Supporting contraceptive choice in self-care: qualitative exploration of beliefs and attitudes towards emergency contraceptive pills and on-demand use in Accra, Ghana and Lusaka, Zambia

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ABSTRACT: Supporting women to use emergency contraceptive pills (ECPs) as both a back-up and a regular, on-demand contraceptive method can increase self-managed contraceptive options and enhance reproductive autonomy, particularly for vulnerable populations. ECPs are currently regulated for use in an “emergency” situation; however, some evidence suggests that women also value this method as a regular, on-demand option used to prevent pregnancy with foresight and confidence. Beliefs and attitudes towards ECPs and their on-demand use in Accra, Ghana and Lusaka, Zambia were explored through in-depth interviews (IDIs) and focus group discussions (FGDs) with women ages 18–34 and men ages 18–30 in Accra and Lusaka. Structured interview guides and focus group discussion guides were used to explore societal and community norms, knowledge, behaviour, and attitudes. IDIs were analysed using deductive, thematic coding, and FGDs were analysed using inductive, thematic coding. Three major themes emerged: first, ECPs are a trusted method and often preferred as an easy and effective option; second, people value ECPs as an on-demand method, yet fear that repeated use could have harmful health effects; finally, anticipated stigma among users of ECPs is higher than experienced stigma, except among young women. The findings that emerged from this research suggest that the repositioning of ECPs as suitable for on-demand use would be an important step towards reducing the stigma and discrimination that is often associated with the method while expanding the range of self-care contraceptive options available to meet the differing needs of women, young women and vulnerable populations.

Keywords: emergency contraception, on-demand, self-care, stigma, adolescents, self-managed care

Introduction
Supporting women to use emergency contraceptive pills (ECPs) as both a back-up and a regular, on-demand contraceptive method can increase self-managed contraceptive options while enhancing reproductive autonomy and informed decision-making. Repositioning ECPs as a primary, on-demand contraceptive method could potentially also serve to destigmatise ECP use by framing it as a conscientious choice used in the same way as other short-acting contraceptive methods. This

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approach is particularly relevant for vulnerable populations who face an increased risk of exposure to stigma and discrimination.

ECPs are the only short-acting contraceptive method available to women and girls that provide a second chance to prevent pregnancy after unprotected intercourse or after method failure. They are also the only hormonal short-acting method that can be used episodically, making it an attractive option to consumers who do not want to use contraception continuously. Despite this unique position in the contraceptive method mix, in the majority of countries in sub-Saharan Africa, knowledge and use of ECPs remains quite low.¹

ECPs are currently manufactured, branded, and regulated for use in an “emergency” situation when unexpected intercourse occurs and contraception is not used, or when a contraceptive method fails; however, data from various studies and across settings suggest that women, including young women, also value this method as a regular, on-demand option used to prevent pregnancy with foresight and confidence, similar to how a condom or diaphragm is used.²,³ “On-demand” in this paper refers to using ECPs only when needed, as a planned, primary method, as opposed to as a back-up method. In a 2011 study in Kenya that looked at 182 purchasers of ECPs at pharmacies in five urban areas, researchers found that 58% had purchased ECPs more than twice in the last month and concluded that many of the women surveyed, particularly those who had sex on an infrequent basis, chose to use ECPs as a regular contraceptive method.⁴ In a separate study, interviews with women who had ever used ECPs in Nairobi (n = 539) and Lagos (n = 438) found fairly high reporting of ECPs as their main contraceptive method: 14.8% in Nairobi and 40.8% in Lagos; however, the frequency of use was fairly low, with women using ECPs between two and five times in a six-month period.⁵ In a 2014 analysis that reviewed 19 studies across 16 countries, reported reasons for interest in or use of a coital-dependent oral contraceptive product included convenience, ease of remembering, ability to conceal use, lack of coital interruption, and infrequent sexual activity.³

Globally, women who purchase ECPs are generally young (under 30 years of age),⁴,⁶–⁸ educated,⁴,⁶–⁸ employed⁴ or wealthy¹,⁶ and unmarried¹,⁷. Existing studies show that ECP users were more likely to be nulliparous,⁷ unmarried,¹ and use a barrier method.⁶ Previous research has largely focused on women in urban and peri-urban areas, but we have limited information about ECP use among women living in rural areas. Some research has been able to capture that women in urban areas use ECPs more than women in rural areas, but this varies by country and is likely dependent on the public health programming and social marketing strategy of ECPs specific to that country.¹,⁶

Women who report using ECPs find that they are convenient and easy to use and they appreciate the ability to take it confidentially.⁴,⁵ However, many barriers to ECP access persist: misinformation, the persistence of myths, the perception that ECPs are being abused, and stigma.⁴,¹⁰–¹⁴ In the Democratic Republic of Congo (DRC), when asked about the impact of the availability of ECPs in their community, participants in one study reported that it should be available regardless of the user’s age; however, some expressed that access for young women and adolescents may encourage risky sexual behaviour.¹⁰ Providers, in particular, across regions continue to perceive that women overuse ECPs and that ECP users are more likely to engage in risky sexual behaviour.¹⁰–¹³ In Senegal, providers reported that ECP users were more likely to have unsafe sex, have multiple sexual partners, and not use contraception.¹³

Despite the World Health Organization’s (WHO) classification of repeated ECP use as Level 1 in their Medical Eligibility Criteria (2015), indicating “a condition for which there is no restriction,” there continues to be the perception that ECPs should not be used repeatedly, as a primary, on-demand method.¹⁴ Globally, ECPs are explicitly promoted and labelled for emergency use only. One obstacle is the levonorgestrel 1.5 mg product label which does not indicate that repeated use is safe and states that the product “is not intended for routine use as a contraceptive”.¹⁵ This is a gap in information available to consumers about an essential self-care contraceptive option.

