps and ensured that the study was widely distributed. Kenya's Family Planning Guidelines were revised to include EC protocols. Regular discussions between policymakers and technical resource persons ensued. These discussions were aimed at sensitizing the country, particularly its health workers, in the pilot areas selected. A Global Resources Packet

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was adapted in Swahili and English for local use. Health workers incorporated EC in their health talks. The need for STD protection and routine family planning was emphasized in counseling.

Implementation met several obstacles. Initial demand for EC was low. Information, education and communications materials were not readily available. There were too few sites piloted which, in turn, restricted the number of potential clients. Also, only medical service providers were trained. Further, community sensitivity to EC curtailed marketing. Despite these obstacles, the demand outpaced supplies and more EC had to be imported for distribution.

Lessons Learned

- ➔ EC is easily introduced when policymakers are on board. Allow policymakers to implement and lend strong support behind the scenes.
- ➔ Low profile introduction works well in avoiding controversy and backlash.
- ➔ Collaboration with other agencies in this field creates a synergy that enhances strategy development and problem solving.
- ➔ Use of a dedicated product facilitates introduction and makes EC more acceptable to clients and providers.
- ➔ The development of policy and guidelines should be completed prior to implementation. It elevates the initiative to a national program, giving it the recognition and protection it would not have if it were perceived as an NGO initiative.

This initiative is being monitored by Population Council and will be evaluated in the near future.

EMERGENCY CONTRACEPTION: SPECIAL CONCERNS

ADOLESCENTS

Pramilla Senanayake, Assistant Director, IPPF, explored common concerns around adolescents and EC. Adolescents do not always associate sex with pregnancy. They often do not consider

themselves “at risk” for pregnancy until after the first missed period, making them unlikely candidates for EC unless specific education campaigns accompany EC promotion. Adolescents’ misconception about when pregnancy is likely to occur is not the only area of concern. When the client is an adolescent, concerns related to morals and irresponsible conduct weigh heavily in the encounter. Generally, provider concerns tend to focus on areas like client’s lack of knowledge, contraindications, side effects, teratogenicity, patient misuse of medication and research. Adolescent clients on the other hand, tend to be concerned with the provider’s ability to communicate health messages in easily understood and emotionally acceptable terms, the ease of access to the product and its cost.

Dr. Senanayake called attention to attitudes which commonly surface when the client is a sexually active adolescent. “Is it ethical,” she asked, “to withhold EC from an adolescent?” and “why is it wrong to use EC as the primary contraceptive when sexual intercourse is irregular?” There is no data to support fears that access to EC promotes promiscuity or discontinuation of routine contraception. Such attitudes, she suggested, denigrates young women’s intelligence and assumes deliberate carelessness. Instead, schools, media, teachers and hotlines could be used to reach young people.

Senanayake encouraged cost-benefit analysis in advocating for EC. “Speak to parliamentarians about cost comparisons [and] ensure that governments see the need and cost efficiency of contraception.” Providers will need to counsel clients on the dangers of STD infection to discourage male abandonment of the condom. Dual protection is essential.

REFUGEES AND DISPLACED POPULATIONS

Charlotte Gardiner, Senior Technical Officer with UNFPA, explored concerns related to EC and refugee or displaced populations. Political, economic and natural disasters have rendered many Africans

homeless within and outside their national borders. Even rural-urban migration has contributed to temporary squatter settlements. In crises resulting from civil unrest or environmental disasters, women and children are at the forefront of the migration to “greener pastures.”

Among the displaced, reproductive health has come to be recognized as an important issue in health interventions. More is now known about the prevalence of rape and sexual exploitation within displaced populations and the degree to which sex is used to secure basic needs in those communities. As a result, UNFPA’s guidelines for a minimal, reproductive health intervention included emergency contraception, condoms and medicines for STD treatment.

Emergency contraception is seen as an important step in preventing unsafe abortions, unwanted pregnancies, maternal mortality, suicides and other post traumatic disorders. In order for EC to be effectively utilized, women must know of its availability and have easy access to it. EC is not intended to be administered without education and counseling. Neither is it intended to remedy sexual exploitation. UNFPA encourages the reorganization of refugee camps to reduce opportunities for sexual exploitation.

