

Population Review

Volume 48, Number 1, 2009

Type: Article pp. 119-134

Introduction and Scaling-up of Emergency Contraception: Lessons Learned from Three Regions

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Abstract

Emergency contraception (EC) has been around for decades, but the first serious introduction and scale-up efforts started in the mid 1990's. This paper reviews programmatic experiences that sought to expand access to emergency contraceptive pills (ECP) in Africa, Asia and Latin America over the last decade. This multiregional review identifies the individual phases of the introductory processes as well as facilitators and barriers to successful scale-up of ECP service provision. Characteristics of successful projects included conduction of multi-sector diagnostic assessments; careful consideration of legal and policy issues; collaborative advocacy and technical assistance for inclusion in public family planning programs by national and international institutions; as well as attention to programmatic areas such as capacity-building, supply-chain and awareness-raising. Lessons learned from varied developing country experiences are discussed as is the need for increased attention to evaluating and disseminating project results.

Keywords

Emergency contraception, advocacy, service provision, communications activities, legal and policy issues,

Introduction

Emergency contraceptive methods can be used after unprotected coitus to prevent unintended pregnancies. Currently, the most recommended post-coital hormonal contraceptive method is the use of dedicated progestin-only pills: 1.5 mg of Levonorgestrel administered as one or two doses. These must be taken as soon as possible, within five days after unprotected intercourse (Bastianelli, Farris, and Benagiano 2008). Combined oral contraceptives can also be used as emergency contraception (EC) using what is known as the Yuzpe regimen (250mg of Levonorgestrel plus 50mg of Ethinyl-estradiol, within 72 hours of intercourse, followed 12h later by an identical dose).

Although the concept of EC has been known for several decades, concerted efforts to make this option available began during the mid 1990's. Work for its introduction took off internationally thanks to the consensus arrived at in a conference convened in 1995 by the Rockefeller Foundation in Bellagio, Italy (Berer et al. 1995). This event was co-sponsored by several international reproductive health (RH) organizations, which later convened in the International Consortium for Emergency Contraception (ICEC) and its various regional chapters (ICEC). These organizations agreed to implement the recommendations contained in the consensus paper, which spanned five main areas of action: biomedical research to improve methods; advocacy and technical assistance for policy and regulatory change; improvement of service provision; information, education and communication (IEC) activities to generate awareness among potential users; and monitoring and evaluation (Berer et al. 1995).

This paper summarizes the results of an inter-regional review of programmatic experiences in the three areas of action concerned with the introduction and scale-up of hormonal EC (i.e., advocacy, service provision, and communication activities) in Africa, South and South-East Asia (SSEA) and Latin America and the Caribbean (LAC). Previous literature covers the latest biomedical research on post-coital contraceptive methods and their population-level effects (Bastianelli, Farris, and Benagiano 2008; Croxatto and Ortiz 2004; Trussell and Cleland 2007). Therefore, this topic will not be covered here. In addition, we do not include EC use of intrauterine devices in this review because provision of these services requires different programming than EC pills (ECP). Moreover, most programs do not use it extensively due to its lower cost-effectiveness if the woman does not plan to continue using it later for regular contraception.

1. Methods

We conducted searches and reviewed documents presenting program experiences in Africa, SSEA and LAC regions over the last ten years. Additionally we consulted with key experts on the topic. The central questions guiding this paper referred to the steps for successful introduction and scaling-up of EC services in developing countries. These tasks included steps to introduce the method; potential risks during the introduction process and barriers encountered in the field; provider capacity-building; strategies to disseminate EC knowledge; and how to estimate and satisfy potential demand. Many of the reviewed experiences have not been published in peer reviewed publications. Therefore, some figures cannot be verified except through contact with the sources.

2. Results

2.1 Diagnostic assessments: a critical first step

The World Health Organization (WHO) has proposed a strategic approach for contraceptive introduction that focuses on quality of care and people's needs and rights (Simmons et al. 1997). The three stages of the introduction process include a diagnostic assessment, development and testing program innovations, and the scaling-up of successful innovations in RH (Fajans, Simmons, and Ghiron 2006).

