

ORIGINAL ARTICLE

Mainstreaming EC in Ethiopia's Public Sector: Project Results and Implications for Scale-up

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Abstract

Background: Building on nearly a decade of momentum, the Federal Ministry of Health (FMOH), the Ethiopian Society of Obstetricians and Gynecologists (ESOG) and Population Council (EC Afrique) launched a two-year project in 2004 to mainstream emergency contraception (EC) in the public sector.

Objective: The project aimed at improving reproductive health (RH) care among young women and to reduce the abortion rate by expanding access to EC in the country. Its overall goal was to demonstrate the feasibility of integrating EC within the public sector's broader contraceptive mix.

Methods: The project undertook a set of activities aimed at improving provider competency, increasing public demand and ensuring commodity security. The final evaluation drew on service statistics from 33 intervention sites, and knowledge, attitude and practice surveys conducted with family planning service providers and clients in the health facilities involved in the project.

Results: EC users were primarily unmarried women between the ages of 20-24, although male partners were increasingly involved in EC decision-making and procurement. This runs counter to predominant perceptions of EC users as adolescent girls. Sexual assault was the least commonly cited reason for EC use, reflecting its current position as primarily a family planning method. Television advertisements and clinic-based health education were the most commonly cited forms of communication on EC, while print media reached the fewest respondents. Both clients and providers believe that pharmacy provision of EC is socially acceptable, and agree that one Birr is the optimal price for sale in the private sector.

Conclusion: Scaling up EC mainstreaming activities in Ethiopia will effectively position EC as a core component in the national family planning program and post-rape care services. Furthermore, there is need to strengthen the capacity of providers so as to encourage EC users to seek HIV/STI counseling and testing services. To ensure that EC serves as a gateway to more comprehensive RH care, it is critical to stress "bridging" as a key element of the services.

Keywords: Emergency contraception, family planning, adolescents, levonorgestrel

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In May 2005, the FMOH, ESOG and the Population Council (EC Afrique) initiated a pilot project entitled "Mainstreaming Emergency Contraception in the Public Sector" to introduce EC into the public health system. In this project, five of the most populated regions of Ethiopia and 33 health facilities were involved. Through this project, *Postinor 2* (a progesterone only drug) the first ever dedicated EC pill was introduced in Ethiopia, and the lead article in this special issue is devoted to this project (5). One of the major objectives of this project was to register this dedicated product in the country, and in 2006, Beker Pharmaceuticals and Medical Supplies received an authorization by Drug Administration and Control Agency(DACA) to import a dedicated EC product called "*Postinor 2*" from Gideon Rector Pharmaceuticals after passing a thorough registration process. However, this product has not been available in the market because of its high cost. The other critical feature of this project was to involve the Addis Ababa, Gondar and Jimma Universities in order to encourage medical students to conduct independent research on EC and thereby provide them with RH information and services to prevent unwanted pregnancy including HIV/STIs..

More recently, DKT-Ethiopia has started social marketing another EC dedicated product called "Postpill", a *levonorgestrel*, which has become very popular among young people. DKT has trained pharmacists to enable them provide the necessary information about the drug to clients and making this drug available to those who are in need of it and thereby eliminating the need for advance prescription. At present, this dedicated product is available in most pharmacies in the country. Although DKT is doing a commendable job in the private sector, taking similar initiatives to the public sector to make EC available is still a challenge that we should overcome.

Finally, I would like to thank the Editorial Board members of the EJRH, the Nairobi Population Council staff for editing and suggesting valuable comments on the selected articles in this special issue.

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Introduction

Recognition of the need to introduce emergency contraception (EC) into the public sector began in 1997, when the National Reproductive Health (RH) Needs Assessment noted that EC could play a critical role in "limiting unwanted pregnancy, reducing the need for unsafe abortion; ... lowering rates of maternal morbidity and ...[providing] an additional tool for rape management" (1). The Assessment also found that access to family planning services was limited by providers who were perceived to be "out of touch" with the needs and concerns of their young clients. In 1998, Ethiopian delegates attended an international conference in Malawi on EC where they developed a framework for introducing EC services in their country. This framework called for the establishment of a multi-sectoral advisory body and the integration of EC into ongoing training programs and national family planning guidelines (2). Shortly thereafter, the 1999 annual meeting of the Ethiopian Society of Obstetricians and Gynecologists (ESOG) endorsed EC's ability to "reduce dramatically the country's soaring levels of unsafe abortion" (3).

