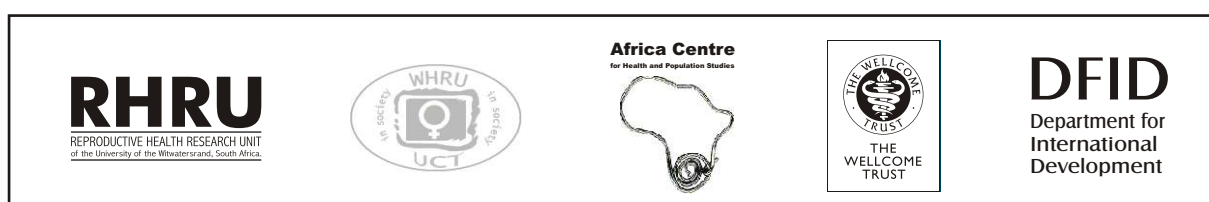

EXPANDING CONTRACEPTIVE CHOICE: AN AFRICA STUDY OF EMERGENCY CONTRACEPTION

A multi-centre situational analysis of emergency contraception provision
and utilisation at public sector clinics in South Africa

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SUMMARY

Availability of emergency contraception (EC) in South Africa is particularly important because of high rates of unwanted pregnancy and teenage pregnancy, and soaring STI/HIV and AIDS rates. South Africans are increasingly advised to use condoms to prevent sexually transmitted infections. Recognising the importance of access to EC, as a back-up contraceptive method where condom failure occurs, this study was undertaken in response to the lack of information on the availability, provision and use of EC in South Africa. It provides an overview of the findings from the research study **Expanding Contraceptive Choice: An Africa study of Emergency Contraception**, and aims to inform South African policy makers, health managers and providers on factors affecting availability of and accessibility to EC.

This multi-centre situational analysis of EC provision and utilisation was undertaken at public sector primary health care facilities in 3 provinces of South Africa between November 1999 and August 2000. National, provincial and local policies with regard to the provision of emergency contraception were reviewed. The study was undertaken in the provinces of Gauteng, KwaZulu-Natal and Western Cape. Key informant interviews were held with 26 policy makers from national, provincial and local governments, and from research and non-governmental organisations. Interviews were held with 89 managers, 197 providers and 1068 clients of 89 public sector primary health care facilities in 2 urban and 2 rural areas. In addition, 165 simulated client visits were undertaken at health facilities and private sector pharmacies in 2 of the study sites. Although the focus of the study was EC, much ancillary data, relating to reproductive health service provision, were collected.

Reproductive health services provided at two thirds of the health facilities included: family planning; STI counselling and treatment; primary health care curative services; well-baby services; HIV/AIDS counselling and testing; termination of pregnancy counselling and referral; pap smears; and pregnancy testing. However, pregnancy testing and pap smears had limited availability in the 2 rural study sites, and HIV counselling and testing was not widely available in the deep rural site.

EC is available, free, at public sector health facilities in South Africa and is usually supplied in the form of ordinary combined oral contraceptives, most often Ovral-28[®]. However availability is generally restricted to working hours from 07h00 to 16h00, on Monday to Friday. EC had been provided by 54% of providers in the 3 months prior to their interview. Provider knowledge of EC was relatively good with 89% knowing that the cut-off point for EC supply after unprotected sex was 72 hours. Although most providers had a reasonable knowledge of EC mode of action, 12 providers believed that EC pills were abortifacients. Almost all providers (97%) reported that they counselled EC clients about long-term contraception options. Some providers were concerned about EC promotion as they felt that it could affect uptake (65%) of and compliance (25%) with long-term contraception methods. There was also concern that EC did not protect against STIs/HIV and could discourage condom use.

While just over a quarter of providers believed that judgmental attitudes of health personnel was an impediment to access and use of EC, almost all felt that lack of knowledge on the part of clients was the biggest obstacle. In corroboration of providers' opinions, it was found that only 23% of the clients had ever heard of EC, and few (9%) of those who knew of EC had used it. The need for EC is highlighted by the large proportion of women interviewed (65%) who had had a pregnancy when not ready. After explaining EC to clients interviewed, attitudes towards its use were found to be positive, with 90% indicating that they would use it if needed. EC was provided to 72% of the simulated clients. Whilst 67% of the simulated clients were counselled on the use of long-

term contraceptive methods, little attention was paid to counselling about their risk of STI/HIV acquisition after unprotected intercourse.

Findings indicate that if women know of EC, where to get it, and how soon to take it, they could access it if needed. A carefully designed intervention programme to promote EC awareness is urgently needed. For providers, training should focus on accurate information about mode of action, dosing interval, safety and efficacy and opportunities provided for counselling on long-term contraception and prevention of acquisition of STIs/HIV. The importance of EC as a back up to condom failure should be emphasized and providers should use every opportunity to counsel clients about the dual risk of pregnancy and STI/HIV infection.

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GLOSSARY

AIDS	Acquired Immune Deficiency Syndrome
COC	Combined Oral Contraceptive
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
EDL	Essential Drugs List
GP	Gauteng Province
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IUD	Intrauterine Device
KZN	KwaZulu-Natal
MCC	Medicines Control Council
NCPG	National Contraceptive Policy Guidelines
PHC	Primary Health Care
POP	Progesterone-Only Pill
STIs	Sexually Transmitted Infections
TOP	Termination of Pregnancy
WC	Western Cape Province
WC1	Western Cape Metropole (Urban)
WC2	Western Cape Boland (Rural)

PART 1. BACKGROUND

Introduction

The purpose of this report is:

- To provide health service providers at the study sites with information on factors affecting availability and accessibility of emergency contraception (EC).
- To provide information to health policy makers and providers, health education personnel and health researchers about the provision and use of emergency contraception.
- To provide information on the quality of service with a particular emphasis on reproductive health services.

This report consists of a brief overview of the background to the study, a summary of the overall results for all sites, conclusions and recommendations.

Objectives of the Study

- a) To analyse the context in which emergency contraception is provided: high teenage pregnancy rates, high STI/HIV rates with increasing emphasis on condom use and barrier methods, the contraceptive mix available, access to and acceptability of abortion, high incidence of rape, local and international contraceptive policy.
- b) To obtain baseline data about emergency contraceptive utilization and provision from public sector health care facilities.
- c) To identify barriers to emergency contraceptive use.
- d) To identify strategies for improving knowledge about and access to emergency contraception.

Study Sites

- Hlabisa health district, KwaZulu-Natal (KZN) (Rural)
- Southern Metropolitan Local Council, Gauteng (GP) (Urban)
- Metro (Urban) and Boland (Rural) health regions in Western Cape (WC)

Approval to conduct the study was obtained from the ethics committees of the Universities of Cape Town, Durban-Westville and the Witwatersrand, and permission to conduct the study was obtained from the relevant health authorities.

Methodology

A. Contextual Analysis

- a. Examination of local and international published literature, policy documents and grey literature.
- b. Interviews with policy makers and programme managers at national, provincial and local level to obtain information on policy relating to emergency contraception supply. Interviews were conducted in July 1999.

B. Clinic-Based Situational Analysis of Emergency Contraception

Study type

Multi-site cross-sectional clinic-based survey.

Health service assessment

The services were assessed using the methods listed in Table 1 below. Although the focus of the study was emergency contraception, much ancillary data were collected relating to reproductive health service provision.

Table 1. Summary of methodology for health service assessment

Objectives	Method
To measure the structure of health services as they relate to the provision of EC	Facility checklist Family planning manager interview (Structured questionnaire)
To assess provider quality of care, knowledge of and attitudes to the provision of EC	Provider interview (structured questionnaire)
To assess the knowledge and use of EC by clinic clients	Client interview (structured questionnaire)
To assess the quality of care with respect to EC: client assessment	Use of simulated clients requesting EC at clinics in GP and KZN

Sampling

This multi-centre study was undertaken at 89 public sector primary health care facilities in three provinces of South Africa. All facilities included in the study offered family planning services as well as some primary care services.

