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ARHP Commentary – Thinking (Re)Productively

In support of community-based emergency contraception ☆

Dawn S. Chin-Quee[a,*], John Stanback[a], Victoria Graham[b]

[a]FHI 360, Division of Health Services Research, 359 Blackwell Street, Suite 200, Durham, NC, USA
[b]USAID, GH/PRH/SDI, 2100 Crystal Drive, Arlington, VA, USA

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Community-based family planning is a proven, high-impact practice for extending reproductive health services to women, particularly those in hard-to-reach places [1]. Accordingly, many community-based family planning programs facilitate and support the provision of condoms, oral contraceptive pills and even injectable contraceptives by community health workers (CHWs). Emergency contraceptive pills (ECPs)—a method for which there are no contraindications and the user herself can determine need—are not routinely included among the contraceptive methods provided by community health workers. We think this is shortsighted, especially in light of the unique position that ECPs occupy in the method mix and the CHW's ability to meet the needs of potential clients in a way other providers often cannot or do not. The putative link between microcephaly and the Zika virus in the Americas that resulted in calls for women to avoid or delay pregnancy [2] also serves to underscore the value of this proposition.

Emergency contraception, which includes dedicated emergency contraceptive pill products, combined oral contraceptive pills (Yuzpe method) and post-coital insertion of intrauterine devices (IUDs) provides women who have had unprotected sex with an opportunity, after the fact, to prevent an unintended pregnancy [3,4]. IUDs are the most effective form of EC, and with continued use, can provide long-term protection from pregnancy [5]. However, IUD insertions require a clinical procedure by a higher-level provider than a CHW, which make IUDs less convenient and more difficult to obtain than emergency contraceptive pills (ECPs) within five days of unprotected sex.

Initially, there was excitement at the prospect of offering women a post-coital method in the form of a pill. Reduced rates of unintended pregnancies and abortions were touted as likely outcomes with increased access to this method [6,7]. However, subsequent studies–including randomized controlled trials–indicated that increased access, including advance provision of ECPs, had no public health impact on these rates [8,9]. A call for CHW provision of ECPs may therefore be called into question for lack of proven widespread effect. Nevertheless, the method has proven effective for individual women who use it [10]. Further, advocates have argued for a woman's individual right to this method [4,11] and the World Health Organization (WHO) recommends that "comprehensive contraceptive information and services are provided to all segments of the population", especially to "disadvantaged and marginalized populations," [12] which are the populations that CHWs typically serve. As such, it would be remiss to disavow CHW-provision of ECPs and to single out CHW clients for denial of this service.

In spite of the wide availability of ECPs in many cities around the world, they are expensive and relatively under--utilized in most countries, particularly in rural areas where the poorest of the world's poor still live [3]. A few countries, such as India, Bangladesh and Pakistan provide ECPs at the community level, but they remain exceptions. ECPs are little known and even less used among rural women in most poor countries. For

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* Corresponding author. Tel.: +1 919 544 7040.
E-mail address: dchin-quee@fhi360.org (D.S. Chin-Quee).

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example, rural women in the Democratic Republic of Congo, Madagascar, Niger, India, the Dominican Republic and Nicaragua were less likely to have heard of ECPs than their urban counterparts. Similarly, women in urban areas of Madagascar, Burkina Faso, and Ukraine [13] as well as Nepal [14] were more likely to have ever used ECPs than women living in rural areas of those countries.

We believe that now is the time for CHWs everywhere to provide ECPs in their communities. We know that in general unmet need for family planning is higher in rural than urban areas [15], and is largely due to lack of access to family planning services and methods. For that reason, we should double our efforts to achieve equity between urban and rural women and to use all the means at our disposal to do so. Community-based emergency contraception (CBEC) is an easily implemented public health initiative and would be timely given the need to help women avoid pregnancy in Zika-affected areas. Below, we briefly outline the *Why*, *Who*, and *What*, as well as the *Where* and *How*, of the way forward for CBEC.

1. Why CBEC?

The many reasons why emergency contraception should be provided in community-based programs range from the obvious to the relatively obscure: ECPs provided via CHWs would increase access to this method for rural women who have relatively poor access to pharmacies and clinics compared to urban women. Stockouts of regular family planning methods and the need to travel long distances to a health facility for service remain common occurrences in rural areas, thus many women may have unprotected sex while waiting to initiate or continue a regular contraceptive method. With CHWs living in the same villages as potential clients, ECPs (as well as condoms and pills) would be more readily and conveniently obtained. This is particularly important in cases where the CHW may be the only representative of the health care system available to provide post-rape care.

Even where clinic services are available, CHWs may be less judgmental than clinicians and more willing to provide ECPs. Studies of providers and key opinion leaders in Senegal, Nigeria and India confirmed that clinic-based providers were reluctant to provide ECPs to young unmarried women and felt that ECPs should be dispensed by prescription and by medically-trained personnel only [16–18]. However, women, men and youth may feel more comfortable requesting ECPs from a CHW who is a member of their community and has earned their trust. A study in Rwanda that compared CHWs who added family planning services to their workload with counterparts who had not, showed that in both groups the overwhelming majority of clients reported that their CHW "spoke to them in a friendly way" (over 90%) and could be trusted to keep their privacy (over 95%). Moreover, when asked their preference for future health services, clients from both groups indicated that they much preferred to go to their CHW than the health clinic. The remainder indicated that it would depend on the nature of health services required [19].

ECPs may also be available from the private retail sector (e.g., in drug shops), but instructions and counseling are important elements of appropriate and successful use of ECPs, especially for illiterate women. Commercial sector providers may not be as willing to offer counseling and/or dedicate the time to provide education and instructions or address myths and misconceptions about the method as a CHW would. Moreover, ECPs may more readily fulfill its role as a bridge to more effective methods in the hands of CHWs (versus private commercial sector providers) [20–22] with whom client-provider interactions may prove more amenable to counseling and the provision or referral for regular, ongoing methods.

Finally, women who live most of the year without their partners can be found in both rural and urban areas. However, it is critical for women whose access to health care facilities is limited to have community-based distribution of ECPs when men return home unexpectedly. A consumer study conducted with three distinct groups of women in Nepal (never heard of ECPs; were aware of but never used ECPs; had ever used ECPs) underscored this point. About 16% of women in all three groups reported that, on average, their partners were home for only four months of the year and for that reason, were not currently using a contraceptive method. However, ever use of ECPs was reported mostly among urban women, while those who had never heard of ECPs were not only less likely to be currently using a contraceptive method than their counterparts, they were also more likely to live on the outskirts of urban or in rural areas [14].

2. Who can provide CBEC?

With minimum investments in time and resources, appropriately trained CHWs or CBD workers can provide ECPs. Whether male or female, paid or volunteer, literate or illiterate, any community health worker can be trained to safely provide ECPs, as they have no contraindications and women themselves are aware of when they may need ECPs. Training a CHW to provide ECPs is simple, particularly compared to other methods which require careful training about health screening, counseling for side effects, and techniques such as safe injection and waste disposal.

3. What kind of EC should be provided?

There are three options for ECPs: Yuzpe, which was described earlier and two options for dedicated ECPs—1.5 mg of levonorgestrel (LNG) or 30 mg. of ulipristal acetate (UPA)–both of which are indicated for use up to 120 h or five days after unprotected sex. However, UPA EC is more effective than LNG EC after the first 72 h