The Family Guidance Association of Ethiopia (FGAE) and the Population Council piloted EC introduction through the coital dependent methods (CDMs) study in 2001. The study was designed to increase young people's access to CDMs by improving supply at the facility level and generating demand within the community (4). Working within FGAE's national network of youth-friendly clinics, the project developed a "branded" range of post-coital methods and trained providers on their provision.

A single, youth-oriented graphic was included on re-packed female condoms, male condoms and vaginal foaming tablets. FGAE employed the Yuzpe regimen of EC since no dedicated EC pill existed at that time in Ethiopia.

Each packet contained four tablets of high-dose, combined oral contraceptives, simple instructions (in Amharic) on correct use, and two male condoms to encourage dual protection. Peer service providers were trained to distribute these methods. By mid-2003, 5,000 units of EC had been distributed to selected FGAE youth centers nationwide.

The study demonstrated that untrained health care providers had limited familiarity with EC and held some misconceptions regarding its use. Most were aware that oral contraceptive pills could be used for emergency purposes, though knowledge of type, dosage and timing was low. The baseline study found that only 28% of the 1053 providers surveyed had ever administered EC and almost half believed its use would lead to increased promiscuity. Less than half (44%) were aware of EC's three-day efficacy period. While the CDMs study demonstrated that EC could be successfully provided through non-governmental organizations, the bulk of health care services in Ethiopia are delivered through the public sector.

To ensure broad accessibility, the Ministry of Federal Health (FMOH), ESOG and the Population Council (*EC Afrique*) conducted a pilot project between May 2005 and December 2006 to introduce EC into the country's public health system. This article provides an overview of the project's interventions and outcomes in order to inform scaling-up of EC services nationwide.

Interventions

As identified in the CDMs study, correct knowledge of EC among Ethiopian service providers was low. To ensure quality services, the project undertook efforts to train providers in each of the participating facilities. A total of 69 doctors and nurses were trained to provide EC during the first round of training in early 2004. In late 2006, 121 providers participated in a second round of training intended to promote the sustainability of EC services after the project's conclusion.

Trainings were conducted by members of ESOG, using a manual developed specifically for the project. This manual was drafted by a team of ten experts from partner organizations, and was adopted at a national expert review workshop. It was based on materials produced by the Population Council in Bangladesh, and modified to reflect the specific needs and knowledge of Ethiopian service providers (5). The manual was pre-tested in Addis Ababa before being endorsed by the FMOH.

In addition to conducting in-service training, the project worked to build interest among students by offering small grants for degree-related research on EC. A call for proposals was issued to all medical, nursing or community health students at the country's most prominent universities (Addis Ababa, Gondar and Jimma Universities) in early 2006. Study coordinators at each site mentored students in conducting the research and *EC Afrique* provided funding for the field work. A total of ten projects were selected through the national competition, which examined EC in the context of social and medical issues such as sexual assault, pharmacy provision and adolescent access. Many of these studies are published in this volume.

Under the direction of a professional journalist, a mass media campaign was conducted throughout 2006. The campaign targeted opinion leaders and potential urban middle and upper class clients, and included: a one-minute informational television commercial on EC featuring locally popular young adult actors; an interview with the project coordinator on the regular women's television talk show, *Kesetoch Admass*. The 60-minute interview, which aired in 20-minute installments for 3 consecutive weeks, focused on EC and its impact on the prevention of unsafe abortion as a way of reducing the country's high maternal mortality and morbidity rates; a series of short informational news spots in leading national media e.g. *Addis Admass* (weekly newspaper) and *Lanchi in Lante* (radio program), which highlighted the importance of EC in a variety of situations. In addition, the project developed a youth-oriented poster that communicated key messages about EC use and timing in Amharic.

To ensure continued commodity supplies, a final component of the project was the introduction and registration of a dedicated EC pill in the country. Permission to import Postinor 2 was granted by the Ethiopian Drug Administration and Control Authority (DACA) in August 2004 and 40,000 units were procured using funds made available by *EC Afrique*. Working with the local pharmaceutical company Beker, ESOG and *EC Afrique* secured product registration based on the success of this project. In December 2006, DACA officially approved Postinor 2 for use in Ethiopia's public and private sectors.

Evaluation Design and Methodology

The study design involved two approaches namely: continuous monitoring of utilization data from service statistics and a post-test measurement at the end of the two year pilot phase of the project. Through the project, EC was provided in 33 facilities in the country's five major regions (Addis Ababa, Oromiya, Amhara, SNNPR, and Tigray) (Table 1).