Discussions highlighted the urgency of attending to reproductive health needs in refugee camps. In the absence of community, stable relationships, and sufficient resources, the new social interactions which have emerged pose serious challenges to reproductive health.

SEXUALLY TRANSMITTED DISEASES

Davy Chikamata, MD, Regional Medical Advisor, Population Council, Kenya, focused attention on the particular concerns of EC use in an environment marked by a high incidence of sexually transmitted diseases (STDs). Reproductive tract infections are seen in 60% of women coming to clinics in Southern and East Africa. HIV prevalence in antenatal patients have doubled in many of these countries. Studies in Malawi and Tanzania in 1996 and in Zimbabwe in 1995 have shown

condom use to be low. While EC has no direct effect on STDs, its promotion however may exert the following effects indirectly:

- ➔ discouraging consistent condom use;
- ➔ encouraging non-barrier methods of contraception; and
- ➔ discouraging male responsibility for contraception.

In order to harmonize EC integration and STD prevention, use of barrier methods should be emphasized with EC promoted as a backup especially for youth and unmarried women. EC should also be promoted and distributed with barrier methods. Messages should reinforce mutual monogamy, protected intercourse and delaying onset of sexual intercourse. Choice is central to improving health so harm reduction strategies should be employed in STD/HIV prevention campaigns.

Areas in need of closer study include the effect of EC on consistent condom use among young adults, the effect of EC on subsequent contraceptive choice and the effect of distributor type (e.g. community based distribution vs. clinic) on compliance.

Research issues dominated the discussion with spirited exchanges over the importance of training non-medical distributors as well as medical workers.

STEPS TO INTEGRATING EC INTO ROUTINE REPRODUCTIVE HEALTH SERVICES

Dean Phiri, Ministry of Health, Zambia, discussed Zambia's strategy for integrating EC in reproductive health care. While EC has been introduced, it is not yet integrated in routine reproductive health care. A needs assessment was conducted to inform the process. Findings revealed that the service delivery sites were not adequately staffed and that the staff in place were not sufficiently trained. Based on these results, it was recommended that training for health workers be reinstated. Other recommendations were to review current legislation, allow advertisement of EC, integrate EC in reproductive health services and provide EC.

Zambia is currently reviewing relevant legislation, has developed an intrasectoral strategy planning group and has developed an integrated reproductive health policy. A strategy and implementation plan has also been designed. Zambia's Family Planning Policy and Guidelines now includes EC in the method mix. A dedicated product, PC4, has been procured and the first phase of an EC operations research exercise has been completed.

Zambia is constrained in its efforts by:

- ➔ lack of experience in this area;
- ➔ high staff turnover in the health sector;
- ➔ disruptions inherent to national health reforms also underway; and
- ➔ negative provider attitudes.

However, multisectoral participation in the development of new reproductive health policy has made the policy development process easier.

Winnie Moleko, Project Coordinator for South Africa's Programme for Expanding Contraceptive Choice, recommended the following steps for EC integration:

- ➔ conduct baseline studies on general awareness and attitudes towards EC;
- ➔ conduct community consciousness-raising campaigns based on the gaps identified in the baseline studies;
- ➔ implement a consciousness-raising campaign to disseminate the results of the studies, inform communities about the advantages of EC and its availability and encourage grassroots community participation in the dissemination of this information;
- ➔ decide which product the country will use;
- ➔ develop user-friendly information, education and communication materials;
- ➔ develop distribution plan that is effective in ensuring the broadest access possible;
- ➔ ensure that supplies are continuous and closely monitored;

- ➔ monitor and evaluate EC services and use results of evaluation to provide feedback and support to health workers; and
- ➔ use evaluation results to stimulate problem solving among health workers and policy makers.