The WHO Consolidated Guideline on Self-Care Interventions for Health and Well-being 2021, update to the original 2019 guideline, recommends over-the-counter access to ECPs without a prescription as a self-care option and acknowledges that self-care interventions represent a significant movement towards greater choice, autonomy, and self-determination.¹⁶ The guideline also notes that self-care is important for
populations negatively affected by gender, cultural, and power dynamics and for vulnerable persons, highlighting that self-care interventions for sexual and reproductive health play a particularly important role, given that many people are unable to exercise bodily autonomy, an aspect critical to the full realisation of reproductive health and rights. Hence, the key principles placed at the centre of the guideline’s Conceptual Framework include human rights and gender equality.

Country context

In Ghana, 21.3% of women of reproductive age (WRA) (ages 15–49) report currently using a modern method of contraception, while an unmet need is 20.7%. In 2017, 4.4% of married contraceptive users reported using ECPs; this percentage increased to 18.9% among unmarried, sexually active contraceptive users, according to the Performance Monitoring for Action (PMA). Despite the prevalence of emergency contraceptive use in Ghana, we know relatively little about the motivations, barriers, and facilitators associated with using ECPs. A qualitative study in 2008 among a small number of users of ECPs recruited from pharmacies in Accra found that ECPs were a strongly preferred method, that side effects from ECPs were acceptable and that participants had little knowledge of other contraceptive methods.

In Zambia, 32.5% of WRA report currently using a modern method of contraception, while unmet need is 21.1%. Among WRA, 43.4% report having sex in the past four weeks. According to the 2018 Zambia Demographic Health Survey (ZDHS), 30% of WRA, and 32.5% of sexually active, unmarried women reported knowledge of ECPs, compared to the reported 21.4% of WRA in the 2013/2014 ZDHS, and 9.3% in the 2007 ZDHS. A cross-sectional descriptive study involving 200 women 18–49 years old admitted to the University Teaching Hospital for an abortion procedure in Lusaka, Zambia found that only 15 (7.5%) of the women interviewed had ever heard of ECPs; the main source of information was from friends (80%). Aside from this study, no recent literature related to emergency contraception and Zambia was found.

Overall, while evidence suggests many women are using ECPs as their main method of contraception, there is a gap in the literature related to attitudes and preferences among ECP users and potential users. This study sought to explore women’s and men’s attitudes, beliefs, and opinions regarding ECPs and on-demand use of ECPs and understand the factors that influence users to choose ECPs as their primary method. ECP users’ experience and perception of stigma when accessing ECPs were also examined. The results are then discussed in the context of self-managed care and meeting contraceptive users’ needs based on what they want from their contraceptive use experience.

Methods

This study used qualitative methods to explore knowledge, attitudes, and practices among women and men of reproductive age in Accra, Ghana and Lusaka, Zambia through a combination of focus group discussions (FGDs) and in-depth interviews (IDIs). These capital cities were chosen for their urbanicity, as the majority of ECP use happens in urban areas. FGDs and IDIs acted as complementary, not substitute, data collection methods to allow exploration both of societal and community norms, knowledge, and attitudes regarding ECPs (through the dynamics of FGDs) and of personal user experiences, including barriers and motivators to use (through the more private conversations in IDIs). The primary ECP product formulation available to users in our study was levonorgestrel 1.5 mg.

Participants

Study participants were recruited from Accra, Ghana from July to August 2019 and from Lusaka, Zambia from November to December 2018. A recruitment screening questionnaire was used to determine eligibility based on the study’s inclusion criteria: women between the ages of 18 and 35 who have either never used ECPs (non-users) or have used ECPs in the past 12 months (recent users) living in the selected study areas, or men between the ages of 18 and 30 who have either never procured ECPs (non-buyers) or have procured ECPs in the past 12 months (recent buyers). Local recruiters, familiar with the study area, used purposive snowball sampling to identify potentially eligible participants, screen for eligibility, and be referred to other potentially eligible participants. To diversify responses and experiences, recruiters targeted recruitment in several different areas and neighbourhoods of Accra and Lusaka. Potential participants were
excluded if they had used or procured ECPs more than 12 months ago, did not live in Accra or Lusaka, or were not in the eligible age range for participation. Eligible participants were then invited to a central location, for FGDs, or a location of their choosing, for IDIs. On the day of the discussion or interview, each participant was read and given a study information sheet and provided written consent, including permission to audio record, in the form of a signature or thumbprint. Where a thumbprint was used to provide consent, the process was witnessed by the notetaker. All participants were reimbursed for travel.

The study population for the FGDs was women ages 18–35 and men ages 18–30. To obtain a diversity of ideas, FGDs among women were stratified by users of ECPs (have used ECPs in the past 12 months) and non-users of ECPs (have never used ECPs) and among men were stratified by those that have procured (either purchased or received) ECPs in the last 12 months and those who have not. FGDs with women were also stratified by marital status, with more FGDs conducted among unmarried women. Based on previous qualitative experience with similar topics, each stratification group had a saturation target of 2–3 FGDs, and the study team debriefed regularly to ensure progress towards saturation throughout the study. In total, 16 FGDs among women and 6 FGDs among men were conducted in each country, with 6–8 participants per FGD. Following real-time debriefs with the interviewers and review of the transcripts at the conclusion of data collection, saturation was achieved for each stratification in both study locations.