Diagnostic assessments include multi-sector consultations and dialogue to identify potential challenges and sources of resistance to an innovative technology. As a multi-party exercise, the assessments improve knowledge, support and consensus among country participants. These activities also extend decision-making abilities beyond the ministries of health (MOH). As Fajans and colleagues (2006) point out, studies of this type should include background reviews, stakeholder input and expert consultations, as well as qualitative and quantitative surveys to evaluate the perspectives of decision makers, providers and users (Fajans, Simmons, and Ghiron 2006).

These activities often sensitize the political leadership and other community stakeholders that may otherwise raise obstacles during the introduction. In this manner, pre-introductory actions help assess the context, create public awareness and help minimize community backlash.

Experiences from the field in the reviewed regions show several types of diagnostic assessments. Some were more limited in scope than WHO recommendations. Nevertheless, pre-introductory studies have had a positive impact on introduction activities, while avoiding complications that arose when this step was not appropriately completed.

In Africa, assessments were carried out in Ethiopia, Ghana, Kenya, and Zambia (Baiden, Awini, and Clerk 2002; Muia et al. 2002; Muia et al. 2000; Muia et al. 1999; Skibiak 1995; Steiner et al. 2000). These studies provided information about levels of awareness, receptivity to EC, training needs of service providers and user preferences about service provision modalities. For example, in Zambia the assessment confirmed that pharmacists were the preferred EC provider for most women, and that there were fewer differences between age groups than between different segments within a specific age group. Adolescents did not differ greatly from older women in their preferences for ECP suppliers; however, within the adolescent group, out-of-school youth obtained ECP from a pharmacy almost twice as frequently as in-school youth, who preferred outpatient dispensaries to which they were more likely to be referred by peer counselors (Skibiak 1995).

Another assessment in the Kakuma Refugee camps in Kenya showed public resistance to print materials (e.g., posters) about EC designed to be displayed in public places. On the other hand, the study confirmed support for dissemination carried out through interpersonal communication as well as for the availability of ECP, especially for rape victims. (Muia 2000)

In South Asia, the Bangladeshi MOH requested a feasibility study before considering the introduction of EC into public health outlets (Hossain and Khan 2007). The study confirmed acceptability among women and identified the most appropriate strategies for national scale-up (FRONTIERS 2005). Instead of requiring local research, Pakistani authorities looked into the Bangladeshi ECP program in detail. They took an in-depth study tour during which they met with all stakeholders, including top program managers and NGOs distributing ECP to discuss their experiences. This was followed by a two-day consultative meeting with the participation of all top program managers from Bangladesh, who recommended the introduction of ECP as part of

family planning (FP) services provided by the MOH (M.E. Khan, personal communication, January 2008).

In LAC, pre-introductory assessments included surveys to measure knowledge and prescribing practices among public health providers and private obstetricians, as well as awareness by pharmacists (Givaudan 1998; Langer et al. 1999). These studies determined very low levels of awareness and widespread beliefs that EC may be abortifacient. An introduction project was carried out in collaboration with Mexico City's judicial authorities to provide EC to rape victims. One of this project's most useful lessons was that, although non-medical providers treating rape survivors agreed on the convenience of making EC services available, they were often reluctant to recommend ECP because their service protocols did not specify whether they were authorized to offer it. This was also the case among medical and paramedical providers in other settings, since the FP service delivery guidelines did not discuss the method (Vernon et al. 1997). These studies underlined the need to undertake provider training and update service delivery guidelines and protocols as vital for the introduction of EC in the country. Acceptability studies and operations research testing provider training and IEC strategies took place as well (Vernon 1998a).

Lacking adequate diagnostic assessments, the best case scenario was the need for renewed efforts to correct initial shortcomings. In at least one case, a poor initial appraisal of the local environment led to complications that impaired the introduction effort in the long run. The following examples from Africa and LAC illustrate these scenarios.