Seven of these facilities were NGO clinics, representing areas where these NGOs dominate RH service provision. Site selection was based on criteria that included monitoring capacity and overall functionality, and was made in collaboration with study coordinators based in each region's medical schools. After provider training, an initial allotment of 10,000 units of Postinor 2 was allocated among the facilities. Product usage was monitored at each of the 33 participating hospitals and health centers, and additional supplies were delivered as needed.

To evaluate the impact of the project, three sets of data were collected (Table 2). First, basic service statistics, including basic client profiles, were recorded for every client who received Postinor 2 in each of the 33 project sites between May 2005 and December 2006. A total of 3999 cases of EC use were reported during the 20 months of service provision. Second, toward the conclusion of the project period, providers were interviewed to assess their experiences with EC.

Knowledge, attitudes and practice (KAP) survey was conducted with 121 providers from the five regions participating in the project in October and November 2006. The survey was self-administered and was completed by all providers who attended the second training exercise, and was distributed immediately before the commencement of training. The bulk of these respondents were nurses (73%) followed by midwives (14%); only three doctors were included in the survey.

Table 1: Project sites, by region

Region	Health Facility	Region	Health Facility
Addis Ababa (16 facilities)	Tikur Ambessa Hospital	Amhara (5 facilities)	Gondar Hospital
	Zewditu Hospital		Gondar Health Center
	St. Paul's Hospital		Azezo Health Center
	Yekatit 12 Hospital		Teda Health Center
	Ghandi Hospital		FGAE Clinic
	Meshualekiya Health Center	Oromiya (4 facilities)	Jimma Hospital
	Kolfe Health Center		Jimma Health Center
	Gulele Health Center		FGAE Clinic
	Lideta Health Center		Marie Stopes Clinic
	Teklehaimanot Health Center	Tigray (4 facilities)	Mekele Hospital
	Woreda 23 Health Center		Mekele Health Center
	Woreda 19 Health Center		Kasetch Health Center
	Yeka Health Center		Semen Health Center
	FGAE Main Clinic	SNNPR (4 facilities)	Yirgalem Hospital
	Marie Stopes Obstetric Center		Awassa Health Center
	Kirkos Health Center		FGAE Clinic
	Marie Stopes Clinic		

Table 2: Data Sources

Region	Number of Respondents/Cases		
	Service Stats	Provider KAP	Client KAP
Addis Ababa	2659	58	205
Oromiya	194	22	283
Amhara	271	16	n/a
SNNPR	478	14	280
Tigray	397	11	n/a
TOTAL	3999	121	768

Third, a client KAP survey was conducted in health facilities in Addis, Jimma and Awassa in the week following the provider survey. A total of 768 health center clients coming for all services were interviewed by nurses who completed the EC training. No nurses were assigned to collect data from the facilities they normally worked in. Respondents comprised all clients and companions, male and female, who presented at the clinic during the week-long data collection period.

Interviewers were stationed throughout the facility in order to capture a diverse sample of clients. They were instructed to approach clients only at the end of their visit, and to obtain written consent before commencing the interview. The survey sought general information on client contraceptive attitudes and practices as well as awareness and perceptions of EC. The sample was intended to serve as a proxy for awareness among the segment of the population that is most likely to seek institutionalized health care services.

The data were entered into Epi-Info by ESOG staff in Addis Ababa, with support from EC Afrique. Analysis was done using SPSS; a chi-square test was used to measure the strength of association in bivariate relationships.

It is also important to point out two major limitations of this project evaluation. First, the absence of baseline data rules out the possibility of making pre- and post-intervention comparisons. Secondly, lack of data for the control or non-intervention sites makes it difficult to directly attribute the outcomes noted at the end of project survey to the interventions. The service statistics provide the most comprehensive view of the project's impact over time, but cannot account for intervening factors.

The client and provider KAP surveys evaluate the impact of provider training and awareness-raising activities by examining exposure and reported behaviors, but the strength of this analysis is limited by the absence of baseline data.

Results

The client KAP survey found that overall knowledge and use of EC in Ethiopia remains low. Only 20% of those interviewed stated that they had ever heard of EC, and 20 (0.03%) of the 768 women and men interviewed reported that they or their partners had ever used EC. The majority of the clients (83%) also indicated that information on EC was not widely available to women in their communities.