The study population for the IDIs were women ages 18–35 who had used ECPs in the past 12 months. The journey to use of ECPs was expected to differ between unmarried and in union (married or cohabitating) women, given the differing levels in use documented in the literature, and so recruitment was stratified by marital status with the intention to reach saturation within each of these subpopulations. Given trends in the use of ECPs along marital lines, 20 IDIs with unmarried ECP users and 10 IDIs with in-union ECP users were to be conducted in each country. To monitor whether saturation was achieved, the data collection team debriefed daily, and audio recordings were listened to regularly and in real time. If saturation was achieved before the intended sample size was reached, recruitment stopped and if saturation was not reached, additional FGDs or IDIs were recruited.

**Instrument development**

A focus group discussion guide was developed and used by the discussion moderator to guide the discussion but was flexible enough to allow for free-flowing thoughts and ideas from the participants. The FGD guides presented several fictional scenarios followed by probing questions that asked the FGD participants to respond and react to the scenario in terms of what advice they would give or what the person in the vignette might be thinking about or doing as she or he made decisions. The examples of the scenarios are as follows:

- **Dorcas** is a 24-year-old married woman. Dorcas and her husband have one child and have decided they would like to wait about a year to have another child. They are using condoms to prevent pregnancy but last night their condom broke. Dorcas is worried about becoming pregnant and comes to you to ask if you know of anything she can do to prevent pregnancy now that this has happened.
- **Gifty** is a 21-year-old unmarried woman. She has been dating Godfrey for a few months now. They decided to have sex last night but were not planning on doing so and they didn’t use anything to prevent pregnancy. Gifty is worried about becoming pregnant and comes to you to ask if you know of anything she can do to prevent pregnancy now that this has happened.
- **Esi** is a 28-year-old married woman. Esi’s husband works far away and sometimes stays there for a few days. Esi and her husband have two children and do not want another child for a while. Esi is not using family planning because her husband is not home very often.

The IDIs were conducted using a structured interview guide that asked questions of respondents framed as a consumer journey from awareness to decision-making to use of ECPs. This approach considers the lived experiences of the user during each stage, (or touchpoint), in their health-seeking “journey”. The structured interview guide covered topics such as awareness and knowledge of ECPs, factors that influenced decision-making, procurement source, price, experience, and satisfaction using the method, and details around use patterns.
The interview and discussion guides were developed by the PI (first author) and reviewed by SA and MM of the study team. The interview and discussion guides were pretested in a community with characteristics similar to the study communities. The discussion guides were translated into local languages and portions were back-translated to review them for translation accuracy and meaning. The discussion guides were introduced during the local training of research assistants and modified based on their input as well as from immediate debriefing feedback from the field after the first two FGDs. Data were collected in January and February of 2019 in Zambia and in October and November of 2019 in Ghana.

Data collection
Each discussion or interview lasted, on average, 45–60 minutes and was conducted in a local language: Twi, Ga, and Hausa in Ghana and Bemba and Nyanja in Zambia. All discussions were audio-recorded with consent from every participant. Prior to the start of the discussion, basic socio-demographic information was collected from all participants. The moderator for each discussion was one of two research assistants fluent in the local language with prior qualitative data collection experience. A second research assistant took notes during the discussion. Each recording was transcribed and translated to English and the notes taken during the discussions supplemented the transcripts.

The interviewers for both the FGDs and the IDIs were trained research assistants, both male and female, who were local to the capital cities, though not local to the specific community where they were working, and who spoke the local language. The research assistants were more educated than the FGD and IDI participants, on average, but were there to guide the discussion rather than offer their own opinions or advice. After deep discussion with the local co-PIs in Ghana and Zambia, and based on their deep expertise in qualitative research, both male and female research assistants were recruited for data collection, with the anecdotal knowledge that some women prefer to talk to men, seen as a figure of authority, while others prefer to talk specifically about health issues with women, as many providers with whom they have interacted have been women. These preferences are not revealed preferences and likely averaged out across the study sample.

Analysis
For the FGD, an inductive coding approach was used to let themes emerge directly from the data and not from an initial set of codes developed a priori. After an initial review of the transcripts, open coding was used to identify a list of emerging ideas and topics, and the codebook was developed to outline the coding framework. A deductive thematic analysis was used for the IDIs to identify and examine patterns, or themes resulting from each in-depth interview using Dedoose software. A codebook was developed at the outset of analysis using the hypothesised consumer journey from awareness to product use as the overarching framework.

For both the FGDs and IDIs, the more nuanced topics emerging from the data were then used to develop a list of more specific codes within the coding framework. These analysis codes were then used to create a list of concepts that grouped together data of similar content. From there, these concepts were defined as the major themes emerging from the data across IDIs and FGDs. GJ and MM coded the transcripts; GJ, MM, AK, and SA participated in the data analysis; all authors participated in the interpretation of the analysis.

The study was approved by the Research Ethics Board at Population Services International, Washington, DC (REB #27.2018, received January 22, 2019), the Ghana Health Service Ethical Review Committee in Accra, Ghana (GHS-ERC 003/04/19, received July 11, 2019), and the National Health Research Authority in Lusaka, Zambia (received November 5, 2018).