Ezra Teri, Associate Director, Pathfinder International and Regional Emergency Contraceptive Pills

Coordinator, outlined similar steps for consideration:

- ➔ determine the magnitude of the problem (abortion and unwanted pregnancy);
- ➔ study country needs and demand for EC;
- ➔ identify key stakeholders and policymakers and work with them to introduce EC (these could be local, regional or international players);
- ➔ review national policy and service delivery guidelines and revise as needed;
- ➔ establish a network of implementing partners (in both public and private sectors)—do not work in a vacuum;
- ➔ identify dedicated product and promote it countrywide;
- ➔ work with broad partnership to get product registered for country use;
- ➔ plan and implement site-wide training of providers involved with EC services;
- ➔ develop or adapt information, education and communication (IEC) materials and ensure wide availability;
- ➔ promote EC in all health service facilities;
- ➔ monitor service provision, record keeping and EC side effects; and
- ➔ share experiences.

ROLE OF SOCIAL MARKETING IN THE PROMOTION AND DISTRIBUTION OF EC

Robert Karan, Population Services International (PSI), explored the potential contribution social marketing could make to broadening access to EC. PSI already operates in most of the SADC member states. PSI most often works to complement an existing government program, though it works in conjunction with the commercial sector (advertising agencies, wholesalers, retailers). PSI is

a partner in the Global Consortium and has been studying EC marketing and ways to introduce EC to governments in the developing world.

Social marketing operates on the principle that individual purchase of a product is the most tangible demonstration of behavioral change. Impact is evaluated through sales. Income earned is also potentially available to support national efforts to promote the intended change. In social marketing, the prerequisites are:

- developing an appealing brand;
- establishing an affordable price;
- training providers/distributors; and
- integrating EC with other contraceptive methods.

PSI believes that EC presents an opportunity for looking at broader contraceptive use and that its promotion should be linked to other methods of contraception. PSI, too, is concerned about the transmission of STDs and HIV within the context of EC promotion.

A PSI study of EC in Nigeria, where EC (Postinor 10) can be purchased without prescription, found that people were not sufficiently educated in the proper use of EC. Further, pharmacists were unfamiliar with how the product worked. Education of providers, consumers and linked condom promotion are essential elements of social marketing. In order to stage a meaningful advertising campaign for consumer awareness, government support is needed.

STRATEGIZING FOR CHANGE

Small working groups were convened to assess their respective country's need for EC. Delegates were asked to assess the appropriateness of existing reproductive health policy for integrating EC, the operational readiness of their health care systems and the receptivity of the larger

community to EC. In addition, groups were asked to outline a framework for guiding a national plan of action. Delegates from countries already involved with integrating EC were randomly assigned to country groups not yet involved with EC. Each group was assigned a facilitator and guided by a common set of questions.

All country delegates felt that there was a need for EC to be integrated in national family planning programs. Rates of abortion, teenage pregnancy in particular and unintended pregnancy in general, contraceptive prevalence and maternal mortality were generally felt to be suitable indicators of need. Most felt that a needs assessment was warranted but expressed grave concerns over the location of resources for conducting a needs assessment. While most countries have a national family planning policy and guidelines, few of these documents recognized EC as a part of the method mix. A dedicated EC product was not registered in most of the countries represented. However, many delegates acknowledged that the Yuzpe method was practiced in isolated cases and some wondered about promoting its continued use in the absence of specific policy and a dedicated product. Despite the pre-conference survey reports of "no known public opposition" to EC, delegates conveyed serious apprehension over open discussions of EC, citing fears of community opposition to EC.

ACTION PLANS

Delegates proposed various frameworks for guiding national action plans. These proposals would be presented to the appropriate managers upon returning home. In some cases, delegates mapped out a plan for multisectoral collaboration in presenting their proposals to their respective health ministries.

Some of the elements in the frameworks developed are represented in the following table.