In Senegal, initial introductory efforts did not include diagnostic surveys prior to the launch of EC services. This prevented adequate attention to potential obstacles such as inadequate health care facilities and limited provider capacity. ECafrique and its partner Equilbres et Populations took this lesson into account when considering strategies for expanding the program and proceeded to conduct a national strategic assessment on the need for EC in Senegal in 2005 (Population Council 2006). This study's results permitted improved awareness creation and advocacy efforts, resulting in a successful collaboration with the Senegalese MOH. As explained by Dr. Nafissatou J. Diop from the Population Council in Dakar, Senegal, this lesson led these organizations to initiate activities in Guinea Conakry, Congo and Ivory Coast with similar surveys, which also provided valuable information to design training and programming strategies for scale-up within their national public health systems (personal communication, May 2008).

In Uganda, omitting a diagnostic assessment and multi-sector consultations had longer lasting consequences. In this country, even after ECP were registered and available commercially, a social marketing project failed largely because it generated intense pressure from faith-based groups on the MOH. Partly as a result of this social opposition, the public sector's support for EC continues to be limited, except in emergency camps for internally displaced persons (IDPs) where rape is a major issue. A thorough assessment of the perspectives of community and religious leaders, or consultations with them to identify misconceptions and find more culturally appropriate methods to increase awareness, could have saved resources and decreased the adverse reactions (J. Keesbury, personal communication, January 2008).

In LAC, Brazil was the first country to introduce EC services in public healthcare facilities at a national scale. National guidelines were modified to include the Yuzpe regimen of EC as early as 1997. Progestin-only pills were introduced in 1999. This was less than a year after a national meeting to discuss the method's potential, convened by the MOH in collaboration with the Population Council. The 1997 guidelines were widely disseminated among professionals. Following this extensive dissemination effort, a national survey assessed providers' knowledge of

the method. Although this study found high awareness about EC, it also showed poor prescription practices. This raised concerns and led to additional training efforts (Díaz 2007; Galvao et al. 1999). An adequate prior assessment of provider's capacity might have saved resources by informing program managers what topics needed to be covered and emphasized during dissemination activities.

In general, a consistent lesson arises from all three regions: pre-introduction studies save resources by allowing more efficient allocation and avoiding investments in strategies with uncertain success possibilities. Further, when conducted in a participatory manner involving other community stakeholders in addition to health authorities, diagnostic assessments can pave the way for a more successful introduction process.

2.2 Regulatory framework and policy changes

The logical first step of the introduction of EC is having existing products approved for the method (in the case of the Yuzpe regimen) and dedicated progestin-only products registered by regulatory authorities. The second phase involves including both EC regimens in provider guidelines. We observed that, more often than not, public-sector provision of EC products and services was a separate process and occurred well after the previous steps had been completed. Nevertheless, the three processes have not always followed this sequence. For example, two of ICEC's first regional introduction projects—Kenya and Mexico—illustrate different strategies that will be described in detail below. In general, introduction strategies relied on a range of activities to achieve changes in the regulatory and policy areas. From registration to national scale-up, introduction activities need to adapt to national specificities of the legal, cultural and policy environments, as well as the capacity and reach of the public sector.

- Method and product approval and registration. At the time of the Bellagio consensus, no dedicated progestin-only products existed. In Europe, there were products containing Ethinil-estradiol and Levonorgestrel specifically packaged for EC. However, efforts did not focus on making these medications more widely available because biomedical research proved Levonorgestrel alone to be better tolerated and more efficacious. The challenge was that Levonorgestrel-only products were registered only in Europe. Over the following years, in alliance with Gedeon Richter, ICEC succeeded in registering Postinor® in many countries. The International Planned Parenthood Federation (IPPF), PATH and Population Services International (PSI), among other NGO, also participated or led such efforts, collaborating both with Gedeon Richter and with other manufacturers like HRA Pharma (Vernon 1998a).

As of the end of 2007, dedicated ECP were commercially available in 28 of the 47 countries in Africa and 13 out of 19 countries in the SSEA region, as well as all countries in LAC, except for Costa Rica and Panamá. Progress in registration has been slower or has not started in most Arab countries of North Africa and the Middle East. Other Islamic nations with higher use rates and more positive attitudes towards contraception in general have not been characterized by adverse cultural reactions during the introduction process.