Results
In Ghana, a total of 30 women participated in the IDIs, while 27 women participated in the IDIs in Zambia. A total of 122 women participated in 16 FGDs in Ghana, while 120 women participated in 15 FGDs in Zambia. Across the FGDs among men, 47 men participated in Ghana and 28 in Zambia. Tables 1 and 2 show the demographic breakdown of FGDs and IDIs respectively.

Three main themes emerged from the data analysis across Ghana and Zambia. First, ECPs are a trusted method and often preferred as an easy and effective option by women and men in both countries. Second, ECPs are valued as an on-demand method, yet people fear that repeated use of ECPs could have harmful health effects.
While myths about ECPs are prevalent, the unique value proposition of ECPs carries more weight in decision-making. And finally, perceived stigma among users of ECPs is much higher than experienced stigma, except among young women.

ECPs are trusted and often preferred as an easy and effective option
Participants in both Ghana and Zambia, across sub-groups, perceived ECPs as an effective method of preventing pregnancy and as a unique alternative to other methods of contraception. Commonly cited benefits included that the method works quickly, is simple and easy to use. Respondents liked that ECPs give them an option to prevent pregnancy when they have unprotected sex. ECPs were seen as a way to reduce the stress and worry of pregnancy that normally comes with unprotected intercourse. Many participants also felt that preventing pregnancy using ECPs was safer, easier, and less expensive in comparison with abortion.

She can buy [ECPs] because like I mean the risk after [unprotected sex] is really expensive like abortion is expensive, is about 1000 cedis. I don’t really know but I heard it is expensive… So trust me she can buy it, even GH¢100 she will buy it, and wherever the money is she will get it. 200 cedis she will find the money to buy it.” [Unmarried woman, 18–24, Non-User, FGD, Ghana]

“[ECP] also saves you from stress and will not make you think too much after having sexual intercourse with someone.” [Man, 18–30, Buyer, FGD, Ghana]

Participants were consistent in their belief that ECPs were a method that would almost always prevent pregnancy if taken correctly. Participants felt that if the ECPs failed and the user became pregnant it was because the user did not take it within the correct time frame, the pills might have been expired, or the purchased pills were of a low-quality brand. Many respondents knew that for ECPs to be most effective, the method needs to be taken as soon as possible after intercourse. However, some participants did believe that every individual’s “system” is different and ECPs might not work for all those who take them. First-time users who were confident in ECPs from the start cited their friends’
successful experiences with ECPs as reasons why they never doubted the method would work.

“I only expected that it wouldn’t fail me, that is all … I use to talk to friends or let me say I have friends and then we girls talk a lot and some people do say those things doesn’t work for them yeah so you don’t know maybe it is their system and my system is also different. It might work for me and might not work for you and since am the one taking it I would just have to work on myself and wish that it will work for me as well.” [Unmarried woman, 18–35, User, IDI, Ghana]

Overall, participants viewed ECPs as an appealing and valid option for a method they could take to prevent pregnancy, especially in cases of emergency. Only the women that participated in the IDIs were asked if they would ever use ECPs again and the majority of respondents (n = 50) said yes. Thirteen of these respondents explicitly stated that they would only use ECPs again in case of an emergency. For the respondents that said no (n = 7), they cited reasons of wanting to become pregnant in the future or because they were scared of the method’s side effects. While the majority of participants said they would use ECPs again, only half (n = 27) said they would use it as a regular method for reasons such as ECPs being the easiest method to use, being fearful of other methods’ side effects, or how the ECP has always been a reliably effective method for them. For the 30 that said they would not use ECPs as a regular method, most cited fear of the potential consequences of using ECPs frequently or fear of the method’s side effects, and few mentioned preferring another contraceptive method.

Non-users of the ECP were not asked why they never procured the method, but non-user FGD participants often reported ignorance around the method, never experiencing the type of emergency situation that would call for ECPs, or fear of ECP side effects. Overall, in both countries, users and non-users of ECPs had similar attitudes towards the method, but users were more knowledgeable and confident in their knowledge of the method. Non-users were more likely to express ignorance on aspects of the ECP.

ECPs are valued as an on-demand method, yet myths persist and people fear that repeated use of ECPs could have harmful health effects

To determine whether participants used or were interested in using ECPs as an on-demand method, they were asked the context around why they purchased or would purchase ECPs, and whether they would be interested in using ECPs as a regular method. The on-demand benefits of ECPs were attractive to many participants, especially for those who have infrequent intercourse. In both countries, for married women with husbands who travel frequently or young unmarried women not in a committed relationship, they reported that a desirable benefit of ECPs was that ECPs are a contraceptive method that can be taken only when one has intercourse. The ECP allows a user to avoid common errors that come with using other methods, such as forgetting a dose or letting the method lapse, and to avoid “wasting” other methods (i.e. using a method and experiencing its side effect despite not having any intercourse).

“Unplanned sex is why I was saying you need to buy in bulk, because you don’t know when fire will come. It is always better to prevent than to cure.” [Man, 18–30, Buyer, FGD, Ghana]

“Sex just happens, its unpredictable, you could not predict it. So, it is better it is just home or in your handbag wherever you go, and that is not a problem. And if you have the finance supporting you, then you can buy as many as possible. Besides you might never know, maybe just you neighbour or friend comes to say I need your help. So, like buying multiple doses at home is not a problem.” [Unmarried woman, 18–24, User, FGD, Zambia]

To further gauge attitudes toward using ECPs as an on-demand method, participants were asked if they themselves or members of their community would be interested if multi-packs of ECPs (several ECP doses provided in one pack) were available. Many participants expressed interest in the multi-pack because purchasing ECPs this way would allow them to be always prepared. The preparedness mindset was common among users of ECPs, particularly men of both countries, as they stressed the benefits of being able to maintain a state of preparedness by having the method already on hand.