Western Cape (WC) - Random sample (weighted by annual patient load) of health facilities from 2 of the province's 4 health regions, 1 urban region and 1 of the 3 rural regions:

- 30 of 158 facilities in the urban health region (Cape Metro - WC1)
- 28 of 60 facilities in the rural health region (Boland - WC2)

The relatively large sample size was undertaken at the request of the provincial health authorities in order to give a representative sample for regional planning.

Gauteng (GP) - Purposive sampling of 17 public sector clinics offering family planning in the Southern Metropolitan local council. Half of the selected clinics had had training on emergency contraception in 1998 as part of another study.

KwaZulu-Natal (KZN) - Sample of all 14 public sector health clinics (or facilities) in the Hlabisa health district.

Data collection procedure

Between November 1999 and August 2000, clients or women accompanying clients, health care providers and clinic managers were interviewed. Each selected facility was visited over a 1- to 2-day period by a trained team of interviewers. Verbal and written explanations of the study were provided in the home language of the selected interviewee and consent was obtained from each clinic attendee.

In addition, data were obtained by means of simulated client visits to the selected KZN and GP health facilities and pharmacies in the KZN and GP study sites.

Data collection instruments

All data collection tools were pre-tested and standardised prior to commencement of the study. Copies of these tools are available on request.

Scenarios, which should elicit the recommendation of emergency contraceptive pills were developed for the simulated client assessment. The scenarios included the following 3 simulated clients:

- a young women, ±18 years
- an older women, ± 35 years
- a young man, ± 25 years

contraceptive pills should be available at every level of service including clinics, mobile units and community level distribution (page 24). Under the section dealing with expansion of current contraceptive mix, EC is listed as a core method. This section states: “ ECPs should be extensively promoted and made available. They are safe, and effective, have few contraindications and, although not recommended for regular contraception, they can be used repeatedly for emergency contraception”. Furthermore, under the heading of clinical practice guidelines from which existing clinical practice commonly differs from current recommendations, the following are important in relation to ECP supply:

- “Informed choice: all women, men and young people should be provided with the contraceptive methods they request, subject to the meeting of medical eligibility criteria, without influence of service provider bias.” (page 25)
- “Timing of initiation of hormonal contraception ... until reliable early pregnancy testing is routinely available, a client's history must be taken as sufficiently accurate to exclude the possibility of pregnancy (with the knowledge that in any case oral contraceptives, injectables and ECPs will not abort an established pregnancy)” (pages 25-26).

Interviews with Key Informants

Twenty-six policy makers and planners were interviewed (6 from national government, 15 from provincial and local government and 5 from research and non-governmental organisations). Themes that were explored included the availability of policies and guidelines for the provision of EC, the methods (products) available, education and training of personnel, available resources and legal obstacles (if any) to the provision of EC.

A summary comparison of guidelines and protocols obtained from the interviews with various key informants in July 1999 is shown in Table 3. The Western Cape and the Gauteng provincial authorities as well as the Western Cape local government had adopted the draft national policy guidelines whereas the other sectors had their own policies. KZN provincial and local authorities differ from the others in that a physical examination to exclude pregnancy was a requirement.

Table 3. Comparison of EC guidelines (Mini-dissertation, R Kharwa, University of Durban-Westville, 1999)

Checklist	National guidelines^a	Gauteng Local	KZN Provincial	KZN Local
Inclusion of EC in Contraception Guidelines	Yes	Yes	Yes	Yes
Last updated	1999	1998	1997	No date
Information on EC	Adequate	Adequate	Adequate	Adequate
Number of hormonal products recommended	4	Not specified	1	1
Pregnancy the only contraindication	Yes	Yes	No	No
Information on who can provide, how often and to whom	Inadequate	Lacking	Lacking	Lacking
Counselling Information	Given	Given	Given	Given
Restrictions on availability	No	No	No	No
Physical examination required	No	No	Yes	Yes
Training for staff	Specified	Not specified	Not specified	Not specified
Monitoring of EC use	No	Yes	No	Yes

^a National Framework and Guidelines for Contraceptive Services, Second Draft, 1999. Both provincial and local authorities in the Western Cape as well as the provincial authorities in Gauteng followed these guidelines.

PART 2. RESEARCH FINDINGS

Contextual Analysis

Products Available in South Africa and their Scheduling Status

At the time of the study (1999-2000) products on the South African market that could be used for EC included:

1. Oral contraceptives such as Ovral-28[®], Nordette[®], or Microval[®] which are cut-up, not labeled and packed for EC use.
2. E-Gen-C[®], a dedicated product, appropriately packed and labeled for administration as EC. E-Gen-C[®] contains an information leaflet with instructions on correct use.

Since the initiation of the study in 1999, two important advances have occurred. In 1999 a position paper was drawn up by our project team and was submitted to the Scheduling Committee of the MCC requesting a change in scheduling status to Schedule 2 for EC products¹. Although Microval[®] was technically available from pharmacies without prescription to any one over the age of 16 years, products containing oestrogen required a doctor's prescription. In November 2000, all hormonal products for emergency postcoital contraception were rescheduled by the MCC to Schedule 2 (South African Government Gazette No. 21687, Notice No. 1077 of 3 November 2000). This means that any of the hormonal contraceptive products, when used for emergency contraception, can now be obtained from a pharmacist without a doctor's prescription. In January 2001 a second development occurred with the marketing of a dedicated levonorgestrel product (Norlevo[®]). Although cost is a factor mitigating against this product's widespread use, it represents an advance in convenience and there is a reduced incidence of nausea and vomiting relative to the combined product. The appropriate doses and 1999 cost are given in Table 2.

Table 2. Products available for use as emergency contraception in South Africa

Brand	Type of EC ^a	Dose - tablets (12 hours apart)	1999 Cost - public sector (total dose)	1999 Cost - private sector (total dose)
E-Gen-C [®]	COC	2+2	R2.85	R24.62
Ovral28 [®]	COC	2+2	R0.27	R3.38
Nordette [®]	COC	4+4	R0.52	R4.06
Microval [®]	POP	25+25	R3.56	R25.34
Norlevo ^{®b}	POP	1+1	Not available	Not available

^a COC = combined ethinyl estradiol and norgestrel/ levonorgestrel. POP = Levonorgestrel alone

^b Marketed in January 2001 and available at a cost of R60.01 per total dose (December, 2001)

Guidelines and Protocols

The most important document on contraception policy in South Africa is the Department of Health's **Framework for the National Contraception Policy Guidelines** (NCPG) which has undergone numerous revisions since 1999. The final NCPG was adopted in May 2001 and launched in February 2002. This document acknowledges that EC is neither widely promoted, nor easy to access and that provider knowledge is generally inadequate. EC is rated as an important contraceptive option that should be more actively promoted, especially in the adolescent method mix together with the active promotion of condoms for dual protection against STIs/HIV and pregnancy (page 27). According to these national guidelines, emergency

¹ Smit JA and Gray AL. Legal Constraints to the Provision of Emergency Contraceptive Pills. The Views and Recommendations of the Emergency Contraception Research Group of The Africa Centre for Population Studies and Reproductive Health and the Pharmaceutical Policy Practice Group of The University of Durban-Westville. Position Paper submitted to the Medicines Control Council and South African National Department of Health for review of ECP scheduling status. July 1999.