Within project sites, however, utilization of EC steadily increased throughout the project period, with almost 600 units being distributed by the project's final month from initial non-available services (Figure 1).

Of the study sites were located. Overall, 67% of all EC units distributed by the project were through facilities in Addis Ababa.

Client characteristics

Service statistics indicated that most users (71%) were young adults aged between 20 and 29 years (Table 3). Almost half (47%) of the clients were aged between 20 and 24 years while younger adolescents (aged 19 years and below) comprised only 20%.

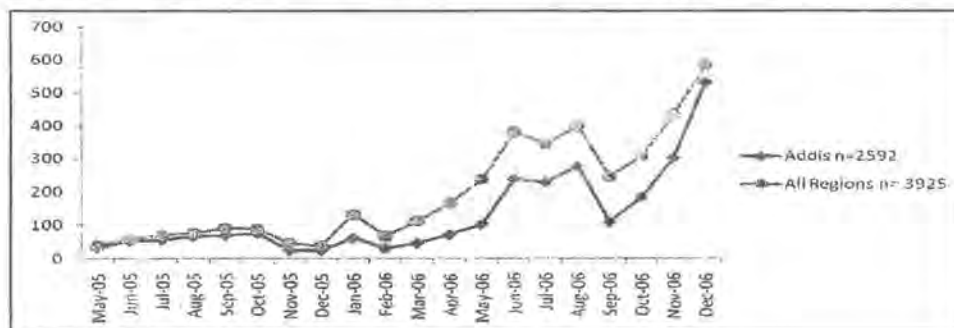
A similar age distribution is found in the client KAP survey: of the 20 clients who reported having ever used EC, 14 (70%) were between the ages of 20 and 29 years.

According to service statistics, a substantial proportion of users (41%) were married. This proportion was even higher when disaggregated by region; in Tigray for example, 55% of the clients reported that they were married. This is similar to the pattern observed in the client KAP survey in which 11 of the 20 of those who had ever used EC identified themselves as married (Table 3).

Whereas women constituted the majority of clients (96%), some men also obtained EC for their partners. A total of 173 men accessed EC during the study period, and in one region, Oromiya, nearly 22% of all EC clients were men. The client KAP survey provides further indication of male involvement in EC use.

According to the 20 women who identified themselves as EC users, nearly half (45%) had talked to their partners before making the decision to use the method.

Figure 1: Number of EC Units distributed in all Project Sites, May 2005- December 2006



Source: service statistics

Table 3: Characteristics of EC Clients

		Service Statistics n=3996 (%)	Client KAP N=20 (%)	Provider KAP n=66 (%)
Age category of EC clients				
	10-14	1	0	n/a
	15-19	19	0	n/a
	20-24	47	40	n/a
	25-29	24	30	n/a
	30-34	7	15	n/a
	35-39	2	15	n/a
	40-50+	1	0	n/a
Gender of EC clients				
	female	96	85	n/a
	male	4	15	n/a
Marital status of EC clients				
	Married	41	55	n/a
	Not currently married	59	45	n/a
Reason for EC use				
	Unprotected sex	81.4	84.6	80.3*
	Contraceptive failure	14.2	15.4	42.4*†
	Sexual assault	4.4	0.0	37.9*

*reasons for use among last 3 EC clients, multiple responses allowed
†condom breakage

Furthermore, almost two-thirds (61%) informed their partners before using the method, and in all cases it was reported that their partners supported their decision.

The provider KAP survey, however, also shows an unwillingness to deliver EC services to male clients.

In this case, providers were asked how they would respond to an unmarried adolescent girl who claimed to have engaged in unprotected sex two days prior and was seeking advice on how to avoid a pregnancy and that of an unmarried adolescent boy in a similar situation who wanted to obtain EC pills for his girlfriend.

The findings indicated that providers were significantly more likely to report a preference to deliver EC services to adolescent girls than to adolescent boys (Table 4).

Table 4: Provider attitudes toward EC and other reproductive health services to adolescents girls v. boys (n=68*†)

	Girl scenario %	Boy scenario %	p-value
Provide EC	91.5	41.2	0.019
Provide FP advice	63.6	47.1	0.000
Provide STI/HIV counseling	38.1	50.0	0.000
Provide condoms	23.7	32.4	0.000
Advise against adolescent sex	11.0	13.2	0.000
Do nothing/ Refuse EC	0.0	7.4	n/a

*multiple responses allowed

† Only providers who had dispensed EC at least once were asked this question

Source: provider KAP

All three data sources indicate that clients most frequently sought EC after engaging in "unprotected sex". Although the provider KAP allowed multiple responses, the trend across all the data sources demonstrates that contraceptive failure is the second most frequent reason for use, followed by sexual assault.