While ECPs were seen to have a variety of benefits, responses indicate the negative attitudes toward them as an on-demand method largely originate from beliefs about the method’s hormonal content and perceived side effects. There was a wide range of beliefs regarding the side effects
experienced when taking ECPs in a one-time instance, but there was a consensus across all sub-groups that frequent use of ECPs could lead to severe health problems. “Frequent use” was defined differently by different participants (definitions ranged from taking ECPs more than twice a month to more than once a year) so that even those that claimed they used ECPs as a regular method or their main method might reject the notion that they were frequent users.

The perceived negative consequences of hormones led many not to use ECPs at all, or only use ECPs in emergencies. Many non-users of ECPs, across sub-groups, expressed that fear of side effects was one of the main reasons they did not use the method. An overwhelming majority of participants were concerned about the level of hormones in ECPs and other contraceptive methods more generally. Many feared the lasting repercussions of long-term use of hormonal methods, such as destruction of one’s reproductive system or womb, alteration of one’s menstrual cycle, and infertility.

“Those are hormones you know, and when one takes them they change the hormone set up in the body, and if you take them a lot your body won’t know what’s normal and what’s not normal thereby destroying yourself in the process destroying your body make up of hormones and it may create another problem.” [Married woman, 25–34, User, FGD, Zambia]

While most participants agreed that hormones were dangerous, there was disagreement as to whether ECPs or other contraceptive methods were more likely to damage one’s system. Some felt that other methods had higher hormone levels and that relying on these methods for long periods of one’s life could lead to damage. Condoms were often recommended by participants in order to avoid using hormonal methods regularly. Some felt that one could use ECPs only in rare emergency cases. Many participants used the calendar method to avoid using a regular hormonal method. These women expressed a preference for the “natural” methods and tracked their “safe” days and “danger” days. ECPs were a desirable method for these women as it gave them a back-up option if they had intercourse during their unsafe period. Both married and unmarried Ghanaian women were more likely to use fertility awareness and combine the calendar method the with use of ECPs than Zambian women.

Participants reported the myth commonly believed, that frequent ECP use leads to the destruction of one’s womb, and that community members believe that taking ECPs is equivalent to having an abortion.

“You should be going around sensitising people so that people know the correct information by doing this you are going to help a lot of people who find themselves in my situation, this in turn will help prevent unwanted pregnancies because there those who are against ECPs because they feel you are promoting abortion so if you gave them the right information they will get to understand the importance of ECPs.” [Married woman, 18–35, User, IDI, Zambia]

Participants reported a variety of other myths as well. They were generally unclear on how ECPs prevented pregnancy. Common beliefs included that the ECPs have a high acidity which destroys sperm, or that ECPs cause the sperm to “flush out” of the system (e.g. ECPs wash away the sperm, and ECPs cause one to urinate out the sperm). There were also many misunderstandings surrounding side effects that affect menstruation, such as reports that ECPs cause constant bleeding after taking.

“I think you using it several times is going to affect her, because the pill is taken in to react toward the sperms. And as it is reacting, it tries to kill sperms. And I believe it contains some acidic substance which if care is not taken may pour on the flesh in the womb. And as it keeps on reacting. And the time that she will begin to have a child, it will affect her on that side and or something.” [Man, 18–30, Buyer, FGD, Ghana]

“I didn’t want to continue using emergency pill each time I had sex. It’s not advisable you can have side effects, you can have prolonged period, ectopic pregnancy, where the fetus stays lodged in a wrong area. So those are some of the side effects of ECPs if you are using them on a daily basis.” [Married woman, 18–30, User, IDI, Zambia]

“It’s just the bleeding that I know of. The kind of bleeding that doesn’t seem to end such that when your husband misses you and he comes again, he finds that you are on your period, he comes again and finds that you are on your period, those are
cases where your man finds another woman to help him satisfy his needs, so, that is what happens when you continuously take them. You will be bleeding continuously and in the end, your man leaves you.” [Married woman, 18–24, User, FGD, Zambia]

Overall, while some participants were afraid of ECPs due to potential consequences, most felt they were or would be able to take ECPs while keeping these warnings in mind.

“I think [ECPs users] would be willing to pay for a package of multiple doses of ECPs, looking at the fact their spouses are usually away, and it can be best that they buy and stock these pills so that they will not have to be visiting the pharmacy or the health clinics frequently whenever their husbands come home. But when you look at it the concept of these ECPs I think they were specifically made for the purpose of emergency situations. So, for it to be sold in multiple doses, it’s going to cause a situation where people will just be taking it whenever they have unprotected sex, so it could be today and the next day which follows and that is going to cause an effect on the people consuming the ECPs this way. So [I] am saying women would be willing to buy, but I don’t think that could be a right move.” [Unmarried woman, 18–24, Non-User, FGD, Zambia]

Anticipated stigma among users of ECPs is much higher than experienced stigma, except among young women

“I normally don’t like buying these from the pharmacy in my area so that people will not have much to say about me … I don’t want the pharmacist to see me and say that I am a spoilt girl … But some time ago I bought it here because it was an emergency and I thought the person will not be nice, but interestingly the person was very nice. So, my expectations were that I thought the person will be rude, but I didn’t get any of that.” [Unmarried woman, 18–35, User, IDI, Ghana]

When describing purchasing experiences, users of ECPs rarely reported experiencing stigma when procuring ECPs. Participants reported feeling nervous, scared, or shy, expecting stares from others and rude providers prior to procuring ECPs for the first time, but very few ended up having the unpleasant experience they feared. Most women from both countries reported procuring ECPs from pharmacies or drug stores and found pharmacists and drug store staff to be generally nice and helpful and, though they often did not provide counselling, sold ECPs quickly and quietly without passing judgement. Participants would report a history of procuring ECPs from another community, sending partners, friends, or children to procure or other tactics due to fear of stigma, but realised that their local procurement experience would be stigma-free once they actually did it.