The Department of Health's Standard Treatment Guidelines and Essential Drugs List (EDL) for South Africa Primary Care Level (1998) recommends only monophasic oral contraceptives containing 0.5 mg norgestrel and 0.05 mg ethinyl estradiol (equivalent to Ovral®) for postcoital contraception. This formulary is based on efficacy and cost rather than expansion of options available.

Clinic Assessments

Participants

The sample sizes for each group of participants for each region are listed in Table 4. Only one selected clinic manager was unwilling to participate due to management changes. All 89 managers of the other clinics willingly assisted when approached.

Response by service providers was excellent (99%) despite the acknowledged work pressure. There were difficulties with only 3 interviews. One person refused with no reasons given, another was on leave on the interview day and a third was not interviewed as she had already been interviewed while working at a different clinic in the region. One clinic (WC2) therefore does not have a provider interview although the clinic manager was interviewed. One service provider, although willing to be interviewed, declined to comment (on religious grounds) on all questions in the attitudes to EC section. This individual is included in the total of 197 interviews but a missing response was recorded for all attitude questions.

Client participation was good, with 86.5% of all selected clinic clients, agreeing to be interviewed. Participation was lower in the urban areas and people were less likely to agree if they were approached at the end of the consultation. The main reason for non-participation was lack of time.

Table 4. Number of participants

	WC1 (Metro)	WC2 (Boland)	GP	KZN	Total	Overall Response Rate
Clinic audits	30	28	17	14	89	98.9 %
Clinic Managers	30	28	17	14	89	98.9 %
Clinic Providers	90	44	31	32	197	99.0 %
Clinic Clients	352	338	170	208	1068	86.5 %
Simulated (Mystery) Clients						
- Clinics	0	0	102	44	-	-
- Pharmacies	0	0	6	13	-	-

Clinic Manager Interviews and Facility Checklists

Managing authorities and type of service

In KZN all the clinics were under district management with the exception of Hlabisa Hospital that was under provincial management. In GP the local authority managed all clinics. In both Western Cape sites most clinics fell under local authority management (73.3% in the urban area and 89.3% in the rural area).

It proved very difficult to clearly ascertain from the interviews whether clinics were offering vertical or integrated family planning services although this had been one of the aims of the study.

Range of public health care services available

Although all facilities surveyed have family planning services, one third of facilities did not have pregnancy testing (blood or urine) available to them (Table 5). This was a particular problem in the rural sites. Most clinics indicated that they offered termination of pregnancy (TOP) counselling and referral (90%) with Gauteng being lower at 77%. In KZN, the most rural of the sites, the scope of reproductive health services was particularly limited with respect to testing. Only two facilities at this site offered pregnancy testing and pap smears. All facilities at the other sites offered pap smears, although in rural Western Cape (WC2) pregnancy testing was also unavailable at many clinics (61%). Five clinics in KZN did not offer HIV/AIDS counselling and 7 did not offer HIV testing despite this province being particularly hard hit by the HIV epidemic. Most facilities in the other sites offered these services. With the exception of one facility in the Western Cape, all offered STI counselling and treatment.

In both rural areas, antenatal and delivery services at the survey clinics were much more common than in the urban sites. Just under half the facilities (49%) offered antenatal services with most of these being in the two rural sites (Table 5). Most of the KZN clinics offered antenatal and postnatal care with many (71%) offering delivery services.

Table 5. Range of primary health care services available at facilities

	WC1 N=30 (%)	WC2 N=28 (%)	GP N=17 (%)	KZN N=14 (%)	Totals N=89 (%)
Family Planning	30 (100)	28 (100)	17 (100)	14 (100)	89 (100)
Sterilisation	0 (0)	6 (21)	1 (6)	0 (0)	7 (8)
TOP Counselling and Referral	29 (97)	25 (89)	13 (77)	13 (93)	80 (90)
Pap Smears	30 (100)	28 (100)	17 (100)	2 (14)	77 (86)
Pregnancy Testing	29 (97)	11 (39)	17 (100)	2 (14)	59 (66)
Antenatal Services	3 (10)	26 (93)	3 (18)	12 (86)	44 (49)
Delivery Services	0 (0)	4 (14)	2 (12)	10 (71)	16 (18)
Postnatal care	10 (33)	27 (96)	7 (42)	13 (93)	57 (64)
HIV/AIDS Counselling	29 (97)	28 (100)	16 (94)	9 (64)	82 (92)
HIV/AIDS Testing	30 (100)	28 (100)	15 (88)	7 (50)	80 (90)
Other STI Counselling	29 (97)	28 (100)	17 (100)	14 (100)	88 (99)
STI Treatment	29 (97)	28 (100)	17 (100)	14 (100)	88 (99)
Well Baby Clinic	26 (87)	27 (96)	17 (100)	14 (100)	84 (94)
PHC Curative	30 (100)	28(100)	15 (88)	12 (86)	85 (95)

Family planning services

Of the 89 facilities, only 15 (16.9%) had specific signs advertising family planning services both inside and outside the building. A further 23.6% had a sign either inside or outside the building. Surprisingly, 59.6% had no signs indicating the availability of a family planning service, particularly at health facilities in the rural sites (25 of 28 in rural Western Cape and 12 of 14 in KZN). Sixty four percent of those with a sign, had this in English only, while the rest had combinations of English, Afrikaans and Xhosa.

The majority of clinics (88.8%) provided family planning services during all facility opening hours. Just over half (51.6%) had separate queues for family planning clients during all hours of service, while 6.7% had separate family planning client queues on certain days. Thus at 41.7% of facilities, there was no dedicated queue for family planning clients. Consultations took place in a private consulting room in all facilities except for 2 in KZN. Six facilities out of the whole sample did not appear to have visual privacy and 4 did not have auditory privacy for family planning consultations.

All clinics in the survey usually had the following oral contraceptives available: Nordette[®], Triphasil[®], and Microval[®]. No facilities stocked Nordiol[®] while 5 in the Western Cape apparently did not usually have Ovral[®]. Unlike KZN and GP the majority of clinics in the Western Cape (54 of 58) also stocked Biphasil[®]. With respect to injectables, all clinics stocked Nur-Isterate[®] and medroxyprogesterone acetate (as Depo Provera[®] and/or Petogen[®]).

Male condoms were distributed at all facilities in the sample, while female condoms were only available at 11.2% of all facilities. Some managers indicated that there was sometimes a problem with a stock-out of male condoms. Twelve of these 15 managers were from the Western Cape, and one from KZN said that there was often a stock-out. The majority of managers (84.3%) felt that condom quality was good or excellent. Few facilities (25.8%) had spermicides available, with none of these found in KZN.

KZN was generally poorly supplied with Information, Education and Communication (IEC) material, with the Western Cape urban site being best supplied for most topics with the exception of materials on the female condom, where Gauteng fared better (Table 6). The languages most commonly represented were English and/or Afrikaans with the exception of the HIV/AIDS material where isiXhosa was also well represented (35.5%). Of the 6 facilities (43%) in KZN who had material on HIV/AIDS, half had English only material. The Zulu language was poorly represented in the total sample partly because of the scarcity of materials at the KZN facilities and partly because of the larger facility sample sizes from the Western Cape where isiXhosa is the most common language spoken.

The Western Cape had between 50% (WC2) and 60% (WC1) of clinics with material on EC, falling to 41% in GP. Only one clinic in KZN had any material on EC.