As the method becomes better known and demand increases, manufacturers and licensed distributors have become attracted to the new markets and are increasingly willing to assume the costs of product registration without the assistance of reproductive health NGO, as noted by Alexandra Wood from ICON/IPPF (personal communication, September 2007). A new generation of generic EC pill manufacturers, mostly from Asia, is aggressively undertaking

registration efforts across the developing world, with a particular emphasis on expanding markets in that continent and Africa.

Interest by private-sector actors and demand potential are also related to whether ECP are registered to be sold by prescription or over-the-counter (OTC), even in countries where prescription drugs are in practice sold OTC. This probably relates to the fact that in many settings, pharmaceutical firms are only allowed to carry out mass advertising if a product is registered for OTC sale, as was explained by Audrey Schweitzer from HRA Pharma, a major manufacturer of EC products (personal communication, September 19, 2007). Commercial distributors and manufacturers also have more incentives to invest in promotion for OTC than for prescription-only medications because consumers can respond purchasing directly. In turn, potential users may feel more comfortable buying and using OTC products because they are certified as safe, besides being more likely to have heard about EC if mass media commercials advertise EC brands. As the for-profit sector becomes more active, it will be important to evaluate if consumers get adequate messages about correct use from commercial communications activities, especially about using ECP only as a back-up method.

Although currently most developing countries have at least one registered dedicated EC product, it would be desirable to have more brands registered because that would help to drive down the prices in pharmacies. Without the resources and experience of large pharmaceutical companies, product registration is often still too burdensome for some non-profit actors who would gladly introduce lower-priced, socially marketed brands.

- Inclusion in national guidelines. Besides legal approval of the method and registration of dedicated products, experiences to date suggest that inclusion in national RH guidelines is necessary for mainstreaming efforts. NGOs have encouraged this by organizing international workshops and symposia to disseminate expert knowledge and advocate for regulatory and policy changes. Several NGOs also offer technical assistance to update FP guidelines with EC information.

In LAC, introducing EC in national service delivery guidelines required patience, intensive advocacy and expert strategic planning. Health sector reforms and updates of FP guidelines provided windows of opportunity to introduce it. In several countries, the process started before dedicated pills were available internationally and initially focused on including references to the Yuzpe regimen within existing chapters on oral contraceptives.

Expert meetings, symposia and workshops had significant impact in policy changes. The national meeting held in Brazil in 1996 was among the first of such actions. In the following years, other national symposia and two international meetings contributed to the acceleration of policy changes. Smaller meetings also had an important impact. For example, a workshop held in Mexico City with judicial authorities from eight states led to the provision of information about EC to survivors of sexual violence. In 1998, the first Latin American regional meeting took place in Quito, Ecuador. As a direct outcome, EC was included in the FP guidelines of Ecuador, El Salvador, Honduras, and Venezuela. Consultations started in five other countries (Vernon 1998b). A second international conference, convened by the Latin American Consortium of Emergency Contraception (LACEC) in Quito in 2002, spurred another round of policy changes. However, there have been several setbacks. In Peru, Chile, Ecuador and Argentina, judicial challenges posed by faith-based groups have reached the Supreme Court based on constitutional texts that define life as starting “at the moment of conception”, despite the gathering scientific evidence rejecting the post-fertilization effects of Levonorgestrel (Brache et al. 2007; Croxatto and Ortiz 2004; Croxatto and Fernandez 2006; Croxatto 2007; Novikova et al. 2007).

In SSEA, conferences also made a major contribution to the ECP cause (Population Council 1997). In Bangladesh, India, Pakistan, and Nepal EC was included in FP service delivery guidelines 3-5 years after EC was registered and made available through the commercial sector and NGOs. Inclusion in service delivery guidelines has been typically advocated and facilitated by technical assistance and operations research from international organizations or private NGO.

- Public sector provision. Public sector RH facilities distribute ECP in 8 countries in LAC, 10 in Africa and 7 in SSEA [3]. These figures are the result of a long process of advocacy, technical assistance and strategic planning by many RH organizations, experts and advocates.

Kenya and Brazil were the pioneers in public-sector provision of ECP and services. The former introduced Postinor-2® in public clinics as part of early introductory activities led by ICEC's partners. In Brazil, public clinics provided EC services with combined oral contraceptives before dedicated products were registered in the country. Most other countries in SSEA and LAC that currently provide ECP at no cost in public healthcare and FP facilities generally started this policy within the last five years.