“I am scared of the clinic although I have never gone there for such an issue, but from what people say, I am told that people are not treated well at the clinic especially young women like me. However, at the pharmacy it’s strict business I hand over the money then am given the pill there are no explanations involved as compared to the clinic.” [Unmarried woman, 18–35, User, IDI, Zambia]

Participants noted, however, that young women would be likely to experience stigma procuring ECPs. Participants from Ghana and Zambia, across sub-groups, warned against procuring from the clinic as young people would likely be treated poorly for being sexually active before marriage. They cautioned that providers might even have young patients leave the clinic without providing them with any method.

“If she goes to the government clinic or hospital, she will be treated as if or meant to feel guilty. Make her feel like what she is doing is wrong because she is about to get pregnant. They will make her feel like she is killing a baby. If she goes to the pharmacist, she won’t even have those intimidations because they will consider as a customer, and they won’t bother to ask whether she is married or why she wants to buy ECPs. That is none of their business.” [Unmarried woman, 18–24, User, FGD, Zambia]

Zambian participants were more likely to obtain ECPs from a clinic than Ghanaian participants due to ECPs being more widely available in Ghanaian pharmacies. The participants from Zambia suggested that unmarried individuals who go to procure ECPs from the clinic would likely face judgement. Providers would “shout” at patients for being sexually active before marriage and would be unlikely to provide them with ECPs or contraception as they would encourage them to continue to “misbehave”. Some Zambian participants also reported that if someone went to the clinic to procure alone as a single person, they would be sent away to come back with
their partner, so that way the provider could talk to both of them and educate them on side effects and the dangers of frequent use of ECPs. Unmarried individuals were encouraged to procure ECPs from pharmacies and drug stores to avoid stigma.

R1: In a chemist they will treat you well because they know that you will give them money they will even explain to you, but at a government clinic, they can be hostile, they can even shout at you that you didn’t know, you can even get scared of going there but –

R2: I would encourage her to go to a private clinic cause they will encourage you when you come to the government clinic they will shout at you that why didn’t you know before you had sex, you were supposed to know all those things like that. So a private clinic is better because they care for you very much

R3: Yes they will care for you but sometimes their care is not genuine, because with a private clinic you have to leave some money they won’t tell you that go there they won’t tell you that these things that we have given you they won’t work even if you have gone there after many hours, the fact is that you will buy these things whether you take them in the right way or not, I personally don’t like the private cause they give extra ordinary care which is not even correct

R1: The reason why we go to the government clinic is because even if they shout at you at the end of the day they will give you because you don’t have money

R4: The reason why we go to the government clinic is because we sometimes find nice nurses who have good hearts and those that don’t have good hearts they can know how to handle you when you explain to them they can help you depending on your situation

[Unmarried women, 25–34, Non-Users, FGD, Zambia]

A noted benefit of the ECP was that it gave young women a contraceptive option that they could procure outside of a clinic setting where they might face barriers procuring any contraceptive method. At the pharmacy, however, a young person might run into barriers, depending on how provider biases might influence the interaction, but overall participants felt this scenario was less likely in a pharmacy setting.

“Sometimes when [pharmacists] look at your face and it doesn’t look matured enough they will not sell it to you. They will sack you.” [Unmarried woman, 18–24, Non-User, FGD, Ghana]

While participants rarely experienced stigma from use of ECPs, despite the strong prevailing notion that they would, fear of community judgement meant that ECPs are infrequently discussed, and individuals often hide their use of ECPs from others. Many recommended avoiding the procurement of ECPs at a clinic or travelling to a pharmacy outside of their community to prevent other community members becoming aware of their ECP use.

Both men and women worried that if they kept ECPs on their person, in a wallet or bag, that others might see and judge them as “sexually addicted.” Participants felt that ECPs are still a private topic of conversation that many will have with close friends, family, or peers, but won’t talk about broadly for fear of what others might say.

Participants also expressed concerns surrounding the addition of a multi-pack to the market. Although ECPs are valued as a method that can be used only when needed, participants in both countries, both women and men, felt that the introduction of the ECP multi-pack could lead to abuse. They believed having multiple doses of ECPs on hand could tempt women to have more frequent unprotected sex and take ECPs each time, suggesting that certain types of stigma around ECPs continue to be deep-seated.

Discussion

Overall, the findings that emerged from this research suggest that positioning ECPs as both an on-demand and back-up method, while reassuring users of ECP’s safety when used frequently as their primary method, would be important steps to expanding informed access to a unique and important contraceptive option. A key theme to emerge from our research in both Ghana and Zambia was that ECPs are trusted and preferred over other contraceptive methods as an easy, effective option, despite concerns about side effects and many widely believed myths. Similarly, in the DRC, study participants
favoured ECPs over oral contraceptive pills, citing it being easier to use and less likely to be forgotten. Likewise, in Keesbury et al.’s study, over half of respondents in Kenya preferred ECPs to other short-acting methods. Participants in our study said they value having ECPs on hand if intercourse occurs and for this reason, many like the idea of multiple doses of ECPs sold together.