Table 6. Availability of IEC materials

Topics	WC1 N=30 (%)	WC2 N=28 (%)	GP N=17 (%)	KZN N=14 (%)	Totals N=89 (%)
Family Planning	25 (83)	20 (71)	9 (53)	7 (50)	61 (68)
Male Condoms	23 (77)	22 (79)	15 (88)	5 (36)	65 (73)
Female Condoms	4 (13)	2 (7)	8 (47)	0 (0)	14 (16)
Emergency Contraceptive	18 (60)	14 (50)	7 (41)	1 (7)	40 (45)
HIV/AIDS	26 (87)	27 (96)	17 (100)	6 (43)	76 (85)
STIs	23 (77)	22 (79)	16 (94)	4 (29)	65 (73)
Dual Protection	1 (3)	3 (11)	1 (6)	2 (14)	7 (8)
Termination of Pregnancy	21 (70)	7 (25)	2 (12)	1 (7)	31 (35)

Availability of emergency contraception at clinics

All clinic managers but one (in KZN) were aware that EC in the form of pills (ECPs) was offered at their facility. The majority of managers (92%) indicated that Ovral[®] was the EC product available, 6.8 % (3 in WC1 and 3 in GP) said it was E-Gen-C[®] while one was unsure of the product.

ECPs were available during all opening hours with 3 facilities having 24 hour availability (one in each site except Gauteng). Of the remainder, although 43% opened before 8:00 (7:00-7:45) none remained open after 17:00 and only seven were open on Saturday. This gives very little access to ECP after working hours or at weekends, at any of the sites.

Intra-uterine devices (IUDs) were not used as emergency contraception anywhere although they were available as a contraceptive method at 57.3% of the facilities. IUDs were available at all but one of the Gauteng facilities; 50% of urban Western Cape facilities; 67.9% of rural Western Cape facilities and only at one KZN facility.

Only 7 facilities had a sign indicating the availability of EC (2 in KZN, 3 in WC2 and 1 each in GP and WC1). All were in English with the exception of one Zulu sign in KZN. Less than half of the facilities (44.9%) had IEC material available on ECP with KZN particularly disadvantaged (Table 6).

More than three quarters of the facilities (77.5%) recorded the supply of emergency contraception separately from a regular form of contraception.

Manager knowledge of EC was generally good with 83% indicating 72 hours as the cut-off for giving EC pills, 8% were unsure and the rest gave various periods shorter than 72 hours. In GP all managers said that there were no restrictions on EC supply followed by 73.3% in WC1, 71.4% in WC2 and only 38.5% in KZN. The restrictions that were mentioned by the balance included medical contraindications, pregnancy, minimum age relating to parental consent, and the time limit of 72 hours. Four KZN managers were unsure about restrictions.

Most of the clinics (77.2%) had written guidelines outlining family planning practices with over half (59.1%) having written guidelines specifically on the provision of emergency contraception.

When asked whether advance provision was practiced, 7 managers (all from Gauteng) said yes, 80 said no, and one was unsure. On being asked whether a physical examination (including blood pressure, weight, abdominal palpation and/or internal examination) was required, 51.1% said always. However, 61.4% said that a pregnancy test was never required. The majority of managers (85 of 88) said that counselling on long-term contraception was always given with ECP provision.

With respect to the dispensing of the ECP product, 87.5% of managers said that it was prepared at the time of the request (by “cutting up” a packet of oral contraceptive pills). Four facilities supplied the branded product (3 in WC1 and 1 in Gauteng). A third (33%) of the total said that only verbal instructions were given while 58% said that verbal plus instructions written at the time of dispensing were given to clients.

According to the managers, most clinics (73%) gave family planning in-service training at least annually although only 32.6% had had staff training on EC in the previous year (Table 7).

Table 7. Family planning and emergency contraception training according to managers

	WC1 N=30 (%)	WC2 N=28 (%)	GP N=17 (%)	KZN N=14 (%)	Total N=89 (%)
Family planning training at least annually	21 (70)	19 (67.9)	16 (94.1)	9 (64.3)	65 (73)
EC training in past year	11 (36.7)	10 (36)	4 (23.5)	4 (28.6)	29 (32.6)

Provider Assessment

Provider characteristics

The majority of providers at all sites were professional nurses (see Table 8 below). There were 4 males in the sample (2 from each of the Western Cape sites). The home languages of providers from the urban Western Cape site were almost equally divided between English, Afrikaans and isiXhosa. Most (81.8%) of the rural Western Cape providers spoke Afrikaans at home and all the KZN providers spoke isiZulu at home. In Gauteng, a number of languages were represented, with isiZulu being most common (38.7%), followed by seSotho (25.8%) and isiXhosa (16.1%). Provider ages ranged between 23 and 61 years with an average of about 40 years.

Table 8. Family planning service provider ranks and ages

	WC1 N=90	WC2 N=44	GP N=31	KZN N=32	Total N=197
Professional nurse (%)	87.1	90.1	71.9	81.3	85.3
Mean age in years (SD)	40.1 (9.99)	40.6 (9.22)	41.0 (7.73)	42.5 (7.28)	40.8 (9.07)

Family planning knowledge, practice and training

All providers interviewed (197) were involved in family planning at the facilities where they were interviewed. It should be noted however that some, because of their rank/position, did not directly prescribe/administer contraceptives but were involved in family planning counselling. However, only 81.2% said that they personally offered TOP counselling and referral service; the remainder said that they referred people for this service. Many (71.6%) were involved in taking pap smears with the percentage carrying out this screening function being much lower in KZN (9.4%).

A large majority (81.7%) had completed a certified family planning course. After basic training, 78.6% had completed a general family planning skills course; 72.6% an STI counselling course; 54.3% a course on HIV/AIDS counselling; 44.7% a course on TOP; and only 17.3% had attended courses on rape and sexual violence.

When asked the names of all family planning methods that they knew to be available at their facility, all mentioned oral contraceptives and injectables. Only 82.7% named the male condom and only 51.3% referred to emergency contraception. Both these methods should have been available at all facilities. Reasons for not mentioning condoms are not clear. In many clinics condoms are distributed at numerous points at the facility including by the guard at the gate. Many providers may regard condoms as more of a protection against STIs/HIV than as a family planning method. From Table 9 below it can be seen that not all providers had personally distributed condoms in the last 3 months in KZN only about 50% had. This is because condoms are freely available in many areas of the clinics/hospitals.

The family planning practice questions were asked of those providers who had personally provided family planning directly to clients in the 3 months preceding the survey (N=192). The scope of contraceptive service provision for these providers is given in Table 9. Most had provided injectables and oral contraceptives with 100% in Gauteng having prescribed oral contraceptives and 100% in KZN having administered injectables. The IUD, the female condom and spermicides had been provided by relatively few because of restrictions in availability presently in South Africa.

Table 9. Contraceptive methods provided in the 3 months preceding the survey

	WC1 N=87 (%)	WC N=44 (%)	GP N=31 (%)	KZN N=30 (%)	Total N=192 (%)
Oral contraceptives	84 (96.6)	42 (95.5)	31 (100)	28 (93.3)	185 (96.4)
Injectables	83 (95.4)	42 (95.5)	28 (90.3)	30 (100)	183 (95.3)
Female Condom	2 (2.3)	0 (0)	12 (38.7)	0 (0)	14 (7.3)
Male Condom	71 (81.6)	36 (81.8)	23 (74.2)	15 (50)	145 (75.5)
Emergency contraceptive pills	37 (42.5)	14 (31.8)	15 (48.4)	6 (20)	72 (37.5)
Spermicide	8 (9.2)	2 (4.6)	0 (0)	0 (0)	10 (5.2)
IUD	18 (20.7)	4 (9.1)	11 (35.5)	1 (3.3)	34 (17.7)

Knowledge of emergency contraception

When asked an open-ended question about what they would do if a woman reported having sex without contraception the night before presenting at the clinic, 93.9% (185) said that they would offer emergency contraception. Only 5.1% (10) said they would refer the client to someone else and two said they would not know what to do, both were from the WC1 site.

