

PN-ACK-166  
106884

**Providing Emergency Contraception  
in Ecuador:  
Assessing the Impacts of Training and Practice**

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**August 1998**

The International Center for Research on Women gratefully acknowledges the support for this project provided by the Population Council under the USAID-funded project INOPAL III (Latin America and the Caribbean Operations Research and Technical Assistance in Family Planning and Reproductive Health), Contract CCP-95-C-00-00007-00.

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## **Introduction**

The term emergency contraception (EC) refers to contraceptive regimens that can be used post-coitally to prevent pregnancy. The most common emergency contraceptives are emergency contraceptive pills or the IUD (see box). Even though many forms of contraception have been used for a long time in reproductive health programs throughout the Latin America region—including oral contraceptive pills, IUDs, and injectables—EC in the Americas, as well as in other parts of the globe, remains the world's best-kept secret.

In Ecuador, despite widespread access to contraceptive pills, rates of unplanned pregnancy remain high. In 1994, 92 percent of women of reproductive age were familiar with modern family planning methods, but only 48 percent reported using these methods. Nineteen percent of all pregnancies were reported as unplanned, and 8 percent of these were interrupted pregnancies, as a result of induced or spontaneous abortions. The rates of unplanned pregnancy among women with little or no education increase to 39 percent (ENDEMAIN 1994).

At the same time, concern about rape and violence against women in Ecuador, as elsewhere, is also growing. Some Ecuadorian nongovernmental organizations (NGOs), such as the Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM), regularly provide emergency contraceptive pills to victims of sexual abuse, as do some physicians in the public sector and in private practice. There is no standardization of the use of EC, however, and the majority of health care providers and women know little about the method or how to institutionalize the provision of EC services. Because EC was not included in the country's health norms until 1997, there are no available data in Ecuador on the use of this method.

With regard to adolescents, the cause of pregnancy is basically lack of knowledge about the risk of pregnancy, which indicates that information and services are not available to this group. In Ecuador, 17.5 percent of adolescents between the ages of 15 and 19 are already mothers, and the rate is believed to be even higher in rural areas. Twenty-five percent of all mothers are adolescents (ENDEMAIN 1994).

## Emergency Contraception

*What is Emergency Contraception?* The term emergency contraception covers a number of methods used by women within a few hours or days after they have unprotected intercourse to prevent pregnancy. The most common method, emergency contraceptive pills (ECPs), involves taking an elevated dose of birth control pills, usually an oral contraceptive containing estrogen (*ethinyl estradiol*) and progestin (*levonorgestrel* or *norgestrel*) within 72 hours of unprotected sex, followed by a second dose 12 hours later. A copper-T IUD inserted within five days of unprotected sex is another form of emergency contraception.

*How does it work?* Emergency contraceptive pills work by interrupting a woman's reproductive cycle. Depending upon when in the cycle the pills are taken, they can prevent or delay ovulation, interfere with fertilization, or block implantation. Emergency contraceptive pills are ineffective once implantation has begun. They cannot cause an abortion if the woman is already pregnant.

*What is known about its safety and efficacy?* Emergency contraceptive pills carry few medical risks for most women. It is estimated that a single act of unprotected intercourse during the fertile phase would lead to pregnancy for 8 out of 100 women. If all of these women were to use ECPs, 75 percent of pregnancies would be avoided—that is, only 2 of the 8 women would become pregnant.

*Why is it important to women?* A wide variety of women at risk of pregnancy from unprotected intercourse can benefit from ECPs. Emergency contraception is an important backup when routine contraception fails to work properly; when there is breakage, slippage, or dislodgment of barrier methods or expulsion of an IUD; when a method is used incorrectly; or when sexual relations were not anticipated. Worldwide, one of the most critical uses for emergency contraception has been in cases of sexual assault.

*Sources:* Consortium for Emergency Contraception (1997)<sup>1</sup>  
USAID Fact Sheet on Emergency Contraception (1997)

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<sup>1</sup>The Consortium for Emergency Contraception is composed of seven organizations, working in the field of reproductive health, who are committed to making emergency contraception a standard part of reproductive health care worldwide. The member organizations are the International Planned Parenthood Federation, the World Health Organization, Pathfinder International, the Population Council, the Program for Appropriate Technology in Health, the Pacific Institute for Women's Health, and the Concept Foundation.

This project began within a political/judicial environment where women's health policies did not exist. Ecuadorian legislation on health matters makes vague references to various aspects of reproductive health, addressing it primarily in the context of maternal and child health, and punitively in the case of abortion. The Constitution of Ecuador guarantees the "right to a quality of life that assures health, food, clothing, housing, medical care, and essential social services." The State develops the National Health Policy and determines its application through both public and private services. The law establishes the mechanisms for control and surveillance of health services in the private sector. Parents have the right to determine the number of children they would like to have and educate, which is interpreted as the right of parents to plan their families, but the Constitution does not have a specific chapter addressing reproductive health. There is no legislation concerning the use of family planning methods, except with regard to permanent sterilization, which is addressed in the code of medical ethics. Health service providers have urged enactment of legislation to ensure the inclusion of EC within the policy and programs of the Ministry of Health.

Driven by the need to analyze how EC services can be implemented most effectively, the International Center for Research on Women (ICRW) conducted an assessment of several family planning and women's organizations. This assessment showed that there was interest in integrating EC within existing health services, but that little information was available on either the training needs of providers or the most effective mechanisms to inform women about EC.

It was within this context that ICRW developed an operations research project to look at the use of emergency contraceptive pills in collaboration with four Ecuadorian organizations: the Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF), the Centro Obstetrico Familiar (COF), the Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM), and the Municipio del Distrito Metropolitano de Quito/Dirección General de Higiene (MDMQ/DGH) (see the appendix for background on these organizations). These four organizations feel that EC is an alternative to assist women who might otherwise seek unsafe abortions. Many women

facing an unwanted pregnancy continue to seek abortion despite the legal and social barriers and the medical risks. These organizations believe therefore that joint efforts between the government, the health sector, and the social sector are critical in order to ensure that reproductive health care, including EC as an alternative to prevent unwanted pregnancy, be made widely available.

The three main goals of this project were to

- Train health care providers from the four participating institutions in gender issues and the use of emergency contraceptive pills;
- Develop and distribute appropriate informational materials for both providers and their clients; and
- Expand the research base on the knowledge, attitudes, and practices of the providers and the clients of the four institutions regarding gender issues and EC before and after the project's training intervention.

### **Research Objectives**

The primary goal of the project's research component was to evaluate the impact that training on gender issues and EC had on providers' perceptions, knowledge, and attitudes about EC. The primary policy and program questions were what type and degree of changes in knowledge and attitudes of EC could be expected from a one-day training intervention. A one-day training format was selected to accommodate the busy schedule and time demands of the service providers. It was felt that such a workshop could be successfully replicated elsewhere in Ecuador. The challenge was to assess whether the information communicated in such a short period resulted in significant changes in providers' understanding and perceptions of EC.

In addition to the one-day training workshop, regular supervisory visits were made by the study coordinators for each participating organization. These visits occurred as providers were beginning to put into practice what they had learned from the training. This supervisory follow-on reinforced the effects of training, ensured that EC was administered in a technically correct manner, and provided important insights into the perceptions and practices of the service providers.

The main questions posed by the research were the following:

- What was the understanding of EC and gender before training?
- Did training create greater shared knowledge about EC and a greater appreciation of gender factors?
- What additional effect did implementing EC have on knowledge, perceptions, and attitudes?
- What are the characteristics and experiences of the women seeking EC services, and what does this mean for service providers?

### **Description of the Training Intervention**

The project's principal intervention was a training workshop on gender and EC for professional staff of each of the four Ecuadorian organizations' clinics in Quito. The training intervention for each organization consisted of four one-day workshops. Approximately 25 to 30 providers and health professionals attended each workshop. All of the workshops used the same format and core materials, although slight changes were made based on daily evaluations of the effectiveness of length and depth of materials presented. The workshops were held from June 10–13, 1997. Two well-known international trainers were invited to lead the medical and gender components of the training: Dr. Soledad Diaz of the Instituto Chileno de Medicina Reproductiva, Chile, conducted the medical training component, and Dr. Elza Guevara Ruisenor, a psychology

professor at the Universidad Autónoma de México, developed and led the gender component. Additional sessions of the training were developed and led by staff of the collaborating organizations.