TASKS IDENTIFIED IN ACTION PLAN	Bo	Zi	Ta	Ug	Et	Mo	Mu	Na	Ma	SA	Le	Sw
Report to senior management within MOH		✓	✓					✓	✓	✓	✓	✓
Conduct needs assessment	✓		✓		✓	✓		✓	✓		✓	
Put together multisector planning body					✓			✓		✓	✓	
Develop project proposal					✓			✓				
Construct budget	✓	✓			✓			✓				
Identify donor support					✓			✓	✓			
Pilot project	✓											
Promote Yuzpe method							✓		✓			
Identify & register dedicated product				✓			✓					
Sensitize community	✓			✓			✓			✓	✓	
Integrate EC in on-going training programs				✓	✓		✓			✓		
Introduce training programs for providers				✓	✓			✓		✓		
Review FP guidelines & related policy				✓							✓	
Include EC in national FP guidelines					✓			✓			✓	
Adapt curricula & IEC materials for local use	✓				✓	✓	✓	✓			✓	
Work with media to ensure accurate coverage							✓		✓			

Country names are abbreviated to first two letters, except for Mauritius, abbreviated as Mu, and the Republic of South Africa as SA.

EMERGENCY CONTRACEPTION: DONOR PERSPECTIVES

USAID

Jeff Spieler, Chief, Research Division, Office of Population, USAID, described USAID's commitment to EC integration projects within the developing world. USAID, Washington supports EC integration primarily through biomedical research studies. Dr. Spieler explained that support from the Washington office was predicated on a program's ability to have impact beyond national borders.

Country specific programs are supported by the country's mission, therefore, closer relationships with these missions would be advantageous. Spieler offered advice on what would be considered sound practices in EC integration:

- ➔ cost benefit analysis of dedicated products vs. the Yuzpe regimen for EC;
- ➔ public awareness campaigns that effectively distinguish EC from abortion;
- ➔ pilot projects that address a potential niche;
- ➔ EC initiatives designed to promote EC as a back-up method;
- ➔ EC campaigns which stress barrier methods; and
- ➔ counseling for STD prevention and routine contraceptive use within EC services.

UNFPA

Lalan Mubiala, Country Representative, Malawi, outlined UNFPA's perspective on EC. UNFPA endorses the view that expanded contraceptive choice increases contraceptive use. UNFPA does not recognize abortion as a method of family planning and is committed to reducing the incidence of abortion. UNFPA supports EC as a means of expanding contraceptive choice and a means of empowering women. EC has the potential to play an important role in adolescent reproductive health and is considered a valuable addition to family planning/reproductive health programs. UNFPA shares the view that EC should be positioned as a back-up to routine family planning and be promoted in conjunction with condom use. Mubiala urged countries to consider the following:

- ➔ Should condoms be positioned as the number one method of contraception and hormonal inserts and surgical methods as secondary?
- ➔ Should there be a dedicated product for EC in the private sector and oral contraceptives in the public sector?
- ➔ Should EC use be factored into contraceptive prevalence rates?
- ➔ How can we assure that district health programs, and not just national programs, include EC?

UNFPA works in partnership with governments, though governments are encouraged to form partnerships with NGOs. Only in rare instances, will UNFPA work directly with a national NGO.

DfID

Jenny Allen, Health and Population Field Manager, Malawi, described DfID's commitment to EC. DfID sees EC as part of comprehensive reproductive health care and has supported EC integration through IPPF and PSI. DfID provides core funding through multilateral organizations, bilateral sources and NGOs. DfID has funded research through institutions like WHO and provided funding for novel and innovative approaches to increasing people's access to reproductive health resources. DfID has increased accessibility of reproductive health services in a number of African countries. It supports research in combating STDs and HIV and has also been successful in making new treatments available.

DfID responds to multilateral, bilateral and NGO requests. It responds to NGOs that have UK partners to work with in joint funding schemes. However, DfID's focus is now on working with governments and providing sector-wide support.

LOOKING AHEAD

Peter Purdy of MSCI brought the official deliberations to a close by reminding delegates that there may be a need to build a larger national core group once they return home. He encouraged them to discover the best ways for implementing EC within the context of their particular country's need. Areas for continued focus include:

- ➔ data needs: social indicators and systems indicators;
- ➔ harmonizing EC integration with special issues like STD infection and long term contraception;
- ➔ resources;
- ➔ training needs;
- ➔ media awareness; and
- ➔ evaluation.