Ninety seven percent said that they had heard of emergency contraception when asked directly. Their knowledge was good in that most (88.5%) were clear that 72 hours after intercourse was the cut-off point for using ECP; most of the remainder gave shorter time periods. A lower percentage in KZN (64.3%) had accurate knowledge of this with 14.3% unsure. The majority of providers across the sites (90.6%) said that 2 doses should be given; a few (4.2%) mentioned 3 doses (in the event of nausea and vomiting). Only 4 people said one dose should be given - 3 of these were from KZN and 1 was from GP. The majority of those who gave the correct number of doses (94.5%) knew that the dose interval should be 12 hours. With respect to the mode of action, 41.9% said that ECPs cause changes to the endometrium and/or that they impede implantation. Of some concern is that 12 providers (6.3%) said that it worked as an abortifacient (Table 10).

Table 10. Knowledge of the mode of action of ECPs by service providers

	WC1 N=90 (%)	WC2 N=43 (%)	GP N=30 (%)	KZN N=28 (%)	Total N=191 (%)
Like other contraceptive pills	13 (14.4)	1 (2.3)	0 (0)	6 (21.4)	20 (10.5)
As an abortifacient	7 (7.8)	1 (2.3)	0 (0)	4 (14.3)	12 (6.3)
Changes to endometrium / impede implantation	32 (35.6)	31 (72.1)	14 (46.7)	3 (10.7)	80 (41.9)
Other: e.g. Effect on sperm prevents ovulation / conception / fertilization	26 (28.9)	8 (18.6)	11 (33.7)	7 (25)	52 (27.2)
Unsure	12 (13.3)	2 (4.7)	5 (16.7)	8 (28.6)	27 (14.1)

Almost half the service providers (48.2%) felt that there were contraindications to the use of ECPs with 20.9% being unsure. Of the contraindications listed by the providers (multiple responses were given) the most frequently mentioned were:

- Hypertension - 52.1% (48)
- Cardiac conditions/heart problems - 32.6% (30)
- Past thrombosis - 21.7 % (20)
- Current pregnancy - 20.6 % (19)
- Known thrombophilias -19.6% (18)
- Diabetes - 10.9% (10)

A clear tendency with contraindications was for providers to identify those of oral contraceptives as being the same for ECP.

Most providers (81.2% or 155) indicated that ECPs have side effects with 8.9% saying they had none and 9.9% being unsure. Most of those who mentioned side effects correctly identified nausea (90.3%), vomiting (64.5%), and a change in menstrual cycle (19.4%). Also mentioned were headache (10.3%) and dizziness (3.2%). Many of the other infrequent responses were not actually side effects but related to concerns about mode of action and efficacy.

Most of the providers (84.3%) particularly those from KwaZulu-Natal (96.9%) indicated that they would like to know more about EC. Aspects of EC on which providers wanted to know more included:

- legal and policy aspects (25.3%) including whether it can be given to males for their partners; minimum and maximum age restrictions and how often it should be given to a woman;
- contraindications (11%);
- mode of action (13.9%);
- new research findings on EC (11.5%).

Some providers (14.5%) also expressed the need for general training and refresher training on EC.

Almost three-quarters (72.6%) of providers would prefer to dispense a product specially packaged by the manufacturer for emergency contraception use. Reasons for this choice included:

- correctly packaged and labeled and therefore legally correct (39.9%)
- written information and instructions for the client (35%)
- saves time and is easier for the provider (12.6%)
- there is no waste (9.8%)
- more professional, the client can trust the provider (7%)
- clearly differentiates it from a regular method (4.9%)

Only 9.6% said that they preferred cutting up Ovral® because:

- it was always available and/or they were used to it (47.4%)
- it was the only form available (26.3%)
- it was cheaper (26.3%)

Emergency contraceptive pills: Guidelines

Many providers (69.1%) particularly in the urban Western Cape site (83.3%) said that their facility had written guidelines about the provision of ECP. When available these guidelines could be found most commonly in a central file (62.1%), followed by being posted on the wall (18.2%) or in a personal file (12.1%).

Emergency contraceptive pills: Provision and practice

When asked in an open-ended general question about service provision of family planning methods in the 3 months preceding the survey, emergency contraception was more than twice as likely to be mentioned by providers in the urban areas (GP at 48.4%; WC1 at 42.5%) than in the most rural area of KZN (20%) (Table 9 above). By far the most common product mentioned was Ovral® (88.5%).

When specifically asked about provision of ECP in the preceding 3 months, 53.9% replied in the affirmative, with a further 26.2% having said that they had provided ECP at some stage prior to the study. Fifteen of the remaining 38 who had never provided ECP indicated that they had never had a client who had needed or requested it, two said they did not know about EC, nine indicated that it did not fall within the scope of their practice (junior rank). Only 2 providers, 1 from GP and the other from WC1 indicated that they had never provided it because of their religious beliefs.

Table 11. Supply of ECP by providers (closed-end question)

	WC1 N=90 (%)	WC2 N=43 (%)	GP N=30 (%)	KZN N=28 (%)	Total N=191 (%)
Supply of EC					
In previous 3 months (%)	45 (50)	20 (46.5)	25 (83.3)	13 (46.4)	103 (53.9)
Ever if not in last 3 months	27 (30)	18 (41.9)	2 (6.7)	3 (11.7)	50 (26.2)
Never	18 (20)	5 (11.6)	3 (10)	12 (42.9)	38 (19.9)

The following information summarized in Table 12 below, covers the practice of those who had prescribed EC to clients (n=153). Again Ovral® was the product most commonly supplied, provided by almost all providers with the exception of 3 in the Western Cape. Of the providers who had ever given ECP to clients, those in the Western Cape had been supplying EC over a much longer period on average than those in Gauteng and KwaZulu-Natal (Table 12).

The practice with respect to physical examinations, pregnancy examinations and pregnancy testing differed from site to site. Physical examinations and physical pregnancy examinations were much more likely to be routinely done by providers in KwaZulu-Natal where no one did routine pregnancy testing. This is not surprising in the light of the KwaZulu-Natal provincial guidelines and the unavailability of routine pregnancy testing. Routine pregnancy testing was carried out by 44.4% of providers in Gauteng with 26% doing a physical examination for pregnancy. Western Cape providers very rarely did a physical pregnancy examination routinely.

Table 12. Practices of those providers who have prescribed ECP

	WC1 N=72	WC2 N=38	GP N=27	KZN N=16	Total N=153
Period (months) over which EC has been provided					
Mean	70.8	79.6	36.4	19.4	61.5
Range	1-228	6-300	2-120	1-84	1-300
Product usually given (%)					
E-Gen-C®	1 (1)	2 (5)	0 (0)	0 (0)	3 (2)
Ovral®	71 (99)	36 (95)	27 (100)	16 (100)	150 (98)
Always perform (%)					
Physical examination	38 (53)	22 (58)	9 (33)	13 (81)	82 (54)
Pregnancy test	10 (14)	0 (0)	12 (44)	0 (0)	22 (14)
Pregnancy examination	2 (3)	1 (3)	7 (26)	10 (62)	20 (13)
Always (%)					
Follow-up appointment	50 (69)	32 (84)	24 (89)	10 (62)	116 (76)
Counselling on long term contraception	71 (99)	37 (97)	25 (93)	15 (94)	148 (97)
Written educational material on EC	37 (51)	11 (29)	3 (11)	1 (6)	52 (34)
Written instructions on ECP	40 (56)	18 (47)	11 (41)	1 (6)	70 (46)
Provision for vomiting (%)					
Extra dose provided	49 (68)	17 (45)	12 (44)	12 (75)	90 (59)
To come back to clinic	28 (39)	21 (55)	8 (30)	1 (6)	58 (38)
Antiemetic provided	7 (10)	0 (0)	1 (4)	1 (6)	9 (6)
Ever gave advance supply (%)	0 (0)	0 (0)	3 (11)	0 (0)	3 (2)

Many providers (75.8%) scheduled a follow up appointment for the client requesting/requiring EC and the overwhelming majority (96.7%) counselled all clients about long-term contraception options. Relatively few gave education material on EC (34%) and less than half gave written instructions on how to take ECPs.