The gender issues presentation changed over the course of the four days, becoming more participatory and specific to the gender relations situation in Ecuador. At first, the gender video was not well received, particularly by the male participants, who viewed it as too stereotypical. But once an introduction and debriefing were added, participants viewed the video more objectively and agreed that the kinds of male-female relations portrayed in the video still existed to varying extents among different socioeconomic groups.

The objectives of this training were to (1) educate service providers on gender-sensitive EC service provision and (2) enable them to similarly educate their peers. To fulfill these objectives, the training encompassed information on research logistics of the EC project, gender-awareness raising, and technical medical information on EC. Information on the service providers who participated in the training is presented below in the Study Sample section.

The workshop agenda included a pretraining evaluation of participants' knowledge and beliefs about EC and gender and the presentation of background information on the EC project. This was followed by a session on gender issues and two sessions on the medical aspects of EC provision. The training concluded with a review of the project survey instrument, a posttraining evaluation of the participants' knowledge and beliefs about EC, and an evaluation of the training workshop. A follow-up evaluation was made four months later to determine how attitudes of providers and provision of services had evolved during actual practice.

### **Gender Component**

The gender component of the training focused on defining gender and its importance both

within the field of reproductive health service provision and, more specifically, within the EC project. This component began with a brainstorming session on characteristics usually associated with being a man or a woman and a discussion of how most of these characteristics (with the exception of child-bearing) can be present in either sex. This was followed by another discussion on how gender influences reproduction, sexuality, and the sexual division of labor. This segment included a short video portraying a family going about its typical day, with very traditional role-playing by the mother and father. Before the video was presented, participants were asked to consider whether such traditional roles still existed, particularly among certain segments of the Ecuadorian population. Following the video, participants were asked to rate gender relations on a scale from one to ten in both the participants' personal lives and the lives of potential EC users.

Another discussion centered on general gender assumptions and myths. This discussion encompassed the influence of gender on health services, particularly issues affecting EC use and service provision, including sexual relations, contraceptive choice, decision-making regarding family size, and access to services and quality of care.

### **EC Component**

The medical section of the training began with a participatory activity to link the gender and medical components of the training. Participants were divided into groups that explored issues relating to the use of EC among four target populations to familiarize them with a typical situation facing their client. The four target populations and issues identified were

- (1) *Adolescents*—their sexual behavior, access to contraception information and methods, reaction to EC, and special EC counseling needs.
- (2) *Adult women at risk of an unwanted pregnancy*—their options for dealing with it, maternal mortality associated with abortion, their reaction to EC, and special EC counseling needs.

- (3) *Adult women with risky sexual behavior*—what puts them at risk, what information they need for recognizing they are at risk, the decision-making process following a risky sexual relation, and their special counseling needs.
- (4) *Victims of violence*—the various forms of violence and their consequences, information needed by victims of sexual violence, their decision-making process, and special counseling needs.

Following this introductory activity were two technical sessions on the administration of EC. The first session included a definition of terms, method options, reasons for use, and the application of combined estrogen-progestin and progestin-only pills. The second session included information for and evaluation of the user, patient counseling, side effects, follow-up, and post-EC family planning.

The EC session concluded with role-plays of various EC scenarios. After participants dramatized their particular situation, participants critiqued the EC information and counseling provided. The scenarios included

- (1) Two adolescents debating their options after unprotected sexual intercourse.
- (2) A debate between a doctor advocating EC and a political figure arguing against it.
- (3) A couple planning to have sexual intercourse and the woman advocating condom use while the man advocates EC use.
- (4) A couple experiencing contraceptive method failure and going to a clinic to obtain EC.
- (5) A young woman who had unprotected sexual intercourse and does not wish to be pregnant but whose partner argues that he will marry her and wishes her to carry the pregnancy to term. The woman is seeking counseling.

As described below, both the training workshop and the actual implementation of EC,

supported by ongoing technical assistance, resulted in important changes in providers' understanding and perceptions of EC. Overall, providers reported that the training sessions gave them the understanding of the medical and gender dimensions they needed in order to provide EC services. As for perceptions and attitudes, the training increased concern among providers for the primary or underlying reasons and situations that caused women to need EC services and produced stronger agreement that women should have access to EC services. These changes in perceptions provided a platform to strengthen gender awareness among providers, which in turn can improve the quality of EC services.

### **Study Sample**

The project's study population consisted of providers working in the clinics of the four participating organizations and the women who sought EC services there between August and December 1997. A total of 109 service providers attended a training workshop. However, because of changes in staffing at the clinics, as well as the busy schedules of the providers, only 86 providers completed all the evaluation questionnaires. In order to have comparable data across the three periods of evaluation (pretest, posttest, and postworkshop), the following analyses are based on a total of 86 providers. Table 1 presents information on the profession and organizational affiliation of these providers.

**Table 1. Profession of Provider by Organization**

Profession		Organization				Total
		CEMOPLAF	COF	MDMQ/D GH	CEPAM	
Physician	Count	19	3	14	13	49
	% of Total	22.1%	3.5%	16.3%	15.1%	57.0%
Nurse Midwife	Count	16	14		2	32
	% of Total	18.6%	16.3%		2.3%	37.2%
Nurse	Count		2			2
	% of Total		2.3%			2.3%
Educator	Count		1			1
	% of Total		1.2%			1.2%
Other	Count		1		1	2
	% of Total		1.2%		1.2%	2.3%
Total	Count	35	21	14	16	86
	% of Total	40.7%	24.4%	16.3%	18.6%	100.0%

As Table 1 shows, the number of providers varied among the organizations. The pattern that emerges is consistent with the size of the organizations and the number of clinics from each organization participating in the project; no organization was underrepresented. CEMOPLAF had the greatest representation of providers, about 41 percent, followed by COF (24 percent), CEPAM(19 percent) and MDMQ/DGH, the Municipality of Quito (16 percent).

A second pattern that emerges from the data in Table 1 is the preponderance of physicians as participants (57 percent), followed by nurse-midwives (37 percent). It is not surprising that these two groups constituted 94 percent of all participants, because the training targeted the clinic staff who would be directly administering EC. In terms of the distribution of these professionals across the organizations, the low representation of physicians from COF is interesting (only 3.5 percent of the physicians participating). COF, however, does have a relatively high representation of nurse-midwives. These representation figures result from COF's emphasis on obstetrics and family planning among adolescents. Most of the remaining nurse-midwives work in CEMOPLAF clinics. The Municipality of Quito and CEPAM do not use significant numbers of nurse-midwives in their clinics, because the former provides general

medical services as well, and the latter provides medical services that include legal and psychological counseling.

The percentages of male and female providers are shown in Table 2. It is not surprising that the majority (66, or 77 percent) of the 86 participants were women, because overall more women than men work in the clinics of these organizations.

**Table 2. Sex of Provider by Organization**

		Organization					
		CEMOPLAF	COF	MDMQ/ DGH	CEPAM	Total	
Sex	Male	Count	4	3	9	4	20
		% of Total	4.7%	3.5%	10.5%	4.7%	23.3%
	Female	Count	31	18	5	12	66
		% of Total	36.0%	20.9%	5.8%	14.0%	76.7%
Total		Count	35	21	14	16	86
		% of Total	40.7%	24.4%	16.3%	18.6%	100.0%

The second target group of the project was the women who received EC services after the providers had received training. As shown in Table 3, a total of 166 women visited the clinics of the participating organizations during the evaluation period after the workshop (June through December 1997). For the most part, these women were equally divided among CEMOPLAF, COF, and CEPAM. The Municipality of Quito attended to only 7 women during the study period, in part because the service providers are itinerant; they visit clinics on a 15-day cycle, providing an entire range of health services, not just EC. Thus, it is difficult to coordinate and time these visits with the EC needs of women in the service area. (Additional family planning, demographic, and socioeconomic information on the women users is presented in the Women Who Used EC section.)

**Table 3. Women Users of EC by Organization**

Organization	No. of Women Users	Percentage
CEMOPLAF	49	29.5
COF	55	33.1
MDMQ/DGH	7	4.2
CEPAM	55	33.1
Total	166	100.0

### **Operations Research Design and Methods**

The operations research design used in this project was a single group pretest and posttest design (Fisher et al. 1991). A pretest was administered to providers from clinics of each of the collaborating organizations before their training began, and a posttest was administered immediately after they completed the one-day training course. These tests assessed the participants' perceptions, knowledge, and attitudes regarding gender and EC. A third test—a postworkshop test—was given three months after training to determine whether additional training was necessary or whether continuing technical assistance was sufficient for providers to maintain acquired knowledge.