A second key theme to emerge from the data in both Ghana and Zambia is that ECPs are valued as an on-demand method, particularly for women and men who might be having infrequent sex and do not see the value in using a daily method. Our findings add to the growing evidence that many women prefer and are often already using ECPs as a regular, on-demand contraceptive method. In Raymond et al.’s review, the authors concluded that there is a global demand for on-demand contraception. A 2018 study focused on Albania identified that women using ECPs are largely repeat users.

While participants in our study who have infrequent intercourse were attracted to the ECP’s on-demand benefits, citing only needing to take the method when one has intercourse as a benefit, many also feared that repeated use of ECPs could have harmful health effects and believed common myths about the method. This finding is consistent with other studies that provide evidence of the prevalence of ECP misinformation such as Keesbury et al. who found that 70% of Kenyan respondents thought that ECPs were more convenient than other methods, yet many also expressed fear of infertility and the incorrect belief that ECPs are a form of abortion. A significant portion of participants in our study feared that the ECPs multi-pack would lead to ECPs “abuse” (as defined by individuals’ perception of how often was too often), by leading women to have more frequent or unprotected sex and take ECPs each time. The negative perception of repeated ECP use is a consistent finding across studies, yet there is no evidence to support this view and the WHO has put no restrictions on repeated ECP use. Additionally, despite favouring frequent use, the majority of participants in Ghana and Zambia doubted ECP safety if used more frequently than what is believed to be recommended, fearing the high hormonal content could lead to severe health problems. In the Rokicki et al.’s study, young women in Ghana reported fearing long-term side effects when ECPs are used repeatedly.

The third major theme to emerge from the data is that anticipated stigma among ECP users is much higher than experienced stigma, except among young women. ECP users across both countries rarely experienced stigma when procuring ECPs, particularly in pharmacies, and generally found pharmacists and drug shop staff to be helpful. Counselling was often not provided but this was not the attribute that caused consumers to return and recommend friends and family to a certain pharmacy; instead, they valued quick service and discretion. This finding is in line with the global body of evidence supporting access in pharmacies (typically in the private sector) as a driver of increased ECP access in a community. The privacy and confidentiality that the method affords are important to consider when seeking ways to expand sexual and reproductive health and rights for vulnerable populations.

Participants in our study strongly suggested that young people would experience stigma procuring ECPs and reported being mistreated for seeking contraception before marriage, especially in a clinic setting, a finding reflected in other studies. For example, in a survey among health care providers across service delivery points in Senegal, providers reported hesitancy to provide ECPs to young people and married women. Similarly, in a multimethod qualitative assessment of ECP provision and use on the Thailand–Burma border (2015), researchers found that concern surrounding the abuse of ECPs was a barrier to method provision, and that health care workers had concerns and a knowledge gap around repeated use of ECPs, especially among adolescents. In our study, barriers for young women were perceived to exist at the pharmacy related to age restrictions and how a pharmacist may or may not enforce these restrictions, especially by physical appearance. This finding points to stigma when procuring ECPs as an important factor to mitigate in efforts to support adolescent ECP use. It also suggests that repositioning ECPs as an on-demand method that adolescents use as their primary method and not solely when a perceived “mistake” has occurred may help to reduce the stigma associated with ECP use, thereby allowing this vulnerable population to access contraception more freely.

Our findings signal that ECPs are often valued over other more widely used short-acting methods for their unique attributes and deserve a place...
alongside oral contraceptive pills and injectables as an on-demand, short-acting method. These results also suggest that women, including young women, would benefit from accurate information about ECPs so that they can be confident in their reproductive choice. Communication messages would best respond to ECP users’ needs by encouraging the view that frequent users of ECPs are engaging in safe, responsible behaviour that will not harm their future fertility. Because the majority of ECP users are typically young and may be more likely to use an on-demand contraceptive product, it is particularly important that ECP communication directed towards pharmacists and drug shop staff supports repeated use among young women as a safe and responsible choice.

There are several important limitations that must be considered when interpreting these findings. This qualitative study collected data from communities in Accra, Ghana and Lusaka, Zambia and may not be transferable to less urban areas. However, the consistency of findings across these two different urban areas suggests that these findings may be similar among other urban populations and that these findings would do well to inform ECP programming and service delivery in different urban contexts. Additionally, although the vignettes were used in the FGDs to understand social norms around ECPs, inevitably participants reflect on their own situations in response to the vignettes and may not be representative of wide social norms. We also note the power dynamics that exist between interviewer and respondent and between respondents themselves in a group discussion and that for sensitive topics, such as use of ECPs, social desirability bias may influence what a respondent says or the information they choose or do not choose to share. For example, while we find low levels of experienced stigma when procuring ECPs, it may be that respondents were reluctant to share their experience if others in the group were sharing an opposing experience. And, particularly in this study, we ask about the repeat use of ECPs, which may be seen as a stigmatised practice. The use of the vignettes in the discussion guides tried to address this so that participants did not have to divulge any personal experiences. And finally, while the study includes both women and men, a deeper gender analysis was outside the scope of this manuscript but may reveal important insights and should be considered for future research and analyses.