Although few nurses (5.9%) gave anti-emetics with ECP, many (58.8%) provided an extra dose of EC in the event of women vomiting. Only 3 providers (all from Gauteng) had ever given an advance supply of ECP.

Providers' perceptions/attitudes to emergency contraception promotion and the circumstances of provision

Those providers who had supplied ECPs in the past were asked what they viewed as the three main obstacles or barriers to clients' access to and use of ECP. Top of the list was lack of knowledge on the part of the potential user (79.7%), followed by restrictive clinic hours (51%), shyness of potential users (38.6%) and judgmental and scolding attitudes of providers (28.8%). In all sites, a very high proportion cited lack of client knowledge of the method as the major barrier. Many more Western Cape providers felt that clinic hours limited access whereas this was not mentioned at all in KZN.

Table 13. Perceptions of the main obstacles to clients' access to and use of EC (providers who had personally prescribed ECP)

	WC1 N=72 (%)	WC2 N=38 (%)	GP N=27 (%)	KZN N=16 (%)	Total N=153 (%)
Lack of knowledge (client)	52 (72.2)	36 (94.7)	21 (77.8)	13 (81.3)	122 (79.7)
Restrictive clinic hours	50 (69.4)	22 (57.9)	6 (22.2)	0 (0)	78 (51)
Shyness of potential user	30 (41.7)	24 (63.2)	2 (7.4)	3 (18.8)	59 (38.6)
Judgmental attitude of provider	21 (29.2)	9 (23.7)	11 (40.7)	3 (18.8)	44 (28.8)
Moral / religious worries of potential users	13 (18.1)	4 (10.5)	3 (11.1)	2 (12.5)	22 (14.8)
Providers' religious beliefs; EC is abortifacient	3 (4.2)	1 (2.6)	0 (0)	4 (25)	8 (5.2)

After an explanation about EC **all** providers (197) were asked about their attitudes to the supply and use of EC. The providers' thoughts on the most common advantages are listed in Table 14. Across sites EC promotion is seen as having the potential to reduce unwanted pregnancies (88.3%), teenage pregnancies (18.8%) and abortion/TOP rates (11.7%) and is of particular use in the case of rape (25.4%).

Table 14. Providers' opinions on what advantages the promotion of EC may have

	WC1 N=90 (%)	WC2 N=44 (%)	GP N=31 (%)	KZN N=32 (%)	Total N=197 (%)
May reduce unwanted/unplanned pregnancy	84 (93.3)	44 (100)	26 (83.9)	20 (62.5)	174 (88.3)
Expands women's choice / empowers women	32 (35.6)	16 (36.4)	4 (12.9)	2 (6.3)	54 (27.4)
Especially useful after rape	27 (30)	9 (20.5)	4 (12.9)	10 (31.3)	50 (25.4)
May reduce teenage pregnancies	16 (17.8)	13 (29.5)	2 (6.5)	6 (18.8)	37 (18.8)
May reduce TOP/abortion	7 (7.8)	3 (6.8)	11 (35.5)	2 (6.3)	23 (11.7)

A number of KZN (40.6%) and Gauteng providers (25.8%) saw no disadvantages in the promotion of EC. However, many other providers thought that promoting EC would affect uptake (65%) and compliance (24.9%) with long-term contraception. In addition, almost one third of providers (33%) noted that a disadvantage is that it does not protect against STIs/HIV. A number also felt it would promote promiscuity (16.2%). Eight providers (in addition to one who would not participate in this part of the interview) maintained that a disadvantage of ECPs is that they are abortifacients.

Table 15. Opinions of providers as to the disadvantages of promoting EC

	WC1 N=90 (%)	WC2 N=44 (%)	GP N=31 (%)	KZN N=32 (%)	Total N=197 (%)
May discourage women from using regular method	64 (71.1)	34 (77.3)	17 (54.8)	13 (40.6)	128 (65)
Does not protect against STIs/HIV; may discourage condom use	37 (41.1)	22 (50)	2 (6.5)	4 (12.5)	65 (33)
Not as effective as OC and injectables	34 (37.8)	21 (47.7)	1 (3.2)	4 (12.5)	60 (30.5)
May promote non - compliance with regular method	17 (18.9)	11 (25)	10 (32.3)	11 (34.4)	49 (24.9)
Promotes promiscuity	16 (17.8)	11 (25)	0 (0)	5 (15.6)	32 (16.2)
It is an abortifacient	4 (4.4)	2 (4.5)	0 (0)	2 (6.3)	8 (4.1)

Sixty seven percent of providers felt that there was no minimum age for them to prescribe EC (Table 16). Gauteng providers were most confident of this (80.7%). Similarly 65.9% said that there was no maximum age above which they would not dispense ECPs. In Gauteng, 100% felt that there was no maximum age limit. Most providers across the sites were happy to provide EC to teenagers over 16 years with the percentage decreasing to 83.2% for under 16 years and to 64% to those under 14 years. Eighteen and 25 of these providers felt however, that parental consent was necessary for teenagers less than 16 and 14 years respectively (Table 16).

Table 16. Providers' attitudes to age restrictions

	WC1 N=90 (%)	WC2 N=44 (%)	GP N=31 (%)	KZN N=32 (%)	Total N=197 (%)
No Minimum age	57 (63.3)	30 (68.2)	25 (80.7)	20 (62.5)	132 (67)
No Maximum age	50 (55.6)	29 (65.9)	31 (100)	19 (59.4)	129 (65.5)
Teenager over 16 - yes	87 (96.7)	43 (97.7)	28 (90.3)	28 (87.5)	186 (94.4)
Teenager under 16 - yes	77 (85.6)	36 (81.8)	27 (87.1)	24 (75)	164 (83.2)
Parental consent - yes	12	4	1	1	18
Teenager under 14 - yes	49 (54.4)	29 (65.9)	26 (83.9)	22 (68.8)	126 (64)
Parental consent - yes	15	8	2	0	25

The vast majority of providers (98%) would provide ECPs to unmarried women. Of the remainder, one would not answer, 2 were unsure and only one said she would not do so on the grounds that it promotes promiscuity. Most providers indicated that they would give ECP to married women (96.5%) although 11 felt that they would require the husbands' agreement / permission. Interestingly, there were 2 who said that they would not provide ECP to married women. Reasons for this were that married women should have children; and married women should be on long-term family planning.

Providers were not keen to provide ECPs to third parties. Relatively few providers (27.4%) felt that they would give ECP to male partners although the percentage in Gauteng was much higher than elsewhere at 64.5%. Of those who would not supply to a male on his own, 23.9% felt that both partners should be present to be counselled and to take responsibility; 41% felt that the woman needs to get direct counselling on the method, risks, long-term contraception and follow up; and 14.2% said that the provider needs to take a medical history, menstrual history or perform a physical examination on the women themselves. Slightly more (36%) were prepared to give ECPs to a mother for her teenage daughter with Gauteng again ahead at 71% followed by KZN at 37.5%.