The operations research approach used in this study combined a number of structured interviewing techniques (Bernard 1994) to collect qualitative and quantitative data on the perceptions and knowledge of EC and the role of gender in the provision of EC. More specifically, free lists, pile sorts, and paired comparisons of key terms were used to identify the cultural domain of EC, including ideas about how gender is integrated (see below). The information collected was analyzed through rank order and consensus analysis to reveal the priority themes and topics that providers emphasized during consultation before and after training, and the degree of consensus existing among providers on these priorities.

The project's approach to collecting and interpreting the data to answer the study's main research questions is presented below in four categories: the identification of key concepts and terms, the development of ranking and user questionnaires for providers and for female users of EC, and the use of focus groups.

### **Identification of Key Concepts and Terms**

Before this project began, little was known about the perceptions, knowledge, and attitudes regarding EC and gender among service providers in Ecuador. Given the absence of any baseline information to guide the development of instruments to measure the effects of the training, the first research priority was to identify the key concepts and terms that constitute the cultural domain of "EC." In developing the project's data collection instruments, the following definition of cultural domain was used:

an organized set of words, concepts, or sentences, all on the same level of contrast, that jointly refer to a single conceptual sphere. The items in a domain derive their meanings, in part, from their position in a mutually interdependent system reflecting the way in which a given language or culture classifies the relevant conceptual sphere (Weller and Romney 1988: 9).

It was important to the research that providers be allowed to use their own terms for describing any cultural domain of EC. Therefore, a first step in defining a cultural domain of EC was to elicit key terms or concepts individuals use to describe and understand EC. The data collection technique of free listing was used for this purpose (Weller and Romney 1988).

Before the training workshop, free lists were collected from 59 service providers (physicians, nurse-midwives, and nurses) from the collaborating organizations. These providers were asked to list all the words that come to mind when they think about or hear the term "emergency contraception." The breakdown of these providers by organizations was 25 (CEMOPLAF), 13 (COF), 15 (Municipality of Quito), and 6 (CEPAM). The service providers

listed a total of 167 terms. It is important to clarify here that providers were not requested to free-list separately on the cultural domain of gender. Rather, the approach of the project was to conceptually view gender within the domain of EC. Thus, it was hoped that a number of the key terms and underlying dimensions of the cultural domain of EC would represent gender themes or issues.

The providers' lists of key terms were analyzed using the computer program ANTHROPAC to produce a frequency list, a respondent by term matrix, and a correlation of each provider's list with all the terms mentioned (Borgatti 1992). Using the information produced by ANTHROPAC in follow-up interviews with providers, we were able to identify those terms that were synonyms, cognates, or used by only one person. As a result, the number of key terms was reduced to 40. To further test for semantic redundancy in the 40 terms, we used two additional analyses. First, we sorted the free-listed terms into piles to identify any clusters or subgroups of other terms. For example, the term religion might be an adequate cover term for a number of more specific terms such as Catholic, church, Pope, or God. In the pile sort task, 13 providers were asked to sort cards, each containing one word from the list of 40 terms, into "piles so that items in a pile are more similar to each other than they are to items in separate piles" (Weller and Romney 1988: 20). The result was a reduced list of 14 key terms (see Table 4). As described below, these 14 terms were used to create a paired comparison questionnaire (Weller and Romney 1988). This questionnaire was used to assess changes in providers' knowledge of and attitudes toward EC as a result of the training and experience providing EC.

The lists of 40 and 14 terms were also reviewed extensively by the project's coordinators and the workshop trainers. Drawing from the list of 40 terms and the coordinators' and trainers' knowledge of EC and the goals of the project, we identified a number of additional terms that were not included in the list of 14. Although we were confident that the 14 remaining terms were representative of the providers' cultural domain, a number of concepts or beliefs important to researchers and trainers had not been mentioned by the providers. In part, this is because the free-

list and pile-sort tasks were completed before the providers received training on EC and the related gender issues. The researchers and trainers had their own cultural domain of EC and gender issues, which included some terms or words not mentioned by the providers. Because these additional terms and concepts were included in the training materials, it was important to include in the final list of terms for EC and gender all of the key concepts or issues deemed relevant from the research, programmatic, and policy perspectives. Thus, just prior to the training workshops, a new list of 24 key terms was created. This new list included terms added by the trainers and coordinators, some of which were terms that had not been mentioned previously by providers, and some were terms that were part of the original list of 40 key terms (see Table 4). This list of 24 terms was used to create a rating questionnaire to evaluate changes in providers' overall knowledge of and attitudes toward EC as a result of training and practice.

**Table 4: Key Terms for Describing the Cultural Domain of EC**

List of 24 Terms for Rating Questionnaire	List of 14 Terms for Paired Comparison Questionnaire
1. Unwanted pregnancy	1. Unwanted pregnancy
2. Communication with partner	2. Communication with partner
3. Unprotected intercourse	3. Unprotected intercourse
4. Reproductive rights	4. Reproductive rights
5. Casual sexual relations	5. Casual sexual relations
6. Rape	6. Rape
7. Prevent abortion	7. Prevent abortion
8. Highly effective	8. Highly effective
9. Sexual rights	9. Sexual rights
10. Dosage	10. Dosage
11. Medical side effects	11. Medical side effects
12. Promiscuity	12. Promiscuity
13. Frequent usage	13. Frequent usage
14. Induces abortion	14. Induces abortion
15. Adolescents	

16. Illegal	
17. Immoral	
18. Sex workers	
19. Sexual values	
20. Free and informed decisions	
21. Sexual coercion	
22. Method failure	
23. Stable partnership	
24. Alcoholism	

### **Evaluation Questionnaires for Providers**

The lists of 24 and 14 terms were incorporated into separate questionnaires to assess the perceptions, knowledge, and attitudes of EC providers before and after they completed the training workshop. The list of 24 words was used to create a rating questionnaire. Respondents were asked to rate the strength of the association between each word and “emergency contraception” The strength of the association was measured on a scale of 1 to 10, with 1 representing little or weak association and 10 representing strong or maximum association.

The list of 14 terms was used to create a paired comparison questionnaire that asked providers to rank topics or issues discussed during their consultation with women seeking EC. For each pair of terms, providers were asked to select the term that they give more emphasis to during a consultation. ANTHROPAC was used to generate all possible pairs of the 14 words. A total of 91 pairs of words were generated ( $n(n-1)/2$ ).

Providers completed both the rating and paired comparison questionnaires at the beginning of the workshop, before they received any workshop materials or information, and again at the end of the workshop, after all training activities had been completed. Comparison of

the change in responses to the rating and paired comparison questions provides insight into how perceptions, knowledge, and attitudes changed as a result of the training intervention.

In addition to the rating and paired comparison questionnaires, a short evaluation was also administered at the end of the workshop. This evaluation asked such questions as how well the workshop was organized and implemented, whether the objectives were clear, whether the location and materials were adequate, whether the information provided was clear, accurate, and useful, and whether discussion groups facilitated comprehension and dialogue. Administered along with the above questions, another set of evaluation questions asked providers to rate their degree of acceptance of EC and gender, and the level of importance of considering gender issues when providing EC, prior to and after having received training.

### **Questionnaire for Women Users of EC**

An important postworkshop activity was to assist the trained providers in implementing EC services. Since three out of the four organizations did not have existing EC programs (CEPAM being the exception), it was necessary to develop promotional materials and packages of emergency contraceptive pills. Thus, prior to the training workshop, the collaborating organizations prepared such materials and packets. These materials and instructions for their use were provided to workshop participants for their clinics.

To monitor the administration of EC and collect important background information on women users, a short questionnaire was developed. One section covered important obstetric, gynecological, family planning, and background socioeconomic information. Another covered the topics or themes that were discussed during the woman's consultation with the provider. The possible topics or themes were identical to the 14 terms in the paired comparison questionnaire completed by providers in response to the question of which topics they would emphasize in their discussions with women seeking EC. Finally, the questionnaire contained a series of follow-

up questions, to be asked after the woman had completed the prescribed EC regimen.

### **Focus Groups**

A final data collection activity of the project was to organize focus groups to discuss the results of the paired comparison questionnaires and the experiences of providers in administering EC. COF, CEPAM, and the Municipality of Quito each organized two focus groups with an average of five providers each who had attended the workshop and had administered EC. CEMOPLAF organized three groups. The groups represented the range of providers for each organization. For example, CEPAM included providers from the Servicios Médicos Legales de la Policía, the Comisaría de la Mujer y la Familia, and the Servicios de Atención Primaria del Ministerio de Salud Pública. The focus group information was used extensively to interpret changes in the ranking of key terms after training and again after practice.