Clinic records indicate that only 172 of the 3999 doses of EC were administered to survivors of sexual assault, while providers reported that more than one in every three clients experienced sexual assault. Reflecting patterns across the continent, the survivors recorded in the service statistics were young, with 52% of all cases being between the ages of 10 and 19 (6). Among the very young adolescents (those between 10 and 14 years old), sexual assault comprised nearly 70% of the cases.

Provider Capacity

The provider KAP survey was conducted immediately before one-day training on EC conducted by ESOG. At that point, only one-third (33%) of all providers had received prior instruction on EC. Of these, most (85%) reported that they were trained by ESOG under the current project. The remaining providers had been trained under the FGAE project; none indicated that they learned of EC during their professional training.

The majority of providers surveyed (81%) had discussed EC with their clients, and those who received training on EC were more likely to provide it.

In addition, the majority of trained providers shared information on EC to all likely users even if they did not request it. This is confirmed in client reports, which listed provider interaction as the second most frequent source of information on EC.

Repeat use and "bridging"

Data from the client KAP survey indicate that repeat use is not currently a problem in Ethiopia. Of the 17 clients who reported on frequency of use, the bulk (15) noted that they had only taken EC once in the past year (Table 5). Nearly half of all EC clients adopted a different or new contraceptive method following EC use, most likely because providers routinely counseled them on more reliable methods.

Public Awareness

Although only 20% of respondents to the client KAP survey knew of EC, those who did were remarkably well-informed. As indicated in Table 5, clients who were aware of the method demonstrated levels of knowledge that rivaled, and in some cases exceeded, trained providers.

All but one client correctly identified EC as a method for preventing pregnancy, and nearly 90% knew that EC should be taken within 72 hours of unprotected sex to be effective. While overall knowledge was high, some clients expressed concerns about the potential side-effects of using EC.

Table 5: Percent distribution of EC users by frequency of use and indicators of 'bridging'

	Client KAP n=17 (%)	Provider KAP* n=65 (%)
Used EC only once in the past year	88.2	n/a †
Began using a new or different contraceptive method after EC	55.5	56.1
Were provided any of the following services alongside EC†		
Provided with family planning advice	92.3	69.2
Referred to HIV/VCT services	15.4	56.9
Referred sexual assault survivor to police	0.0	15.4

* services provided to the last 3 clients

† multiple responses were allowed in both surveys

Of those who feared health problems, the largest proportion (41%) believed that it could cause difficulties conceiving in the future. Social problems, such as increased HIV cases (61%) and adolescent sexual activity (59%) were the most widely cited concerns associated with increased EC access (Table 6).

Nearly three-quarters of the clients who knew of EC learned of the method within the past year, which corresponds to the project's media outreach phase. Both clients and providers demonstrated similar exposure to the media campaign, suggesting that it reached a broad segment of the targeted urban populations.

The ESOG television advertisement, which was aired during popular television dramas during the weeks prior to the survey, appears to have reached the widest audience. Although less effective, print media was most likely to reach providers, as was the topical *Kesetoch Admas* television feature. More conventional channels of health communication remained key in creating awareness about EC. Nearly 80% of all providers indicated that they included EC messages in their facility's regular health education sessions.

These efforts may account for the fact that nearly one-quarter of those who knew of EC reported that they had first heard of it from their health provider.

Expanding access

To inform future scaling-up efforts, clients and providers were asked to identify the types of clients who could most benefit from increased access to EC. Clients were much less conservative in their perceptions of acceptable EC users than were providers; most clients believed that access should be extended to a wide range of women, whereas providers saw the need for greater restrictions. While no significant differences existed among trained and untrained providers, training did appear to improve perceptions of the types of clients who should receive EC (Table 7).

Clients and providers were also asked to identify the locations where they felt EC should be made available and the types of providers who should dispense it. Again, clients were more liberal in their perceptions of acceptable access than were providers.

Clients, on the other hand, supported expanded access for sexual assault survivors with over 80% mentioning emergency rooms and nearly 40% indicating police stations. They also supported community access through the new cadre of community-based health providers, health extension workers, as well as expanded adolescent access through secondary schools (Table 8).