Providers in the Western Cape were more likely (66.4%) to think that there was a maximum number of times a woman should be given ECP compared with Gauteng and KZN (23.8%). The reasons advanced for those who thought provision should be limited related mostly to persuading the women to use a long-term method (54.8%) or that the client might be abusing EC (12.5%) when she should be on a long-term method. The limit most frequently mentioned was twice (49%), with a further 26% setting it at 3 times.

Few providers gave unconditional approval to advance provision. The open-ended question asked on advance provision was difficult to interpret as many providers felt it had some merit but gave conditional responses.

Client Assessment

Emergency contraception knowledge and use

Only 22.8% of all clients had heard of EC, with awareness being significantly lower in the most rural area and among older, less educated women (see Table 17 for site breakdown). EC knowledge was superficial with 47.1% of those who had heard of EC, unsure of the appropriate interval between unprotected intercourse and initiating EC. More than half of the women (56.6%) who knew of it were unaware that it was available at the clinic that they were visiting and 8.7% believed that they could not get it at the clinic.

Despite the theoretical availability of EC at the clinics only 9.1% of women who had heard of EC had ever used it (2.1% of all women interviewed). Of those who had used EC, none were repeat users. Half of these women (n=11) had obtained EC from public sector clinics with 6 having purchased it from private sector pharmacies. The main reasons for using EC were non-coercive unprotected intercourse (n=13), method failure or non-adherence (n=7) and coercive sex (n=3)².

Attitudes to emergency contraception

Women were asked about their attitude to the use of EC after an explanation to those who had not heard of it. Attitudes were overwhelmingly positive, with 90.3% indicating that they would use it if needed, 92.3% would recommend it to a friend and 89.3% were willing to pay for it, if necessary. A breakdown of attitudes by site is given in Table 17.

Only 12.5% of respondents foresaw problems with EC use. Issues raised included:

- Abuse: it would be used instead of a regular method
- EC causes health problems and unpleasant side effects
- EC might cause more STI/HIV infection due to non-use of condoms
- EC would increase promiscuity.

Only a handful (n=9) felt it was an abortifacient and thus objected to its use.

Table 17. Client knowledge and use of EC and attitudes to EC by site

	WC1 N=352	WC2 N=338	GP N=170	KZN N= 208	Total N=1068
Women who had heard of EC (% of all)	34.4	18.0	22.4	11.1	22.8
Women who had ever used EC (% of all)	2.8	2.1	2.4	0.5	2.1
Women who would use EC if the need arose (% of all)	88.4	88.8	96.5	90.8	90.3
Women who knew EC was available at clinic (% of those who knew of EC)	28.9	37.7	57.9	17.4	34.6

²More than one reason could be given.

Demographic characteristics and reproductive history of clients

Although there were very similar mean ages for the various sites (average of 26.8 years), the women from the urban areas (Gauteng and Western Cape Metro) were better educated. KwaZulu-Natal women were less likely to be married or employed, highlighting the economic plight of the most rural of the sites.

Most of the clients interviewed had ever been sexually active (93.3%) and had been sexually active in the last year (87%), with very similar proportions across the regions. However KwaZulu-Natal and the rural Western Cape site had higher percentages of women ever pregnant (91% and 90.1% respectively) compared with Cape Metro and Gauteng (85.5% and 77.4% respectively) and the percentages ever pregnant before 20 years were also higher in the rural regions than in the urban areas. See Table 18 for a breakdown of these figures by site.

Over two-thirds (68.4%) of the clients who had been sexually active in the previous year were using a modern contraceptive method. In all sites the most frequently used method was the long-acting hormonal injectable method, used by 71.4% of those using a method, with oral contraceptives used by 14.5% and condoms by only 11.5%.

Accessibility to clinics

In assessing the whole sample, over three-quarters (78.2%) of the clients walked to the clinic, with a further 14.5% using public transport. The majority of clients (79.3%) took 30 minutes or less to get from their homes to the clinic. When asked if clinic times were suitable for them 89.3% said that they were. Only 8% of the total sample was not happy with clinic opening times.

The family planning clients (26.1% of total sample) were very similar to the total sample when looking at transport; 75.9% walked to the clinic and 14% took public transport. The percentage of family planning clients taking public transport as opposed to walking was higher (almost double) than the average in KwaZulu-Natal (36.7%) and much lower in the Western Cape rural site (2.7%). In the 3 sites other than KZN, 89% of family planning clients had travel times to the clinic of 30 minutes or less. Accessibility in KZN appeared to be more of a problem in that only 56.7% reached the clinic in 30 minutes or under despite a higher percentage taking public transport rather than walking.

Although 90.3% of family planning clients across the sites found clinic opening times satisfactory, this dropped to 70% in KZN.

Table 18. Demographics and reproductive history for clients

	WC1	WC2	GP	KZN	Total
Mean age in years (SD)	27.2 (8.1)	27.6 (8.3)	26.2(6.9)	25.5 (9.1)	26.8 (8.2)
% married	36.6	26.9	23.5	13.9	27.1
% with grade 8 or higher	76.7	64.2	81.7	58.7	70.1
% Employed	33.2	39.5	24.7	9.8	29.3
% ever sexually active	92.3	95.9	93.5	90.4	93.3
% sexually active in the last year	86.1	87.0	88.2	87.5	87.0
% ever pregnant	85.5	90.1	77.4	91.0	86.7
% ever pregnant before 20 years (of those sexually active)	42.2	51.2	39.6	59.6	48.0
% ever pregnant when not ready (of those ever pregnant)	63.7	58.6	68.3	77.8	65.4
% using a modern method of contraception (of those sexually active in the last year)	70.6	67.3	85.3	52.2	68.4

*Simulated Client Assessment*³

The first two types of simulated clients visited 14 KZN health facilities and all three types of clients visited the 17 GP facilities. In all, 44 and 102 simulated client visits were made in KZN and GP respectively, and these included repeat visits to validate findings. In addition, 19 simulated client visits were made to 4 pharmacies in KZN and to 3 pharmacies in the GP study sites. Immediately after visiting each health facility, the clients' experiences were captured using a pre-designed assessment checklist.

EC was provided to 74.1% (n=165) of the simulated clients who visited the public sector health facilities and pharmacies in GP and to 68.4% in KZN, and was usually provided as “cut-up” Ovral[®] (83.2%). Other brands provided were: E-Gen-C[®] (6.7%) and Nordette[®] (5.9%). Most (79%) were given 2 doses, 17% were given 3 doses and 4% were given one dose. Only 32% were told that they may experience minor side effects such as nausea and vomiting. Few (13.4%) were warned that EC is only 75% effective in preventing pregnancy. Four clients were given an advance supply of EC. One client was told that EC causes abortion.

For two thirds of the clients (66.7%), providers took the opportunity to counsel on the use of long-term contraceptive methods:

- 32.7% counselled on the future use of a non-barrier method
- 26.1% counselled on the use of a barrier method for future
- 7.9% counselled on the use of a barrier + non-barrier method for future use.

However, little attention was paid to the clients' risk of STI/HIV acquisition after unprotected intercourse:

- Only 19 (11.5%) clients received counselling that they might be at risk for STI/HIV acquisition.
- Only 3 clients were counselled about the importance of watching for signs of STI/HIV.
- Only 9 (7.6%) of those who received EC were told that EC does not protect against STI/HIV.
- Only 2 of the female clients were asked if they had more than one partner.
- While 45 (27.3%) clients were provided with condoms without having to ask for them, only 5 clients were given written or verbal instructions on how to use condoms, and only 4 received a demonstration on how to use condoms.

³ A more detailed account of the simulated client experiences is the subject of a separate monograph and is available on request.