### **The Impact of Training**

Information from workshop evaluation and paired comparison questionnaires and from observations by the trainers was used to assess how providers' perceptions, knowledge, and attitudes regarding EC changed after they received training. Among the key effects were increased acceptance of EC, increased understanding of the importance of gender in relation to EC, and changes in the topics providers would emphasize during consultation. Because the collaborating organizations' principal concern was to provide training that would be useful at the clinic level during the actual consultation before EC was administered, the analysis of the results of training emphasizes the paired comparison information. It should be mentioned here that the information from the paired comparison and the information from the rating questionnaire were overall quite similar, even though the rating questionnaire included more key terms. As mentioned earlier, the rating questionnaire sought to discover knowledge, attitudes, and perceptions without reference to any specific context, such as during the consultation.

## Increased Acceptance of EC and Gender

Overall, the training material was very well-received by the participants. The level of acceptance of EC by providers rose after they received training. Figures 1 and 2 give providers' responses to the questions "What was your level of acceptance of EC?" before training (Figure 1). "What is your level of acceptance after having received training?" (Figure 2). The figures show a substantial increase in providers' acceptance of EC after training.

Figure 1. EC Acceptance Before Training

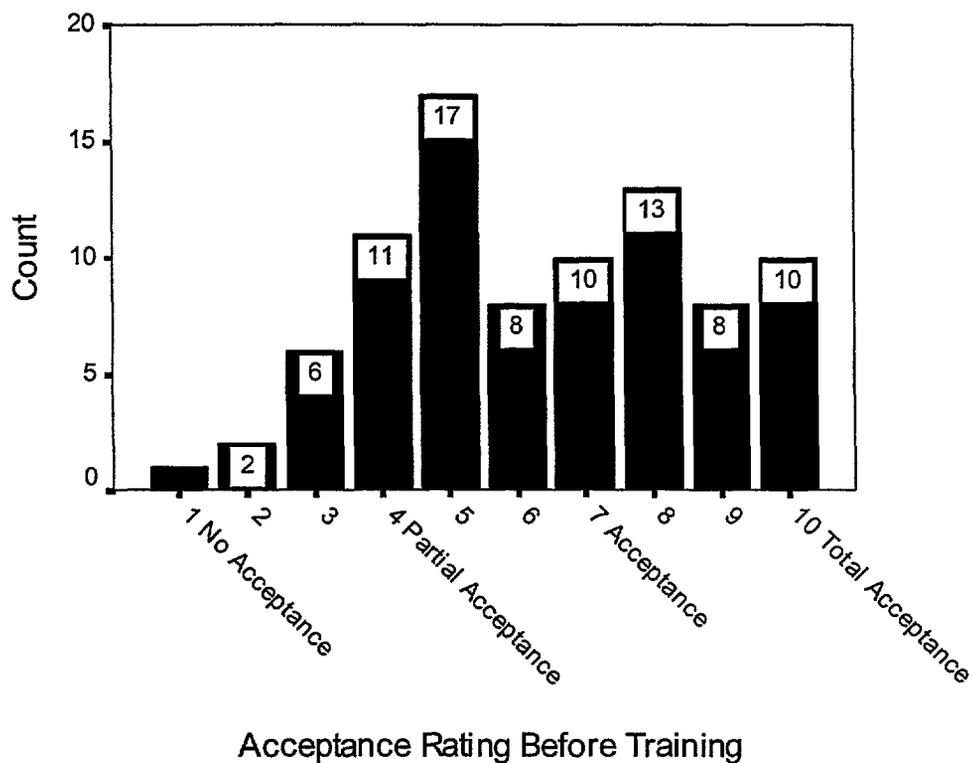
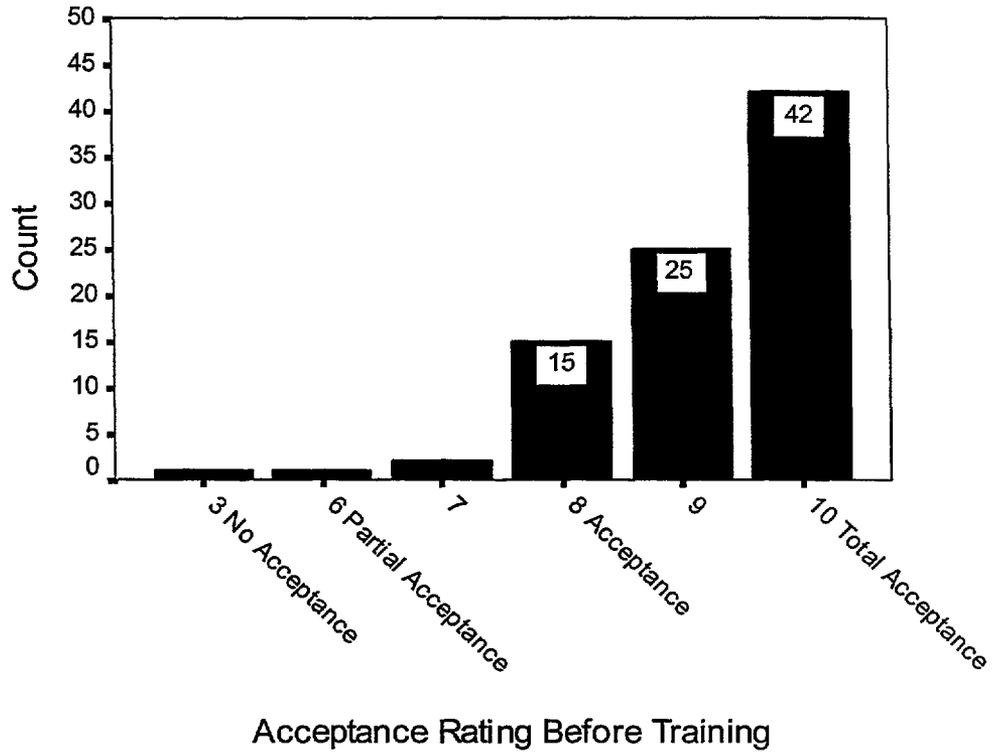


Figure 2. Acceptance of EC After Training



There was also a substantial increase in providers' belief in the importance of including a gender perspective in providing EC. Figures 3 and 4 present providers' responses, before and after training, to the question of "How important is it to include a gender perspective in providing EC?"