As mentioned above, in Bangladesh and India, where the public sector is the main provider of contraception, acceptability and operations research studies were required before introducing EC in the national FP program or granted OTC status (Hossain and Khan 2007; Khan and Md 2003). However, recently the governments of Pakistan and Nepal were sufficiently satisfied with evidence and lessons learned by the Indian and Bangladeshi experiences to introduce ECP in their public health sectors.

In this region, the scaling-up of services has been grounded on vertical strategies, that is, scale-up was initiated typically by first generating buy-in from top national policy-makers, then building capacity among state program managers, then carrying out training of trainers (TOT) workshops in smaller administrative units, and finally training providers on-site. This approach seems to adapt well to cultural specificities of this region, given the organizational culture and rigid power structures in the public health system. After successful national scale-up programs in these countries, long-term technical assistance from donor organizations has been essential to build the managerial capacity to sustain progress.

The above described vertical scale-up strategy contrasts with the Brazilian experience. There, EC service provision expanded horizontally through the system during a national health sector reform and decentralization effort lasting several years. In the decentralized structure of public health-services characterizing Brazil, local authorities were responsible for deciding when to introduce EC. This local decision-making power exists despite the fact that federal service provision guidelines have included the method since 1997. The central government only provides EC supplies to state and municipal authorities who request it, a bureaucratic process that has often limited access (Díaz 2007; Faundes et al. 2007; Heimbürger, Gras, and Guedes 2003; IPPF-WHR 2006).

- Regulatory, legal and policy instability. While the regulatory and policy environment for EC introduction has improved in all three regions, in many developing countries public health norms, policy decisions and public program implementation may be far from stable.

The decision to introduce EC in public FP services is often considered politically difficult by policy-makers, although experience has shown repeatedly that large segments of society endorse free public sector provision of ECP. However in certain settings, not even widespread support—

perhaps from the majority of the population—has prevented negative community reactions and a few judicial challenges against EC. The outcomes of such setbacks have been mixed.

While ICEC partners have joined forces for many EC introduction efforts, in some countries a single international organization collaborated with local partners to introduce EC. The latter were more challenging situations, because a single institution can seldom build consensus among dissimilar socially and politically influential groups. The case of Uganda is illustrative, as public system introduction was rapidly abandoned after strong opposition from faith-based groups against initial activities (Byamugisha 2007).

In other cases, the fear of opposition slowed down policy decisions or court rulings caused them to be reversed. In a recent example, the Chilean High Court overruled a federal executive mandate to provide ECP to all women 14 and older who requested it. Despite initial fears that this ruling banned EC from public provision altogether, apparently it only transfers decision-making on ECP provision to municipal authorities (Faundes et al. 2007; IPPF-WHR 2006; LaNacion.cl 2008; Schiappacasse and Diaz 2006; Westley, von Hertzen, and Faundes 2007). In Ecuador, judicial rulings revoked registration to specific brands of ECP, while others with the same active ingredients maintained their registration status and continue to be sold commercially. The rulings did not affect the limited public-sector provision, which is restricted to specific groups, specifically rape victims (eldiario.com 2006). In other countries (e.g., Mexico and Peru), judicial challenges arose but were ruled in favor of public provision of EC. In Peru, the process stopped public-sector provision for temporarily (Chavez and Coe 2007; Coe 2004; Faundes et al. 2007; Martin 2004). These experiences show that setbacks cannot be ruled out even after introduction seems accomplished and scale-up is underway.