Table 6: Perceived Social and Health Problems Associated with Using EC

	# of clients	%
Can EC cause health problems? n= 761	73	9.6
What type of health problems?* n=73		
difficulty conceiving	30	41.1
causes indigestion	21	28.8
menstrual irregularities	14	19.2
nausea or vomiting	13	17.8
may not work	12	16.4
Can easy access to EC cause social problems? n=768	88	11.5
What type of social problems?* n=88		
increases HIV cases	54	61.4
encourages adolescent sex	52	59.1
encourages promiscuity	45	51.1
problems with family or husband	10	11.4

*Multiple responses allowed
Source: client KAP survey

Providers tended to overwhelmingly identify conventional sources such as health centers, family planning clinics, and pharmacies.

By the end of the project, Postinor 2 was approved for sale at private pharmacies. Previously, EC had only been provided at no cost in the project sites and at minimal cost in FGAE clinics.

To assist pharmacists in pricing the new product, the survey also asked respondents to identify the amount of money (in Ethiopian Birr) that they would be willing to pay for EC in private pharmacies. The most commonly cited price was 1 Birr.

Discussion

The available data indicates that EC can be successfully provided in Ethiopia's public sector family planning facilities. It demonstrates that a latent demand for the product exists and that such demand can be met within the context of current RH programs. With the registration of Postinor 2 in late 2006, the product is now positioned to become a core element of the country's family planning method mix and, once adequate stocks are procured, can be offered nationwide.

Table 7: Percent distribution of clients and providers by perceived appropriateness of EC*

	Client n=762 (%)	Provider	
		Trained n=36 (%)	Untrained n=75 (%)
<i>Indications</i>			
Rape survivors	96.3	97.2	92.0
Women experiencing contraceptive failure	80.3	89.9	69.3
<i>Contraindications</i>			
Pregnant women	1.7	8.3	13.3
Post-menopausal women	2.5	36.1	28.0
<i>Appropriate Users</i>			
Adolescents	76.0	63.9	53.3
Married women	77.9	72.2	42.7
Unmarried women	71.7	61.1	49.3
Women who have sex infrequently	72.0	50.0	49.3

*Multiple responses allowed

Source: Client and provider KAP surveys.

Table 8: Percent distribution of clients and providers by where they felt EC should be made available, Client and Provider KAP Surveys*

	Client n=764 (%)	Provider n=113 (%)
Health center	98.0	96.5
FP clinics	84.6	92.0
Emergency Rooms (ERs)	83.9	28.3
Pharmacies	72.3	49.6
Community level (CBRHAs)	51.1	30.1
Police stations	38.1	17.0
Secondary schools	37.2	17.9

*Multiple responses allowed

Access for sexual assault survivors

While the program successfully increased access to EC in the context of family planning efforts, it was not as effective in making it available to sexual assault survivors. Both clients and providers overwhelmingly identified sexual assault survivors as appropriate clients for EC, but service statistics show that this population did not fully benefit from the program. Greater access can be created by expanding the provision channels, training and equipping health care workers in a variety of locations to deliver EC as a routine element of post-rape care. A study conducted by EC *Afrique* in Zambia, for example, found that trained police officers could effectively provide EC to survivors who presented first to a police station (6). This project found that there is public support for such an approach.

In Ethiopia, ESOG has developed a model of comprehensive care that delivers EC as part of a one-stop shop for post-rape care in a health facility setting.

These models, along with other innovative approaches implemented across Africa, indicate that repositioning of EC can dramatically expand sexual assault survivors' access to the method.

The new cadre of CBRHAs is uniquely positioned to deliver EC services to the broader population including sexual assault survivors. Located close to the community, they can be called upon to provide EC services within the 120-hour window of opportunity, without requiring a costly and time-consuming trip to a health facility. This proximity to the community is especially valuable for sexual assault survivors who may be reluctant to seek formal health care immediately after the assault.

Provider training

An important contribution of this project has been the development of an EC training manual specifically tailored to the needs of Ethiopia. The training program itself has successfully contributed toward increased access to EC in the project sites, most likely by improving provider's confidence in delivering the method. While the training offered by the project was strong on technical aspects, future training would benefit from an expanded emphasis on the social context of EC provision.

EC as a back up method

In countries such as Kenya and Botswana, where EC is more widely available, concerns have emerged over its use as a regular family planning method (7).