Figure 3. Importance of Including Gender Prior to Training

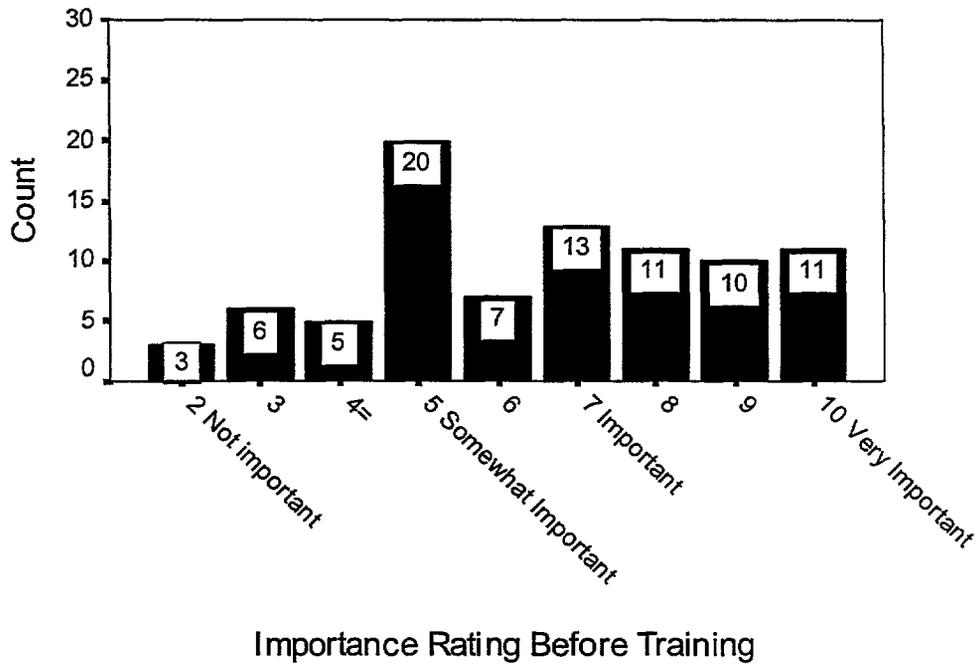
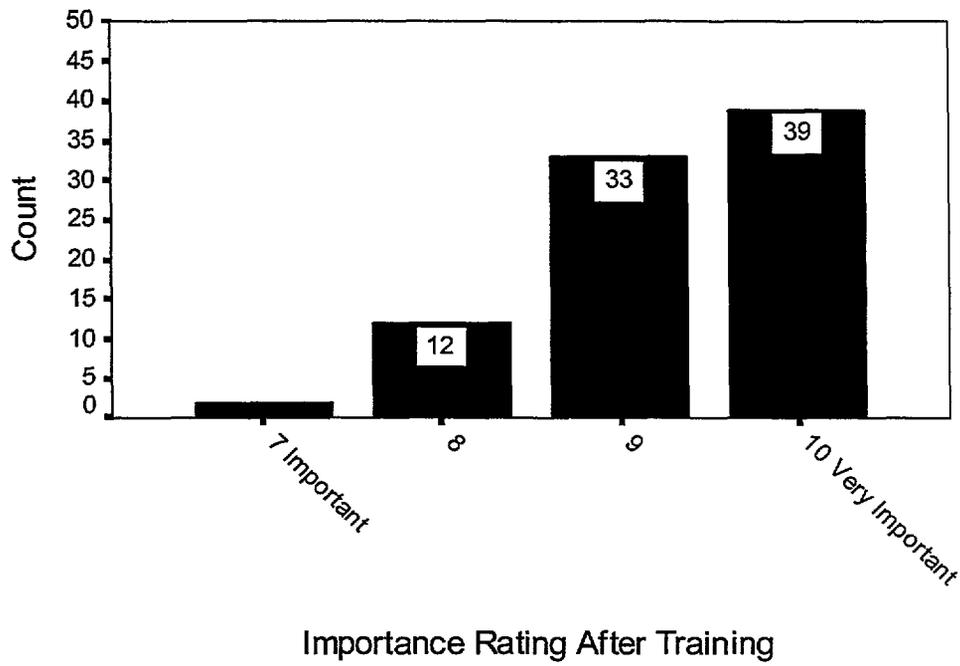


Figure 4. Importance of Including Gender After Training



## Changes in Priority Themes During Consultation

The objective of the paired comparison exercise was to identify which topics or concepts providers felt should be emphasized during their consultation with women seeking EC. The results of the pretest (at the beginning of the workshop) and posttest (at the end of the workshop) paired comparison evaluation are presented in Table 5.

**Table 5: Paired Comparison of 14 Key Terms**

Key Term	Pretest Rank	Posttest Rank	Change in Rank Order
Unwanted pregnancy	1	1	0
Communication with partner	2	9	-7
Unprotected intercourse	3	2	+1
Reproductive rights	4	8	-4
Casual sexual relations	5	4	+1
Rape	6	3	+3
Prevent abortion	7	7	0
Highly effective	8	6	+2
Sexual rights	9	10	-1
Dosage	10	5	+5
Medical side effects	11	11	0
Promiscuity	12	12	0
Frequent usage	13	13	0
Induces abortion	14	14	0

Information from providers who participated in the focus group provides insights on the rationale of providers for their ranking of topics, and why that ranking did or did not change after they received the gender and EC training.

There are several key findings from Table 5. Both before and after training, providers ranked unwanted pregnancy as the most important topic to discuss with women. Before training, providers mainly viewed EC only as a mechanism to reduce the risk of an unwanted pregnancy. They were less concerned with the social, educational, sexual, or gender factors that cause women to seek EC services and with the procedures for administering EC. Their priority concern was to determine whether or not a woman wanted to become pregnant. This priority reflects the view of many providers that unwanted pregnancy is the problem to be addressed in family planning and reproductive health programs because unwanted pregnancies are more likely to lead to abortions, which in turn can result in increased maternal mortality.

The high ranking of unwanted pregnancy continued in the posttest, which is consistent with the more medically oriented information presented during the workshops, which emphasized that one of the benefits of EC was to avoid unwanted pregnancies and thus reduce the need for abortions.

A second important finding from the paired comparison test was that in the pretest providers ranked communication with partner as their second priority topic for discussion during consultation, and in the posttest they ranked it ninth—the most dramatic change in pretest and posttest rankings. To a significant degree, the high pretest ranking reflects what providers reported as a “machista” view: any decision made by a woman related to the number of children she would like, her use of birth control methods, and her pregnancy, real or possible, should be discussed with her partner, regardless of the stability of the relationship. A strong feeling among some providers was that communication between partners is essential when making decisions “of this nature,” and that one partner should not take sole responsibility for such a decision. Pretest,

providers who envisioned attending to a woman involved in a long-standing relationship reported feeling that such communication was essential. Any decision to use EC to help avoid pregnancy should be discussed, they said, and both parties should be encouraged to communicate their perspectives. These providers felt that communication is important in order to avoid a “compromised relationship” that does not respect the rights of women or men and to bring about gender equality. This view that communication between couples is necessary contrasts with the view that communication is not necessary in casual sexual relations. As reported in one focus group, there is no communication in casual sexual relations.

A number of reasons for the steep decline among providers in emphasis on communication with partner were reported. One focus group felt that communication with partner was still important in cases where the relationship permits such discussion, but that otherwise the woman should be the one who decides.

An even stronger position that emerged after training, though, was that a woman should be able to decide for herself whether she wants to use EC to avoid a possible unwanted pregnancy—that she is the only one who should make decisions about her body, life, and fertility. As one provider commented,

In the posttest, [the ranking of] communication between the couple declined noticeably because after the training and practice we realized that when it comes to the decision about whether or not to have a child, the woman has the final word.

The gender and EC training increased awareness among providers of the need to better understand and take into consideration the sexual realities of women that result in the need for EC. These realities include having unprotected sex and casual sexual relations, rape, or being the victim of violence. While the topics of unprotected sex, casual sexual relations, and rape were all ranked relatively high by providers before training, all three terms or topics—particularly rape, which rose three rankings—were given greater priority by providers following training.

Providers said they feel it is important to discuss with women the risks of unprotected sex and casual sexual relations, and the family planning and reproductive health options available to women to protect themselves against unwanted pregnancies, sexually transmitted diseases, and AIDS. In these types of sexual relations, there is no long-standing partner with whom to communicate, and a number of providers commented on how this reality changes the need for a woman to communicate her decisions:

In a casual sexual relationship, or a situation of unprotected sex, the woman assumes the major responsibility; therefore the decision about whether a pregnancy is wanted or unwanted is absolutely her decision.

And,

Often there is no possibility of making the decision as a couple, especially in such situations as the case of rape.

The perceived need to discuss reproductive rights (ranked fourth pretest and eighth posttest) and sexual rights (ninth and tenth) declined after training. In discussions with providers, two reasons for this decline emerged. First, they felt it was more relevant and important to discuss other topics, such as unprotected sex and dosage. Second, although the gender training component of the workshop included discussion of reproductive and sexual rights, providers felt that the concepts are unclear. As one provider commented:

Reproductive rights declined because the term was never really defined and therefore its meaning was unclear to service providers.

Also, providers questioned whether it was feasible to discuss reproductive rights:

We think that people in general do not understand their rights, much less their reproductive rights.

A final reason given by providers for deemphasizing reproductive rights is that providers said a primary consideration is to respect the perspectives of the women who visit the clinics, while trying to provide reproductive and family planning services about which these women may have conflicted viewpoints and partial information. They felt their role is to inform, educate, and make services available, not to advocate a particular position on gender or reproductive rights.

Although the gender training component raised the issue of reproductive and sexual rights, the time available for discussions of these topics was insufficient. After training, providers reported that they had a better idea of what reproductive rights consisted of, but that they were not in agreement or clear on how the concept could or should be incorporated into the provision of EC. Rather, providers reported posttraining that they felt they should focus more on the immediate causes of why women need EC in the first place: unprotected sex, casual sexual relations, rape, and method failure. Although supportive of women's reproductive rights, providers had difficulty conceptually integrating reproductive rights into their daily practice.

Another topic that saw a dramatic change in emphasis pretest (ranked tenth) and posttest (ranked fifth) was explaining the correct dosage for EC. Before training, providers felt that the dosage of birth control pills was rather straightforward and uncomplicated and did not require special attention. However, the trainers focused on the confusion women may have about dosage when side effects of EC such as vomiting occur or when uncertainty as to when to take additional pills exists. The training also emphasized that many women taking additional birth control pills as part of the EC regimen are doing so while under great stress and anxiety, without fully understanding how the pills work to prevent pregnancy. Providers left the workshop with a greater appreciation of the need to better explain how and when to take the pills and how the medication works to prevent pregnancy.