Although registration, provider standards and public sector provision have been described sequentially, the above should not be taken to mean that there is a set sequence that establishes itself as best practice. In fact, these “steps” or “stages” may occur simultaneously or in different order. This can be seen most clearly in countries that started introduction long ago. In Kenya, for example, ICEC was able to establish close collaboration with the MOH, the drug regulation authority, the local representative of the leading manufacturer and NGOs providing RH and FP services locally. Therefore, product registration, its introduction in both private and public clinics and the method’s inclusion in guidelines and standards for public service provision were practically simultaneous processes (Muia et al. 2002). In contrast, ICEC’s partners in Mexico had to introduce EC without a dedicated product in the market and it proved challenging to include detailed information on EC in official provider guidelines. Therefore, they focused on building provider capacity and raising knowledge and awareness about the Yuzpe regimen with available oral contraceptives. According to Alexandra Wood from ICON, IPPF’s subsidiary, product registration and free public provision of dedicated ECP occurred well after this introduction project concluded (personal communication, October 2007). Brazil was atypical in that EC was included in national public service delivery guidelines as the first step in the process. Then, gradually, municipal healthcare facilities started providing EC services over the next couple of years. The last regulatory change there was the registration of dedicated progestin-only pills.

Successful introduction efforts concerning regulation and public sector provision have taken a practical approach and skillfully adapted their strategy to the local conditions. Grabbing opportunities where and when they arise, switching the focus of activities, lowering the profile of communications efforts or—on the contrary—taking a media debate head-on have been a few adaptive approaches observed during our review. However, common lessons can also be drawn from introduction efforts that have progressed to national scale-up, notably that most were multi-

component, multi-sector efforts combining political advocacy, technical assistance and inter-organizational collaboration from the widest possible range of social and political actors.

2.3 Capacity building among EC providers

Training of providers is essential to achieve quality EC services. Although EC has typically been launched with EC-specific training workshops, ideally EC training should be integrated into pre-service curricula and comprehensive contraceptive methodology courses, addressed as a back-up option for cases of method failure and unplanned, unprotected sex.

Family planning counselors need to be prepared to present EC as a back-up for other methods in all counseling sessions, and advice EC clients to resume or adopt regular contraception. Providers should also discuss the need for STI/HIV testing, especially in the case of rape survivors. The latter also need to be referred to other available care if desired (Vernon et al. 1997).

Specific capacity-building for EC provision should continue until it is institutionalized in the RH curricula of medical training institutions. As mentioned, training should encompass both the use of the Yuzpe regime and Levonorgestrel-only pills to achieve EC effects (Hossain et al. 2005).

Regarding the type of providers that have been trained in the delivery of EC services, they have included nursing staff, general physicians and medical specialists like gynecologists, pediatricians or emergency doctors in clinical settings. In addition, operations research from Bangladesh and India confirms that paramedics can also provide quality services (Hossain et al. 2002). Other providers that have been used in different countries like Kenya, Thailand and Nicaragua include pharmacy staff, youth peer-promoters and police officers in rape survivor care and treatment centers (ECAfrique 2004; PATH 2003; Ratanajamit and Chongsuvivatwong 2001; Vernon et al. 1997). Training of each type of provider needs to take into account their level of knowledge about RH, the type of work they do, and the legal status of contraceptive provision in the country.

Training curricula in a variety of formats for medical, paramedical and non-medical providers have been developed, including booklets, PowerPoint presentations, interactive programs on CD and others. Most of them are available on-line (ESOG, ECAfrique and MoH 2005; Hossain et al. 2005; JHPIEGO 1995-2003 ; PATH 2003). Although some dosage and timing recommendations don't reflect recent research findings (i.e., 1.5 mg of Levonorgestrel as a single dose; 120 hours window after unprotected intercourse), these manuals can be updated and adapted to local needs. Consultations with RH managers and providers at different levels are essential to establish institutional buy-in and also help determine the type and depth of information to include, the duration of training and the logistical considerations to organize the workshops.

Experience shows that capacity-building should reach all levels of an organization that will introduce EC (IPPF-WHR 2006). In scaling-up processes, a staggered approach using TOT and cascade training has been successful in public sector settings. In Bangladesh, 300 Master trainers trained 2,300 trainers, who in turn trained about 45,000 service providers across the country (Hossain and Khan 2007; Khan 2004; Khan and Md 2003). Cascade capacity-building strategies can also be used to sensitize and involve stakeholders in non-health settings. In Guatemala, for example, five participants at a pre-conference workshop in Quito in 2002 trained 10 trainers and organized 21 workshops, ultimately reaching 556 participants including service providers like nurses and physicians, NGO staff, and members of the justice system (Kestler and Ramirez 2004). In Ethiopia, a one day workshop model has been developed to train physicians, mid-level paramedical staff and community health workers (ECAfrique 2004; ESOG, ECAfrique, and MoH 2005).