The study has several strengths of note as well. In both Ghana and Zambia, the robust sample size ensured that saturation was reached and that the varying views of women and men in these Ghanaian and Zambian communities were well represented. The themes emerging from the data were largely consistent among both participants from Ghana and Zambia, despite their different contraceptive and service delivery contexts. The study included women as well as men, who are important influencers of use and purchasers of ECPs, and included both unmarried and married women to understand the diversity of perspectives that may be influenced by marital status, particularly for a contraceptive method like ECPs.

**Conclusion**

As the WHO recognises in its *Consolidated Guide-line on Self-Care Interventions for Health*, self-care sexual and reproductive health interventions have the potential to increase choice and provide individuals with informed decision-making opportunities. The results of this study, from two very different contraceptive contexts and where knowledge of, and thus likely, use of ECPs differs, strongly suggest that positioning ECPs as a primary, on-demand method provides a unique opportunity to support self-care as a viable contraceptive approach while advancing decision-making autonomy in sexual and reproductive health.

The onus is therefore placed on all reproductive health care actors (e.g. health workers, providers, health systems, implementing organisations, regulatory bodies, and manufacturers) to support women and young people to access information currently unavailable to them. Manufacturers are called upon to conduct the clinical trials needed to change ECP product labels so that current science around repeat use is reflected, while Ministries of Health and national regulatory agencies are called upon to create pathways to on-demand use, adapting guidelines to respond to clinical best practice as is common in the medical field. Repositioning ECPs as an on-demand method could not only tangibly advance reproductive autonomy and choice for women, young
people and vulnerable populations, but would also respond to the most important stakeholder, the contraceptive user.

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Résumé
Aider les femmes à utiliser des pilules contraceptives d’urgence (PCU) comme contraception de secours, mais aussi régulière, à la demande, peut augmenter les options contraceptives autogérées et l’autonomie contraceptive, en particulier pour les populations vulnérables. Les PCU sont actuellement réglementées pour être utilisées dans une situation "d’urgence" ; néanmoins, quelques données semblent indiquer que les femmes apprécient aussi cette méthode comme option régulière, à la demande, qu’elles utilisent pour éviter une grossesse avec confiance et prévoyance. Les croyances et les attitudes à l’égard des PCU et de leur utilisation à la demande ont été étudiées au cours d’entretiens approfondis et de discussions en groupe avec des femmes âgées de 18 à 34 ans et des hommes âgés de 18 à 30 ans à Accra (Ghana) et Lusaka (Zambie). Des guides d’entretiens structurés et des guides pour les discussions en groupe ont été employés pour explorer les normes, les connaissances, les attitudes et les comportements communautaires et sociaux. Les entretiens approfondis ont été analysés à l’aide d’un codage thématique déductif et les discussions de groupe ont été analysées au moyen d’un codage thématique inductif. Trois thèmes principaux ont apparu : premièrement, les PCU sont une méthode éprouvée et souvent préférée comme option facile et efficace. Deuxièmement, les personnes apprécient les PCU comme méthode à la demande, mais craignent pourtant qu’un usage répété puisse avoir des conséquences nocives sur la santé. Enfin, la

Resumen
Al apoyar a las mujeres en su uso de píldoras anticonceptivas de emergencia (PAE) como método anticonceptivo habitual o de respaldo a petición, es posible aumentar sus opciones anticonceptivas autogestionadas y mejorar su autonomía reproductiva, en particular en las poblaciones vulnerables. Actualmente, las PAE son reguladas para uso en situaciones de “emergencia”; sin embargo, cierta evidencia indica que las mujeres también valoran este método como una opción habitual a petición utilizada para evitar el embarazo con previsión y confianza. Se exploraron las creencias y actitudes hacia las PAE y su uso a petición en Acra, Ghana y en Lusaka, Zambia, por medio de entrevistas a profundidad y discusiones en grupos focales con mujeres de 18 a 34 años y hombres de 18 a 30 años en Acra y Lusaka. Se utilizaron guías de entrevistas estructuradas y guías de discusiones en grupos focales para explorar los conocimientos, normas, comportamientos y actitudes sociales y comunitarios. Se analizaron las entrevistas a profundidad utilizando codificación temática deductiva y las discusiones en grupos focales utilizando codificación temática inductiva. Surgieron tres principales temáticas: en primer lugar, las PAE son un método confiable y a menudo preferido como opción fácil y eficaz. En segundo lugar, las personas valoran las PAE como método a petición, pero temen que su uso repetido pueda tener efectos perjudiciales para la salud. Por último, el estigma previsto por las usuarias de PAE es
stigmatisation escomptée chez les utilisateurs des PCU est plus importante que la stigmatisation vraiment ressentie, sauf chez les jeunes femmes. D’après les conclusions que cette recherche a mises en avant, le repositionnement des PCU comme méthode adaptée à une utilisation à la demande serait une étape importante vers une réduction de la stigmatisation et de la discrimination qui y sont souvent associées, tout en élargissant l’éventail d’options contraceptives autogérées disponibles pour répondre aux différents besoins des femmes, des jeunes femmes et des populations vulnérables.

major que el estigma sufrido, salvo entre las jóvenes. Los hallazgos que surgieron de esta investigación indican que el replanteamiento de las PAE como idóneas para uso a petición sería un paso importante hacia reducir el estigma y la discriminación generalmente asociados con el método, a la vez que se amplía la gama de opciones anticonceptivas autogestionadas disponibles para satisfacer las diferentes necesidades de las mujeres, las jóvenes y las poblaciones vulnerables.