An additional finding was that both before and after training, providers did not seem

particularly concerned about the need to discuss the medical side effects of EC, such as headaches, nausea, and vomiting. Before the project, a strong assumption of the project staff was that these uncomfortable side effects could make many women decide to discontinue the regimen before they completed the second dosage, and lead to situations of confusion about whether to take additional pills in the case of vomiting. As expressed in focus groups, providers felt that these “costs” of taking EC were relatively insignificant given the important benefits of taking the pills: avoidance of an unwanted pregnancy. This finding is of concern because it is in direct contrast with current thinking within the field of family planning, which advocates the importance of discussing medical side effects to allay women’s concerns should they occur.

Finally, the key terms of promiscuity, frequent usage and induces abortion were included in the paired comparison evaluation in order to investigate what are often reported to be some negative consequences of promoting EC: that it will be used frequently as a regular birth control method, that its ease of access and use will lead to greater promiscuity, particularly among adolescents, and that it actually constitutes or promotes abortion. These terms were ranked the lowest both before and after training, and after some practice as shown below. Although there were exceptions, the vast majority of providers were in strong agreement that these myths or negative consequences were not associated with EC and therefore should not comprise a significant part of their counseling. Rather, they felt, as shown in the above discussion, that counseling should begin with an assessment of the situation that created the need for EC, followed by medical matters of dosage and side effects. It should be noted that a few providers, perhaps because of religious beliefs, continued to perceive EC as an abortion, and because of this would not prescribe it, except perhaps in cases of rape.

### **Increased Consensus Among Providers of EC**

An important indicator of the effect of training on providers’ knowledge of EC and gender is the degree to which there was increased agreement or consensus among providers in

terms of their rankings of topics to be discussed with women. To test whether training brought more consensus, we analyzed the rankings of the 14 key terms using consensus analysis in ANTHROPAC. Consensus analysis is both a theory and a method. From a theoretical perspective, it specifies the conditions under which more agreement on the answers to a “test” (e.g., a paired comparison) indicates more shared knowledge; as a method, it provides a way to uncover the culturally correct answers to a set of questions in a situation of intracultural variability (Borgatti 1992). Consensus models focus on a universe of respondents, rather than items, and seek to measure the competence of each respondent and to construct culturally correct responses to a series of questions (Weller and Romney 1988). The culturally correct answer to a question is a function of the amount of agreement among respondents on the answer to that question. Two key assumptions of consensus theory are (1) that each informant (i.e., provider) has some knowledge of the subject matter under study (e.g., EC and gender), and (2) that correspondence between any two informants in their answers is a function of shared knowledge about the subject matter (Weller and Romney 1988).

Applied to the paired comparison data, consensus analysis allows us to ask the following questions: (1) To what extent do providers share knowledge about, or agree about, what topics they should discuss with women who use EC? (2) Are there subdomains in this knowledge that may indicate important subgroups among providers? and (3) What is the estimated knowledge level of each provider vis-à-vis the overall “culturally appropriate” answer as derived from the overall pattern of ranking by providers? It should be emphasized here that what is defined as culturally appropriate is a function of the providers’ pattern of responses to the paired comparison questionnaire. The pattern is derived from the data, and it is useful in situations where no “gold standard” measure is available. This is most definitely the case in EC: there are no a priori right or wrong rank orders of terms; the order used for comparison is that on which there is sufficient consensus among providers.

The results of the consensus analysis for the pretest and posttest information are

presented in Tables 6 and 7. Of interest is whether there was significant agreement among providers on the rank order of the 14 terms. The results are presented as eigenvalues loading on three factors. The consensus model can be said to fit if the ratio of the first eigenvalue is three times the ratio of the second eigenvalue. As can be seen in Table 6, the ratio between the first and second factors is 1.845. The model does not fit, suggesting that before training, providers were not in sufficient agreement to conclude that they shared a cultural model of EC and gender, measured in terms of their responses to the paired comparison of the 14 key terms. Restated, there was not significant consensus among providers on how to rank the key terms.

Table 6. Consensus Analysis Results: Pretest

Eigenvalues				
Factor	Value	Percent	Cum Percent	Ratio
1:	24.035	51.0	51.0	1.845
2:	13.027	27.6	78.6	1.289
3:	10.104	21.4	100.0	
=====				
	47.166	100.0		
Respondent Reliability = 0.961				
Average: 0.470				
Standard Deviation: 0.242				

The results of the posttraining consensus analysis are presented in Table 7. The most significant difference between Tables 6 and 7 is the high ratio between the first two eigenvalues. Factor 1 in Table 7 is 5.408 times larger than factor 2, well above the 3.0 ratio cutoff for consensus. The results suggest that after they received the training, providers were in strong

agreement on rank order of terms, and that the overall pattern of “right” answers can be used to construct the “culturally correct” pattern of responses. The EC and gender training was very successful in helping providers reach consensus on the topics they felt were important to discuss with women seeking EC.

Table 7. Consensus Analysis Results: Posttest

Eigenvalues				
Factor	Value	Percent	Cum Percent	Ratio
1:	42.737	73.6	73.6	5.408
2:	7.903	13.6	87.2	1.067
3:	7.404	12.8	100.0	
=====				
	58.044	100.0		

Respondent Reliability = 0.985

Average: 0.662

Standard Deviation: 0.242

### **The Impact of Practice: Post-workshop**

Immediately after the providers had completed their training in EC and gender, the participating clinics began to offer EC services. This section provides additional information on the women who sought EC services during the three-month follow-up period after the workshop, and provides the results of the post-workshop paired comparison test. The objective of this test was to assess how practice had affected the rank order of key topics to discuss with women seeking EC.

## **Women Who Used EC**

As mentioned earlier and shown in Table 3, 166 women sought EC services at the clinics of the four participating organizations during the six months after the workshop (June through December 1997). The user questionnaire collected basic socioeconomic information on these women. Of the women users of EC, 62 percent were under 24 years of age and were about evenly divided between the two age groups of 12 to 19 years and 20 to 24 years (see Table 8). The remaining 38 percent were almost equally divided between the age groupings of 25 to 29 and 30 to 43. There were noticeable correlations between the organization providing EC and the age distribution of the women users. Not surprisingly, 76 percent of the women who sought EC from COF were under the age of 24. What is surprising is the relatively high percentage of women 12 to 19 seeking EC services from CEPAM. Forty-seven percent of the women attending CEPAM's clinics were under 19 years of age, which, given CEPAM's focus on women who have been raped, suggests either that this very young age group is reporting rape cases more often or that it is particularly vulnerable to rape and physical violence, or both. The ages of the women attending CEMOPLAF's clinics were more evenly distributed, but the highest percentage were still in the 20 to 24 age grouping.

**Table 8. Ages of Emergency Contraception Users by Organization**

		Organizations				Total <sup>a</sup>	
		CEMOPLAF	COF	M.Q	CEPAM		
Ages	12-19	Count	4	18		26	48
		% within Org.	8.3%	32.7%		47.3%	29.3%
	20-24	Count	18	24	2	10	54
		% within Org.	37.5%	43.6%	33.3%	18.2%	32.9%
	25-29	Count	13	5	2	12	32
		% within Org.	27.1%	9.1%	33.3%	21.8%	19.5%
	30-43	Count	12	8	2	7	29
		% within Org.	25.0%	14.5%	33.3%	12.7%	17.7%
	44 and above	Count	1				1
		% within Org.	2.1%				.6%
Total		Count	48	55	6	55	164
		% within Org.	100.0%	100.0%	100.0%	100.0%	100.0%

<sup>a</sup>. The total number of users differs from Table 3 due to missing data.

As for educational background, most of the women had a high school education (secondary) or above (see Table 9). Almost half of the women reported a high school education. Only 8 percent reported a university or college level of education. There were no significant inter-organizational patterns in terms of educational background of women users of EC.