CONCLUSION

The conference ended amidst great optimism. Delegates came prepared to explore ways in which emergency contraception could further reproductive health in their respective countries. They identified how and where emergency contraception might be incorporated in national reproductive health services. They shared their country's experience with determining the need for EC, shaping public opinion and designing effective delivery systems. There was much discussion of how EC services have been managed and models for more efficient management.

Many delegates felt that there was sufficient data on hand to document the need for EC. However, more research is needed to make assessments of local health systems, provider readiness, community attitudes and potential funding sources. Delegates remained divided on the necessity of a dedicated product in the promotion of EC. The cost of dedicated products was clearly a deterrent to acceptance.

By the fourth day, the mood was "let's get this done," as the country action plans clearly demonstrate. There seems to be technical expertise and collaboration for moving EC into the mainstream. Population Council, Pathfinder International, PSI and Margaret Sanger Center International represented participating voluntary organizations working in the region. Experienced researchers, administrators and planners from Zambia, South Africa and Kenya were also identified as resources in this area. A big part of the challenge remains as countries try to identify the resources necessary for integrating EC.

CONFERENCE EVALUATION

SESSION–Presenter	Content was relevant to topic				Message was easily understood				I got a few ideas for use at home			
	Ex	Go	Un	Us	Ex	Go	Un	Us	Ex	Go	Un	Us
Keynote Address –Khama Rogo	94	3	3	3	90	3	3	3	84	16	—	—
Session 1: Emergency Contraception Valerie Koscelnik	58	44	2	—	58	44	2	—	58	40	2	—
Session 2: Rationale for EC John Chipangwi	37	51	12	—	35	51	14	—	35	43	18	—
Josephat Byamugisha	42	46	12	4	38	48	12	4	23	44	25	4
Session 3: EC Case Studies Helen Rees	69	27	2	2	62	35	—	2	69	27	2	2
Yusuf Ahmed	51	43	4	2	38	52	8	2	37	47	13	2
Anne Webb	65	31	2	2	65	31	2	2	49	36	11	2
Issues Breakfast	56	37	4	4	59	33	4	4	56	37	8	4
Session 4: EC & Special Concerns Pramilla Senanayake	60	28	9	2	55	35	6	4	55	41	2	2
Charlotte Gardiner	37	56	4	4	36	50	10	10	25	67	4	4
Davy Chikamata	76	18	4	2	71	22	4	2	66	30	2	2
Session 5: EC Case Studies Jacqueline Johnson	33	59	6	2	21	54	6	—	33	59	9	—
Stella Abwao	59	29	10	2	49	47	2	2	51	38	8	2
Session 6: Steps to Integrating EC Dean Phiri	48	48	2	2	45	51	2	2	34	57	9	—
Winnie Moleko	63	33	2	2	50	46	2	2	42	51	4	2
Ezra Teri	67	29	2	2	58	36	4	2	57	37	4	2
Session 7: Strategizing for Change	61	34	5	—	58	30	12	—	53	34	9	3
Session 8: Framework for Action Plans	57	35	5	3	48	39	10	2	52	32	6	10
Session 9: Group Reports	38	51	10	—	33	50	14	3	36	53	6	6
Session 10: Donor Perspectives Jeff Spieler	58	38	4	—	48	39	14	—	49	37	12	2
Charlotte Gardiner	58	38	4	—	54	36	9	—	56	37	7	—
Jenny Allen	64	29	7	—	61	30	9	—	63	27	10	—

Key: Ex = Excellent; Go = Good; Un = Unsatisfactory; Us = Useless

CONFERENCE EVALUATION

Conference Facilities	Excellent	Good	Leaves much to be desired	Unsatisfactory
Meeting areas	25	53	17	4
Rooms	30	66	5	—
Meals	54	40	6	—
Staff efficiency	47	41	12	—
Staff courtesy	63	37	—	—



Appendix 1

Planned Parenthood of New York City, Inc., Administrative Policy and Procedure for Emergency Hormonal Contraception (EHC)

Purpose: To provide emergency contraception services to all women eligible

Policy: To provide emergency contraception services in an efficient and expedited manner