In addition, because it is less effective than other modern methods of contraception and does not offer protection against HIV and other sexually transmitted infections (STIs), the World Health Organization recommends EC only for use as a back-up method (8).

In this study, while both clients and providers indicated that family planning advice was often part of EC services, only about half of all EC users actually adopted a new method. Providers inconsistently encouraged EC users to seek HIV/STI counseling and testing services, and referred sexual assault survivors for appropriate care. Although the ESOG training curriculum did not explicitly address such "bridging" to other services, the client and provider KAP surveys suggest that it did take place within study sites. To ensure that EC serves as a gateway to more comprehensive RH care, it is critical to stress "bridging" as a key element of the services.

An interesting outcome of the project has been the high level of male involvement in EC. Over half of all women reported consulting their partners before using EC, while a surprisingly large number of men obtained it for their partners. However, providers appeared reluctant to offer EC services to this group, potentially limiting their partners' access to the method. Specific training is needed to address gender issues in EC provision (and in family planning in general) to encourage greater male involvement.

Public awareness

Only 20% of the men and women interviewed at health facilities had ever heard of EC, and it is likely this proportion is lower among those who do not routinely seek health care. This indicates a clear need for increased awareness-raising activities in the country. While clinic-level outreach will always remain an important source of health information, ESOG's television adverts proved to be the single most effective media tool.

As the government works to increase EC knowledge among the general population, such adverts strategically aired during popular programming are most likely to increase the visibility of the method. Young women between the ages of 20-29, who were found to be the most frequent users of EC, should be the target of more intensive media outreach efforts. Campaigns should also stress the importance of EC as a back-up method both in and outside of marriage, and should include messages on 'bridging'.

Conclusions and Recommendations

The study results showed that the three most important reasons for EC use by clients in Ethiopia are: unprotected sex, contraceptive failure, and sexual assault. Scaling up EC mainstreaming activities in Ethiopia will effectively position EC as a core component in the national family planning programme and post-rape care services.

Evidence from the study showed that the majority of providers inconsistently encouraged EC users to seek HIV/STI counseling and testing services.

There is need to strengthen the capacity of providers so as to encourage EC users to seek HIV/STI counseling and testing services. To ensure that EC serves as a gateway to more comprehensive reproductive healthcare, it is critical to stress "bridging" as a key element of the services.

As a next step, it is necessary for the FMOH to build upon these successes by continuing to expand access to EC across the country. The findings of this project are intended to inform and guide this scaling-up process.

Acknowledgements

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ORIGINAL ARTICLE

Knowledge, attitudes, practices and barriers to use emergency contraception among women with unsafe abortion in Jimma Marie Stopes Clinic, South West EthiopiaAnteneh Admasu¹, Bosena Tebeje²**Abstract**

Background: It is observed that safe and effective contraception including emergency contraception (EC) prevents the occurrence of unwanted pregnancy and unsafe abortion.

Objective: To assess the knowledge, attitudes and practices (KAP) as well as identify barriers to the use of EC among women with unsafe abortion.

Methods: This is a cross-sectional health facility based study that involved women with unsafe abortion treated at Jimma Marie Stopes clinic from February 2 to March 16, 2006.

Results: There were a total of 153 respondents, the majority, 131(85.6%) being in the age range 15-24 and single, 88 (57.5%). Only 20 (13.1%) of the total respondents had heard about EC and out of this only seven (35%) correctly identified 72 hours as the time limit for taking EC. The most common source of information about EC were health institutions, and Marie Stopes clinic which accounted for 12 (60%) of the respondents followed by neighborhood and partner each accounting for three (15%). The study has also revealed that after having explained about EC, the vast majority respondents 130 (84.3%) had positive attitude towards the method and showed interest to share information about EC with their friends. Regarding use among those with prior knowledge of EC, only seven (35%) reported previous use. The most common reason given for non-use of EC were lack of awareness about the existence of EC, 132 (86.3%); fear of side-effects, five (3.4%) and the rest reported unavailability of service, partner disagreement, religion and culture.

Conclusion: Most cases with unwanted pregnancy were young people, as they lacked awareness about the existence of EC. As a result, they were led to look for termination of pregnancy as an option in avoiding unwanted pregnancy. It is strongly recommended that IEC materials on EC targeting young people be prepared and widely disseminated.

Keywords: Emergency contraception, unwanted pregnancy, unsafe abortion, KAP.

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