**Table 9. Education of Users of Emergency Contraception by Organization**

Level of Instruction	None	Count	Organizations				Total <sup>a</sup>
			CEMOPLAF	COF	M.Q	CEPAM	
			1			1	2
		% within Org.	2.3%			1.9%	1.3%
	Primary 1-3	Count	4	1		4	9
		% within Org.	9.1%	1.8%		7.7%	5.7%
	Primary 4-6	Count	4	2	2	5	13
		% within Org.	9.1%	3.6%	28.6%	9.6%	8.2%
	Secondary 1-3	Count	8	8	2	4	22
		% within Org.	18.2%	14.5%	28.6%	7.7%	13.9%
	Secondary 4-6	Count	13	35	3	26	77
		% within Org.	29.5%	63.6%	42.9%	50.0%	48.7%
	Vocational School	Count	9	5		8	22
		% within Org.	20.5%	9.1%		15.4%	13.9%
	University or College	Count	5	4		4	13
		% within Org.	11.4%	7.3%		7.7%	8.2%
Total		Count	44	55	7	52	158
		% within Org.	100.0%	100.0%	100.0%	100.0%	100.0%

a. The total number of users differs from Table 3 due to missing data.

In terms of work and employment background, the most frequently reported category was that of student (see Table 10). Thirty-four percent of women users of EC were students, who in turn were attended to primarily by COF and CEPAM, which is consistent with the age group data in Table 8. After students, the two most frequently reported categories are formal sector (government or private) employees (26 percent) and employed in domestic service (24 percent). Only 12 percent of the women were self-employed.

**Table 10. Employment Status of Emergency Contraception Users by Organization**

Employment Status	Salaried		Organizations				Total <sup>a</sup>
			CEMOPLAF	COF	MDMQ/ DGH	CEPAM	
		Count	15	13	3	10	41
		% within Org.	32.6%	23.6%	42.9%	18.9%	25.5%
	Own Business	Count	6	8	2	3	19
		% within Org.	13.0%	14.5%	28.6%	5.7%	11.8%
	Domestic Service	Count	13	9	1	15	38
		% within Org.	28.3%	16.4%	14.3%	28.3%	23.6%
	Unemployed	Count	1	3		2	6
		% within Org.	2.2%	5.5%		3.8%	3.7%
	Student	Count	9	22	1	22	54
		% within Org.	19.6%	40.0%	14.3%	41.5%	33.5%
	Other	Count	2			1	3
		% within Org.	4.3%			1.9%	1.9%
Total		Count	46	55	7	53	161
		% within Org.	100.0%	100.0%	100.0%	100.0%	100.0%

<sup>a</sup>. The total number of users differs from Table 3 due to missing data.

The reasons for women seeking EC services are shown in Table 11. The most frequently reported reasons for seeking EC were unprotected sexual intercourse (67 percent or 109 cases), followed by rape (18 percent or 30 cases) and method failure (13 percent or 22 cases). Most of the women seeking EC because of unprotected sexual intercourse sought services at CEMOPLAF and COF. Not surprisingly, 77 percent of the women seeking EC because of rape attended CEPAM clinics.

**Table 11. Reasons for Seeking Emergency Contraception by Organization**

		Agencia:					
		CEMOPLAF	COF	MDMQ/ DGH	CEPAM	Total <sup>a</sup>	
Reasons for Seeking EC	Unprotected Intercourse	Count	37	44	3	25	109
		% within Reason for Seeking	33.9%	40.4%	2.8%	22.9%	100.0%
		% of Total	22.6%	26.8%	1.8%	15.2%	66.5%
	Method Failure	Count	7	8	2	5	22
		% within Reason for Seeking	31.8%	36.4%	9.1%	22.7%	100.0%
		% of Total	4.3%	4.9%	1.2%	3.0%	13.4%
	Rape	Count	3	3	1	23	30
		% within Reason for Seeking	10.0%	10.0%	3.3%	76.7%	100.0%
		% of Total	1.8%	1.8%	.6%	14.0%	18.3%
Other	Count	1			2	3	
	% within Reason for Seeking	33.3%			66.7%	100.0%	
	% of Total	.6%			1.2%	1.8%	
Total	Count	48	55	6	55	164	
	% within Reason for Seeking	29.3%	33.5%	3.7%	33.5%	100.0%	
	% of Total	29.3%	33.5%	3.7%	33.5%	100.0%	

<sup>a</sup>. The total number of users differs from Table 3 due to missing data.

**Changes in Priority Themes During Consultation: Postpractice**

Table 12 compares the findings from the posttest (completed at the end of the training workshop; same as the middle column of Table 5, reordered here by rank) with changes that were

found in August/September 1997 after about three months of implementing EC, as assessed by the same paired comparison test that was used during the workshop. By the time of this postworkshop evaluation, approximately 70 percent of the 166 users of EC included in this study had visited the participating clinics.

**Table 12: Paired Comparison of 14 Key Terms (Posttest vs. Postworkshop)**

Key Term	Posttest Rank	Postworkshop Rank	Change in Rank Order
Unwanted pregnancy	1	4	-3
Unprotected intercourse	2	1	+1
Rape	3	2	+1
Casual sexual relations	4	3	+1
Dosage	5	5	0
Highly effective	6	8	-2
Prevent abortion	7	6	+1
Reproductive rights	8	7	+1
Communication with partner	9	9	0
Sexual rights	10	10	0
Medical side effects	11	11	0
Promiscuity	12	12	0
Frequent usage	13	13	0
Induces abortion	14	14	0

Overall, the rankings changed far less post-workshop than they had between pretest and posttest.

The most important post-workshop changes in rank order were the drop of unwanted pregnancy from first to fourth rank and the continued increase in focus on unprotected sex, rape, and casual sexual relations. A consistent finding from the focus group data from all four participating organizations was that women are seeking EC primarily in response to having unprotected sex, rape, or casual sexual relations (see also Table 11). Although women are concerned about unwanted pregnancy, they instead express their reason for seeking EC in terms of the causes that might lead to an unwanted pregnancy.

One of the most significant lessons providers learned as a result of implementing EC was that the majority of women do not seek EC in order to terminate an unwanted pregnancy, but rather because they have had a sexual experience that puts them at risk of becoming pregnant. EC is not being perceived by the majority of women users as an option once they believe they are or may be pregnant. This finding has implications for the themes or topics that providers should discuss with women seeking EC. Rather than confirm whether any possible pregnancy would be wanted or not, the provider needs to inquire, in a sensitive and caring manner, about the situation that resulted in a woman's fear of becoming pregnant, whether it was lack of knowledge about birth control, method failure, unprotected sexual intercourse, or rape. These situations in turn are linked to the broader sociocultural and gender context of women's lives. Providing EC has made gender issues of even greater concern for providers.

Another result of comparison of posttest with postworkshop is that communication with partner remained a low priority, in large part reflecting the types of underlying causes and situations of the women who are seeking EC; these women are not in stable, long-term relationships.

### Increased Consensus Based on Practice

Consensus analysis was also run on the post-workshop paired comparison data. The results, presented in Table 13, mirror those found posttest. As was the case for the training, practice reinforced agreement among providers on the ranking of topics for discussion with women who use EC. The ratio of factor 1 to factor 2 increased, compared with posttest. This ratio of 6.002 is well above the cutoff of 3.0 and slightly above the value immediately after training (see also Table 7).

Table 13. Consensus Analysis of Results: Post-workshop

Eigenvalues				
Factor	Value	Percent	Cum Percent	Ratio
1:	45.533	77.5	77.5	6.002
2:	7.587	12.9	90.4	1.352
3:	5.612	9.6	100.0	
58.732		100.0		

Respondent Reliability = 0.988

Average: 0.705

Standard Deviation: 0.180

### Conclusions and Recommendations

The EC project in Ecuador was originally designed to test the effectiveness of a training intervention to assist four organizations to develop and implement EC services. The project expanded its scope to include an assessment of the effects that actually implementing EC

services after the training would have in reinforcing and further changing the perceptions, beliefs, and values of the EC service providers.

### **Conclusions**

The project findings indicate that service providers have a substantial interest in receiving training on gender and EC in Ecuador. Before the training workshops, it was not known how providers would respond to the materials on gender and EC. As would be the case in other Latin American countries, there was concern that providers might view EC as abortion, have religious objections, or feel that EC promoted promiscuity and irresponsible sexual behavior, particularly among adolescents. One overall conclusion is that our fears about the cultural and personal objections to EC did not materialize; in fact, we found more openness to EC than expected and a keen interest in using EC to help women better manage their fertility and sexual relations.

Measured from a number of different perspectives, the project's operation research activities led to the conclusion that the one-day training interventions did in fact provide sufficient information to give service providers the knowledge, skills, and confidence they needed to begin to provide EC. It was important that the type of training provided was completed in one day and thus did not represent a significant time investment by busy professionals. After they received training, providers reported a much higher level of understanding of EC and a greater awareness and acceptance of the importance of a gender perspective.