In regard to capacity-building, a general lesson from the review is the need for frequent follow-up training (refreshers) and supervision given the high rotation of service delivery staff.

2.4 Awareness raising and IEC

Product registration and public provision make ECP commercially available or may “guarantee” universal access, but they do not by themselves increase knowledge or use among the general population.

In countries where dedicated ECP are only sold at private pharmacies, they may be too expensive for poor women and adolescents without independent income. However, while price barriers may play a role, experts agree and data confirm that the most formidable obstacle for expanding access to EC is still simply that potential users ignore they can still a prevent pregnancy after unprotected sex.

Demographic and Health Surveys (DHS) in 22 African countries conducted between 2000 and 2005 show that men and women in most countries in the world have adequate knowledge of other contraceptives, but in 12 countries of Sub Saharan Africa less than 10 percent of women of reproductive age had heard of EC. Conversely, only in five countries had more than 20 percent heard of it (Khan et al. 2007). Likewise, more recent small scale surveys in some SSEA countries show that only six percent of the women in Bangladesh, four percent in Indonesia and one percent in Nepal had heard EC radio spots (Khan and Hossain 2008). This study also shows that, respondents who knew about EC had positive attitudes towards it and preferred it over abortion.

Low levels of knowledge result from ineffective awareness-raising initiatives or insufficient resources to use expensive channels with mass reach, especially electronic media. Except for India and Bangladesh, almost all the programs in the SSEA region have depended on interpersonal communications to educate clients. Bangladesh, India, Mexico and Sri Lanka have used hotlines and websites to provide information and services (Khan and Hossain 2008).

Recent anecdotal evidence suggests rapid increases in sales resulting from more aggressive promotion campaigns, which apparently are highly effective. Television spots broadcasted in India for a commercial EC product—I-Pill®—even reached Bangladesh, where couples were more likely to know about that brand than about the brand that has been available in the country for over five years (Hossain and Khan 2007; Khan 2004; Khan and Md 2003). Evidence suggests that television spots could be one of the most effective means for educating clients in the SSEA region. However, most countries only allow advertising specific brands of pharmaceuticals if they are registered for OTC sale. As this status is rather exceptional, commercial advertising is curtailed.

Other options are social marketing or IEC promoting generic products or the general concept of post-coital contraception. In the past, national or international donors have financed such projects, but such projects are seldom sustained for long and often have limited geographic reach.

Awareness has also been markedly raised through paid airtime by large-scale “social-commercial” marketing campaigns or “pure” social marketing ventures, like in the case of Pro-Salud Interamericana (PSIA) in Venezuela and PSI products in Paraguay and Pakistan (Parker 2005; Vera 2006).

Public relations strategies including components like press conferences, press releases, and media-kits, have also been effective, especially in proportion to their much lower cost (Givaudan 1998). In the absence of commercial advertising, large amounts of un-paid airtime have been devoted to EC when national debates on EC generate news coverage. Often, such public controversies have sky-rocketed user awareness levels. In Mexico, Argentina and Chile, for example, when the legal challenges against EC have drawn the media's attention, sales of EC products increased at explosive rates (LaNacion 2006, 2007; LaNacion.cl 2008; Schiavon 2006). These experiences suggest that it might be worthwhile to strategically evaluate the possibility of raising public debate with groups opposing EC, instead of always trying to avoid controversy. In special circumstances, it may actually be positive to attract spotlights, since it provides excellent opportunities for increasing awareness levels among the general population at very low cost. Individual organizations may want to avoid such activities, especially foreign organizations that risk losing social or political support if perceived as trampling on local values or imposing their own. However, where attitudes towards EC are overwhelmingly positive among the general population and certain key stakeholders, public debate may be a useful tool to expand awareness of and access to EC. As seen from the examples from LAC this was the case in spite of the political influence of some faith-based groups in those settings (Givaudan 1998; Langer et al. 1999; Vernon, Schiavon, and Llaguno 1998). In the SSEA region this was the case as well (Khan, personal communication, January 2008)