PART 3. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Contextual Analysis

- National and provincial policies generally favoured availability and accessibility of EC down to primary care (community) level.
- The Western Cape (local authority and provincial health departments) and Gauteng (provincial authority) followed national guidelines on EC supply.
- Regional differences in policies related mainly to the need for a physical examination (to exclude pregnancy) in KwaZulu-Natal.
- Policies appeared more facilitatory in Gauteng and the Western Cape, in line with national policy.
- Cost remained the determining factor for product availability at public sector clinics.

Clinic Assessment

Clinic managers and facility checklists

Reproductive Health Services

- Some reproductive health services had limited availability in the rural areas:
 - Pregnancy testing was available at only 2 of 14 clinics in KZN and at only 11 of 28 clinics in rural WC.
 - Pap smears were available at only 2 sites in KZN.
- HIV counselling and testing was not universally available in GP and KZN:
 - HIV counselling was not universally available in KZN (64%)
 - HIV testing was only available at half of the KZN clinics.
- Almost all clinics at all sites offered STI counselling and treatment.
- More rural clinics (particularly in KZN) offered antenatal and delivery services.

Contraception

- Most facilities stocked the standard range of contraceptive pills and injectables; few supplied female condoms or spermicides.
- Male condoms were freely available at all clinics with few reports of stock outs.
- IEC material was in best supply in the Western Cape with KZN having the poorest supply.
- Contraceptive services were not well advertised: over 50% had no signs inside or outside the buildings. This is a greater problem in rural areas.

EC Supply and Utilisation

- All but one manager was aware that EC (in the form of pills) was available at the clinic where they were working.
- Ovral® was the product given at most clinics (92%); IUDs were never used for EC purposes.
- Availability of EC at clinics outside of working hours was very limited - only 7 opened on Saturdays and 3 were open after 17:00 (24-hour facilities).
- EC was seldom advertised - only 7 facilities had signs indicating the availability of EC.
- Manager knowledge of EC was generally good.

Providers

Reproductive Health Services

- Most family planning providers were female professional nurses.
- Training in family planning was adequate with 81.7% having attended an accredited course and 72.6% having had an STI counselling course.
- Training in HIV/AIDS counselling was surprisingly low (54.3%) as was training for TOP (44.7%), and counselling on rape and sexual violence (17.3%).
- Most had supplied oral contraceptives, injectables and condoms while few had supplied IUDs, female condoms or spermicides.

ECP Provision

- Over a half (53.9%) of the total had supplied ECPs in the 3 months prior to the study with most in GP (83.3%) having done so. Those in the WC had, however, been supplying ECPs over a much longer period of time, in line with WC policies of promoting ECP since the 1980s.
- Ovral[®] was the product most commonly provided for EC.
- Only 2 people said they would not supply ECPs because of religious beliefs.
- The majority indicated (unprompted) that they would supply ECPs to a woman who reported unprotected sex the night before attending the clinic, if she did not wish to fall pregnant.
- Most (88.5%) had relatively good knowledge of the 72 hour cut-off point for EC supply, with fewer in KZN (64.3%) knowing this.
- Although most providers had a reasonable knowledge of the mode of action of ECPs, 12 providers believed ECPs worked as abortifacients.
- Almost half (48.2%) of the providers thought that there were contraindications to ECPs, with a further 20.9% unsure.
- Most providers (particularly those from KZN) wanted to know more about ECPs.
- Practice in supplying ECPs in KZN differed from the other areas - providers were much more likely to include a physical examination to check for pregnancy (in line with policy) rather than pregnancy testing (mostly unavailable).
- Almost three-quarters (72.6%) would prefer to dispense a properly labelled and packaged ECP product. Only 45.8% provided written instructions when EC was supplied.
- Almost all providers (96.7%) reported that they counselled all EC clients about long-term contraception options.
- Providers (79.7%) felt that lack of knowledge of clients was the biggest obstacle to access and use of ECPs.
- Restrictive clinic hours were regarded as a major barrier by providers in the Western Cape. (51%).
- Just over one quarter thought that judgemental attitudes on the part of providers were an impediment.
- Many providers were wary of ECP promotion in that it could affect uptake (65%) and compliance (24.9%) with long-term contraception methods. There was also concern that it did not protect against HIV and could discourage condom use (33%).
- On the whole age and marital status were not likely to affect providers' decisions to provide ECP or not, although some providers had concerns about provision to teenagers under 16 and 14 years.
- Most providers were not keen to provide EC to third parties such as partners and mothers. GP providers were much more likely to provide EC to partners than elsewhere.
- More WC providers (66.4%) than others (23.8%) felt that the number of times of provision should be restricted to limit abuse and encourage long - term contraception.
- Few providers gave unconditional approval to advance provision probably related again to concerns about long-term contraception uptake.

Clients

- Sixty five percent of women interviewed had had a pregnancy when not ready (77.8% in KZN).

EC Knowledge and Use

- Only 22.8% of all clients had heard of EC, with awareness being significantly lower in the most rural area and among older and less educated women.
- Knowledge of EC was superficial.
- More than half the women were unaware that it was available at the clinic that they were visiting.
- Only 22 of all the women interviewed had ever used ECP.

Attitudes to EC

- Attitudes to EC were overwhelmingly positive (after it was explained to those who had not heard of it).
- Ninety percent said they would use EC if needed and most would be willing to pay.

Simulated client assessments

ECP Provision

- EC was provided to 74.1% of the simulated clients who visited the public sector health facilities and pharmacies in GP, and to 68.4% in KZN, usually in the form of “cut-up” Ovral[®].
- Most providers correctly supplied 2 and some 3 (2 + 1 additional dose) doses of ECPs.

Counselling

- Almost two thirds (66.7%) counseled clients on the use of long-term contraceptive methods, with more counseling about non-barrier than barrier methods.
- Little attention was paid to counseling clients about their risk of STI/HIV acquisition after unprotected intercourse.

RECOMMENDATIONS

1. Policy on ECP provider practice in KZN should be brought in line with the National Contraceptive Policy Guidelines, especially in regard to the need for an internal physical examination before providing EC.
2. An up-to-date user-friendly checklist on EC provision should be developed and displayed on the wall in each consultation room within easy visibility for easy reference.
3. Pregnancy testing should be available at all family planning clinics.
4. HIV counselling and testing should be a universal component of reproductive health services in South Africa.
5. To improve service provision of ECPs, training should focus on:
 - Mode of action: emphasizing that EC is not an abortifacient.
 - Contraindications: contrasting the relative risk for hormone effects with short-term ECP use, to long-term hormonal contraception and pregnancy.
 - Legal issues/provider responsibilities in regard to supply to third parties and young teenagers, particularly to those less than 14 years.
 - Using the opportunity of EC counselling as an entry or re-entry point to long-term contraception.
 - The role of EC as a back-up to condom failure.
 - That EC does not provide protection against STIs/HIV.
6. Training in STIs, HIV, EC, TOP and rape and sexual violence counselling for family planning providers should be increased.
7. Written instructions should always be provided to those receiving EC, including when EC is provided in the form of “cut-up” Ovral[®].
8. To expand contraceptive choice, consideration should be given to introducing Norlevo[®], the POP EC product (which has fewer side effects and is more effective than COC EC products) at public sector health facilities.
9. Develop and test IEC material in appropriate languages on a range of reproductive health topics including EC and dual protection against unwanted pregnancy and STIs/HIV.
10. Improve advertising of ECP supply at clinics and within the community.
11. Advertise the location of after hours ECP supply in family planning clinics (even if that is the private sector).
12. An extensive promotional campaign for ECP through schools and media (radio, newspapers, magazines) advertising campaigns.
13. Even though providers may not distribute condoms themselves, they should use every opportunity to counsel about correct and consistent condom use.
14. Providers should use every opportunity to counsel clients about the dual risk of pregnancy and STIs/HIV.