Procedure: Emergency Hormonal Contraception Procedure

Scheduling Appointments

- Upon a telephone request for emergency contraception/morning after pill the client services representative (CSR) will ascertain if the caller fits the following criteria:
 - Has had an episode of unprotected sexual intercourse within 72 hours.
(If patient has been raped within 72 hours refer according to protocol.)
 - Is not pregnant, or believes she is not pregnant.
- If the caller is eligible the CSR will schedule the caller for an emergency contraception appointment at one of the three centers, following the protocols in the Client Services Representative Manual.
- If the caller does not meet the criteria for this service, the CSR will help the patient access the appropriate service (i.e. pregnancy evaluation if period missed, family planning services or referral).

Services at the Center

Registration

- All clients will be received at the reception area by a client support technician (CST), where the appointments will be confirmed.
- New clients will be given a First Visit Information form and Consent for EHC to complete. Registered clients will be given a Consent for EHC and Medical Information Update to complete.
- The CST will refer the client to the cashier for payment. The cashier will refer the client to the appropriate staff at the site (LPN, RN, or Counselor).

The LPN, RN or Counselor will:

- Conduct sensitive urine pregnancy test.
- Confirm that there was unprotected sexual intercourse within the past 72 hours.
- Emphasize that this method is an emergency method only.
- Review options available.
- Explain there are no absolute contraindications to the combined estrogen-progestin regimen except known pregnancy, and that is only because emergency contraception does not work once pregnancy is established, not because it is known to be harmful.
- Offer PPFA Emergency Hormonal Consent form to be signed and copied.
- Discuss importance of regular use of birth control and related literature.
- Have patient sign PPFA Oral Contraceptive Consent form and offer copy if appropriate.
- Provide STD information.
- Provide client with FDA approved medication label.

- Provide emergency contact information.
- Provide HIV educational information.
- Bring patient to clinician with results of pregnancy test.

The clinician will:

- Explain there are no absolute contraindications to the combined estrogen-progestin regimen except known pregnancy, and that is only because emergency contraception does not work once pregnancy is established, not because it is known to be harmful.
- Emphasize that this method is an emergency method only.
- Observe the results of the pregnancy test.
- Review client's history/monitor for contraindications
- Conduct examination and other lab tests only if indicated (e.g., pelvic exam, blood pressure, STD screening, etc.).
- Inform patients why a complete physical exam, pelvic exam and lab tests are deferred until next scheduled visit.
- Write order for emergency contraception in the medical record.
- Prescribe oral contraceptives when appropriate.
- Present all options if patient's history contraindicates emergency contraception.
- Give patient emergency contraception with instructions and emergency contact number.
- Schedule family planning/follow-up visit if appropriate.

Appendix 2

Conference Program

Sunday

15:00-17:00

Registration

17:00-17:30

Welcome

Chrissie Mwiyeriwa, BVM,
Principal Secretary
National Research Council
Centre for Science and
Technology, Malawi
Peter Purdy, Director
Margaret Sanger Center
International, USA

17:30-19:00

Keynote Address

Population Studies, Gender
Relations and Emergency
Contraception
Khama Rogo, MD
Centre for the Study of
Adolescence, Kenya
Chairperson: Folami Harris,
Deputy Director
Margaret Sanger Center
International, USA

19:00

Poolside Welcome

Monday

08:00-10:00

Official Opening

Honorable Harry Thompson, MP
Minister of Health and
Population, Malawi
Chairperson: W.O.O. Sangala,
MD, Principal Secretary
Ministry of Health and
Population

10:00-10:30

TEA BREAK

10:30-12:30

Session 1

Emergency Contraception- Mode
of Action, Efficacy and Safety
Valerie Koscelnik, Biomedical
Research Fellow
Research Division, Office of
Population
USAID, Washington DC
Chairperson: Chrissie Mwiyeriwa,
BVM, Principal Secretary
National Research Council,
Malawi

12:30-13:45

LUNCH

13:45-15:00

Session 2

Developing A Rationale for
Emergency Contraception
John David Chipangwi, MD,
Principal
College of Medicine, Malawi