As for specific changes in knowledge, perspectives, and values, the training heightened or reinforced providers' views that EC is important to help avoid unwanted pregnancies; it helped to create a stronger perspective that women themselves have the right to make decisions regarding the use of EC; it raised awareness of the need to better understand the sexual realities of women's lives, which include unprotected sex, rape; and casual sexual relations; and it raised interest in the topics of reproductive and sexual rights. The training also created a stronger shared consensus

among providers on what EC is and on the role of gender in sexual and reproductive issues.

The study's evaluation of trained providers after they had been providing EC services for three months found a shift in the focus of their counseling. Moving beyond their pretest/postworkshop emphasis on avoiding unwanted pregnancy, they began to focus on the behavioral and sociocultural dimensions of unprotected sex, rape, and method failure. This shift in focus provides a potential link with a wide range of gender issues: male and female roles in sexual decision-making, cultural perspectives on masculinity and femininity, and reproductive rights.

Finally, as a result of this project, EC has been fully integrated into the services offered by the four participating institutions, and it has been included as an alternative for women in the Family Planning Chapter of the "Reproductive Health Norms" of Ecuador's Ministry of Public Health.

### **Recommendations**

One of the most important recommendations that emerged from the project was that the type of training and technical assistance provided during the project should be made available to other NGOs and, most important, to the Ministry of Health. The training materials used could be modified with minimal effort to be applicable to the specific context of different provider organizations. Also, the lessons learned from this project can be used to strengthen the rationale for including EC in family planning and reproductive health services.

The gender and EC training materials and format can be used as a platform to promote discussion among NGOs and government agencies of gender issues in reproductive health and family planning. One of the key terms or concepts that providers had the most difficulty with was sexual and reproductive health. Providers expressed interest in learning more about gender issues

related to sexual and reproductive health, but also admitted that although the training had touched upon these issues, it was not sufficient to make them feel comfortable bringing up the topic during consultations. Through a combination of training, technical assistance, and practice, a focus on sexual and reproductive rights as they relate to EC could be a useful arena for promoting these rights in general.

Another lesson learned from the project is that the need for further information dissemination on gender and EC is great. Many myths and misconceptions remain about EC and the role of gender. The experience of this project and any follow-up activities need to be communicated to other organizations. Equally important, the promotion of EC needs to reach a wider audience. As evidenced in our project, there is substantial demand for EC services among women.

Finally, research findings from this project are the first available on how a program intervention can create changes in providers' perceptions, attitudes, and values regarding gender and EC. These findings need to be tested in other organizational contexts, with larger samples and a longer time horizon. Of key interest is to identify which components of the training bring about the most pronounced changes in attitudes, and how these attitudes or perceptions are affected by such factors as an individual's profession, organization, sex, or level of education. Of equal importance is to better understand how women users are perceiving EC, and how that perception and the subsequent behavior vary by individual characteristics such as age, education, employment, and relational status.

The gender and EC project in Ecuador has not only helped to institutionalize EC within four different organizations, but it has provided some preliminary findings on how providers' perceptions, attitudes, and beliefs are affected by training and practice. The project has also provided more than 150 women with EC services and produced some important information on these women users. The lessons learned and the experiences of the participating organizations are

an important resource base for other organizations interested in integrating EC into reproductive health and family planning services.

## Appendix: ICRW and the Four Collaborating Organizations

The International Center for Research on Women (ICRW) is a private, nonprofit organization, dedicated to promoting social and economic development with women's full participation. ICRW generates research and provides technical assistance on women's productive activity, their reproductive and sexual health and rights, their status in the family, their leadership in society, and their management of environmental resources. ICRW works in collaboration with researchers and professionals in Asia, Africa, and Latin America to carry out the research and then disseminate the findings to policy-makers.

The focus and areas of operation of the four Ecuadorian organizations that collaborated with ICRW on this project are the following:

*Centro Médico de Orientación y Planificación Familiar (CEMOPLAF)*: CEMOPLAF is a nongovernmental family planning organization (NGO) founded in 1974. It has an average of 25,000 users per month, primarily offering services to the low-income populations in urban, rural, and indigenous areas. CEMOPLAF operates 21 clinic centers in 10 provinces, and 13 mobile services in areas that are difficult to reach.

CEMOPLAF also offers several programs, among which the community-based distribution of family planning assistance in indigenous communities is a highlight. This project supports community leaders and bilingual health promoters who work in four provinces through 116 distribution posts. Family planning services are offered at low cost, in both urban and rural areas, through community physicians and associated health professionals. Social Marketing, another CEMOPLAF program, promotes the use of contraceptives among those segments of the middle- and lower-income populations who can afford to pay some amount for services. CEMOPLAF has institutionalized operations research within the organization through its own Department of Research.

*Centro Obstétrico Familiar (COF)*: COF is a nonprofit, social services NGO, which began educational activities in reproductive health for adults in 1984. COF's activities have emphasized obstetric care, family planning, and pediatrics. COF's central focus has been to provide quality care in reversible family planning methods to low-income people in the urban marginal areas of Quito.

Since 1991, COF has run an integrated Program for Adolescents. This program offers educational activities and services in a variety of areas including sex education, self-esteem, values, anatomy and physiology of the male and female reproductive systems, responsible sexuality, sexually transmitted diseases and HIV/AIDS, family planning, and youth leadership training. COF trains youth from high schools in urban marginal areas of the city of Quito to serve as health education promoters among their peers. Some promoters also receive training in order to distribute certain contraceptive methods like pills or condoms to other sexually active youth. As a result of this program, COF has become a pioneer in service provision and information on sexual and reproductive health for adolescents in Ecuador. The Program for Adolescents has reached 50,000 students in public and private schools throughout Quito. It has also reached 10,000 youth who are not in the formal education sector. In the EC project, COF has participated through its five agencies, the Program for Adolescents, 10 health centers working with the Ministry of Public Health, the Cipriana Duenas Medical Training Center, and one COF agency each in Esmeraldas and Tena.

*Centro Ecuatoriano para la Promoción y Acción de la Mujer (CEPAM)*: CEPAM offers integrated health and legal services for women in abusive situations. CEPAM is a pioneer in promoting the use of EC among its clients. Since its inception in 1996, the reproductive health clinic of CEPAM has offered services to approximately 1,100 women. It also provides training in gender issues, reproductive health, family planning, and domestic violence to health personnel in six subcenters of the Ministry of Public Health and the Southern District of Quito. For purposes

of the EC project, CEPAM coordinated efforts through 11 health subcenters, CEPAM Guayaquil, SENDAS in Cuenca, Utopia, INRED, the Medical/Legal Service of the Police, and three Women's Commissariats.

*Municipio del Distrito Metropolitano de Quito/Dirección General de Higiene (MDMQ/DGH)*: The Municipality of Quito, under the Directorate General of Hygiene, provides basic health services to the urban marginal population that is not served by the Ministry of Public Health. It administers one outpatient clinic and five health teams that visit 38 neighborhoods once a week. Since 1995, the Municipio has been in charge of the "Women, Integrated Health and Education" project, aimed at strengthening the capacity of providers to serve the health needs of poor women.

The Directorate General of Hygiene is the standard-setting, regulating agency in the city of Quito, and it is also responsible for policies in the areas of health promotion, preventive and curative services, and rehabilitation. The Directorate, through its decentralization policies, and with the support and participation of the citizens of Quito, has undertaken a number of sustainable social and health projects.

For the EC project, the Directorate participated through 37 community health posts, 20 crafts training centers, and 2 municipal high schools.

## References

- Bernard, H. Russell. 1994. *Research Methods in Cultural Anthropology*. Newbury Park, CA: Sage Publications.
- Borgatti, Stephen. 1992. ANTHROPAC Software. Analytical Technologies.
- Consortium for EC. 1997. *Emergency Contraceptive Pills: A Resource Packet for Health Care Providers and Programme Managers*.
- ENDEMAIN 1994. The National Demographic and Maternal Child Health Survey. Atlanta: Centers for Disease Control.
- Fisher, Andrew, et al. 1991. *Handbook for Family Planning Operations Research*; 2nd edition. New York: The Population Council.
- Instituto Nacional de Estadísticas y Censos, Datos Básicos del Ecuador, 1995.
- USAID. 1997. USAID Fact Sheet on EC.
- Weller, Susan and A.K. Romney. 1988. *Systematic Data Collection*. Newbury Park, CA: Sage Publications.