As in the case of the other components of introduction and scale-up efforts, the most effective strategies to increase consumer awareness of EC have involved cross-sector collaboration. The use of a rights-based approach in all messages has also been successful and its use increased acceptability. Yet, the many years of advocacy and communication efforts have paid off only to a certain degree. Despite recent improvements, insufficient and inaccurate knowledge continues to be the main barrier behind the large gap between estimated need and reported use or sales of ECP and services (Bond 2008; Kirby 2008; Puri et al. 2007; Samuel et al. 2008; Westley, von Herten, and Faundes 2007).

Effective communication strategies need to be evaluated carefully to identify weaknesses and avoid null or counterproductive results. Beyond the use of media, there is a clear need to mainstream EC in contraceptive talks and counseling in service delivery settings.

3. Discussion

The three regions reviewed in this project could hardly represent a wider variety of cultural contexts. Accordingly, few cross-cutting generalizations can be made and most lessons learned are context-specific in nature. Nevertheless, conducting pre-introductory assessments, promoting inter-institutional involvement, and carrying out activities to generate stake-holder buy-in have been useful in most settings.

Examples of context specificities especially concern the introduction of EC into the public sector. In the absence of scientifically accurate public information, faith-based groups are related to overly cautious attitudes among political decision-makers and have slowed down both registration of EC products and public-sector provision of ECP and services. Sometimes these concerns are proven to be well grounded and, if ignored, can lead to community backlashes or legal challenges, or providers who limit access based on conscious opposition.

Pre-introductory assessments and careful advocacy and training programs can help decrease the likelihood of such set-backs, sensitizing stakeholders and eliminating inaccurate perceptions of

EC's mechanism of action. Even then, eliminating misconceptions about the method can prove to be a recurrent task.

As expected, EC has proved relatively easier to introduce in settings where the prevalence of effective contraceptive methods and access to RH services is already high, like LAC and SSEA. In these contexts, once the misconceptions about the method have been removed, the introduction and scale-up of EC methods can unroll rapidly through well-established structures for the provision of FP services. However, in some of these countries policy makers also appreciate that the potential population-level impact of introducing EC may be marginal. This compounds their reluctance to risk the opposition from conservative groups. In such cases, successful EC introduction efforts have taken a low-profile, rights-based approach starting with segments of the population in very high need, such as rape victims and women living in refugee camps. Establishing EC as a matter of women's rights rather than population control continues to be a useful and ethically warranted course of action.

A common observation across all regions was the persistent low levels of awareness, knowledge and use of EC among both providers and potential users. This underlines the need for expanding capacity-building as well as wider dissemination campaigns to raise user-awareness. The knowledge needed to provide it seems rather straightforward, but cannot be taken for granted. In any case, the specific channels and messages must be carefully chosen to be culturally sensitive. Most of the experiences reviewed for this paper had moderate to high levels of success, at least in the long-term. Publication and reporting biases cannot be ruled out and are difficult to estimate, but may be EC introduction and scale-up are not such a formidable task. Especially, it seems to be technically simple, provided that key stakeholders perceive it as a valuable tool for women and there are reasonable amounts of financial and operational resources available.

Lastly, monitoring and evaluation activities continue to be insufficient or results of many introduction projects have remained unpublished. Our review and consultations yielded very few studies with sufficient evaluation data to allow any quantitative analysis which might help to draw clear distinctions between optimal and sub-optimal strategies. There remains a need to record, evaluate and disseminate processes and outcome evaluations data from exemplary as well as ineffective or even counterproductive efforts. This will help future efforts to adapt and replicate best practices, while avoiding foreseeable pitfalls.

Acknowledgements

The work presented here was made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-98-00012-00. The views expressed in the paper are those of the authors and do not necessarily reflect the views of USAID or the United States Government. The authors would like to thank Jim Foreit, Ian Askew and Patricia Stephenson for their advice on an earlier draft. At the time this project was conducted, Ricardo Vernon was Regional LAC Director, Frontiers in Reproductive Health Program, Population Council.

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