Josephat Byamugisha, MD,
Lecturer
Makere Medical School, Uganda
Chairperson: Cally Ramalefo,
Executive Director Botswana
Family Welfare Association

15:00-15:20

TEA BREAK

15:20-17:00

Session 3

Incorporating Emergency
Contraception in Routine RH
Care- Case Studies
Helen Rees, MD, Executive
Director
Reproductive Health Research
Unit
Baragwanath Hospital, South
Africa
Yusuf Ahmed, MD, Principal
Investigator
Emergency Contraception
Project
University Teaching Hospital,
Zambia
Anne Webb, MD, FP/RH
Consultant
Women's Health Directorate, UK
Chairperson: John Skibiak,
Associate
Expanding Contraceptive Choice
Program Population Council,
Kenya

18:30

Kwacha Cultural Troupe Performance

Tuesday

07:30-08:45

Food for Thought -EC Issues Breakfast

08:45-10:15

Session 4

Emergency Contraception &
Special Concerns
Pramilla Senanayake, MD, Asst.
Director
International Planned
Parenthood Federation, London
Charlotte Gardiner, MD, Senior
Technical Officer UNFPA,
Africa Region
Davy Chikamata, MD, Regional
Medical Advisor
Population Council, Kenya
Chairperson: Martin Palamuleni,
MD, Executive Director Family
Planning Council of Malawi

10:15-10:45

TEA BREAK

10:45-12:30

Session 5

Incorporating Emergency

Contraception in Routine
Reproductive Health Care: Case
Studies, Part 2
Jacqueline Johnson, MS
Associate VP, Clinical Operations
Planned Parenthood
of New York City, Inc, USA
Stella Abwao, MD,
Programme Officer
PATH, Kenya
Chairperson: W.O.O. Sangala,
Permanent Secretary Ministry of
Health and Population, Malawi

12:30-13:45

LUNCH

13:45-15:00

Session 6

Steps to Integrating Emergency
Contraception into Routine RH
Services
Dean Phiri, MD, Director
Maternal and Child Health Unit
Ministry of Health, Zambia
Winnie Moleko, Project Co-ordi-
nator
Expanding Reproductive Choice
Programme Baragwanath
Hospital, South Africa
Ezra Teri, MD, Regional Co-ordi-
nator
Emergency Contraceptive
Programme
Pathfinder, Kenya
Chairperson: Davy Chikamata,
MD,
Regional Medical Advisor
Population Council, Kenya

15:00-15:15

WORKING TEA BREAK Poster Presentations

15:15-16:15

The Role of Social Marketing
in the Promotion of
Emergency Contraception
Robert Karam,
Social Marketing Advisor
Population Services
International, Malawi
Chairperson: Mrs. Dorothy
Ngoma, Programme Director
Banja La Mtsogolo, Malawi

16:15-17:30

Session 7

Strategizing for Change
Small workgroups intended to
begin assessment of county
needs and system readiness for
emergency contraception ser-
vices. Group assignments will be
made in plenary.

Group 1 -Botswana & Uganda

Davy Chikamata
Group 2 -Mauritius &
Mozambique
Folami Harris

Group 3 -Ethiopia & Namibia

John Skibiak
Group 4 -Malawi
Valerie Koscelnik
Group 5 -Tanzania & Zimbabwe
Peter Purdy
Group 6 -Lesotho & Swaziland
Dean Phiri

Wednesday

08:30-10:30

Session 8

Developing a Framework for
Guiding a National Plan of Action
Structured activity for small work
groups aimed at developing a
framework for guiding a plan of
action for integrating EC.

10:30-10:50

TEA BREAK

10:50-12:30

Session 9

Report on Action Plans
Group Reports

12:30-13:45

LUNCH

13:45-15:00

Session 10

Emergency Contraception: Donor
Perspectives
Jeff Spieler, PhD, Chief
Research Division, Office of
Population,
USAID, Washington DC
Lalan Mubiala
Country Representative,
UNFPA, Malawi
Jenny Allen
Health and Population Field
Manager
DFID, Malawi
Chairperson: Gottlieb Mpangile
Program Advisor
IPPF, Africa Region, Kenya

15:00-15:20

Looking Ahead, Next Steps
Peter Purdy, Director
Margaret Sanger Center
International, NY

Evaluation

19:00

Official Closing

Honourable Sam Mpasu, MP
Minister of Information, Malawi

Farewell Braai

Health Education Band

STRENGTHENING REPRODUCTIVE HEALTH THROUGH
EMERGENCY CONTRACEPTION:
LILONGWE, MALAWI - 15-18 NOVEMBER 1998

Margaret Sanger

Center International

Appendix 3

Presenters

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Yusuf Ahmed, MD
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Jenny Allen
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Appendix 5

Pre Conference Survey

Directions: Check the box that corresponds to your answer.

1. Are you aware that women can take hormonal contraceptive pills, emergency contraception ("the morning after pill") to prevent pregnancy after unprotected sex?
 yes no
2. Do you know how emergency contraceptive pills (ECP) work?
 yes no
3. In my country, women can get emergency contraceptive pills from:
 Ministry of Health Family Planning Clinics
 private providers
 chemists
 community-based distribution networks
 don't know
 other (specify) _____
4. Emergency contraceptive pills work by:
 preventing ovulation
 interfering with fertilization
 preventing a fertilized egg from implanting in the uterine lining
 terminating a pregnancy
 don't know
5. There are laws or policies* regulating the use of emergency contraceptive pills in my country.
 yes no don't know
6. Emergency contraception is referenced in my country's national family planning policy* and or guidelines.
 yes no don't know
7. Who can use ECP?
 a woman who just got pregnant
 a woman who had unprotected sex a week ago
 a woman who had unprotected sex within the last 2-3 days
 other (specify) _____
8. Who should not use ECP?
 someone over 35 who smokes
 women with a history of severe migraines
 diabetics with vascular disease
 women who present with blurred or lost vision, trouble speaking or moving
 other (specify) _____
9. Information on EC is routinely provided as a part of family planning counseling in my country.
 yes no don't know
10. Are there groups in your country, which have made public statements against EC?
 yes no don't know
11. Does the community believe EC encourages irresponsible sexual behavior?
 yes no don't know
12. How do you know this?
13. Are you aware of any studies** on EC in your country?
 yes no

* Please include a copy of the law or policy document

** Please include a copy of the study or a reference for tracking it



Appendix 6

Discussion Guide

SESSION 7: STRATEGIZING FOR CHANGE (Should we change? Why should we change?)

Objectives

The purpose of this session is to motivate delegates to begin an assessment of

1. their country's need for emergency contraception
2. the appropriateness of existing RH policy for integrating EC
3. their health system's operational readiness for EC
4. the receptivity of the general community to EC

If 15-20 minutes is assigned to consideration of each of the sections it will take the group 60-80 minutes to complete the exercise. Be creative in facilitating this process so that each country group considers as many of the issues as is possible within the time available for the exercise. The group may consider continuing the discussion up to or after dinner as well. This discussion lays the groundwork for Wednesday morning's deliberations on a national plan of action.

1. ASSESSING COUNTRY NEED

- What constitutes a justifiable need for EC?
- What are indicators of this need?
- What is the magnitude of this need? Is there data to support your assessment?

2. ASSESSING FP POLICY

- Does your country have national guidelines for RH/FP services?
- Do these guidelines acknowledge/regulate the provision of EC?
- Are there any regulations controlling the administration of EC in your country?
Is EC used in your country?
- What kinds of policies would be required to integrate EC in routine FP services?

3. OPERATIONAL READINESS

- What are prerequisites for integrating EC in RH care in your country?
- Are providers knowledgeable about EC? Are providers comfortable with EC?
- Are there dedicated products available for EC?

4. ASSESSING SOCIAL CLIMATE

- How receptive is your community to EC? Do they know what it is?
- How do you know that?
- Are there studies on your community's knowledge, attitudes and perceptions about EC?