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IS EMERGENCY CONTRACEPTIVE ACCESSIBILITY A BARRIER IN DEVELOPING COUNTRIES? A REVIEW

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ABSTRACT: Significant portion of maternal death in developing countries was attributed to induced abortions secondary to unwanted pregnancies. Using emergency contraception as a backup method can contribute to reduce unwanted pregnancy secondary to method failure, contraception non-use and also rape. The need for emergency contraception is clearly demonstrated by the occurrence of unwanted pregnancy and induced abortion. If emergency contraception were easily available and distributed through clinics and non-clinics channels along with appropriate advocacy activities millions of unwanted pregnancy and abortions could be averted. There is a growing concern about the prevention of unintended pregnancy and unsafe abortion to minimize maternal death and this review concentrates on accessibility barriers related to emergency contraceptives that limit its use among women of reproductive age groups.

INTRODUCTION: Unintended pregnancy is a worldwide problem that affects women, their families and the society as a whole which can result from contraceptive non-use, contraceptive method failure and less commonly from rape. Induced abortion is a frequent consequence of unintended pregnancy and can cause serious negative health effects, permanent disabilities and even maternal death. Regardless of the cause, unintended pregnancy and its negative consequences can be prevented by access to contraceptive services, including emergency contraception and by respecting the contraception conventions as well as by respecting the rights of women [1, 2].

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Worldwide more than a quarter of women who become pregnant have either an abortion or an unwanted birth [2]. In developing countries of the 182 million pregnancies occurring every year, an estimated 36% are unplanned, and 20% end in abortion. Of the estimated 600,000 annual pregnancies related deaths worldwide, about 13% (78,000) are related to complications of unsafe abortion [2]. In 2000, there were 19 million unsafe abortions worldwide and there were an estimated 30,000 deaths due to unsafe abortion [3, 4].

In about half of all unwanted pregnancies, conception occurs despite the use of some sort of contraception due to inadequate guidance to use contraception effectively, including addressing feelings, attitudes and motivations of users. One solution to decrease unwanted pregnancy after the occurrence of unprotected sex secondary to contraception non-use, contraception method failure and rape should be familiarizing clients and also

providers about emergency contraception methods [5, 6]. However, accessing EC precedes all other factors that have to be addressed seriously by policy makers and suppliers. In this regard barriers related to accessing emergency contraceptives were addressed in this review

Operational terms:

1. **Emergency contraception (EC):** Refers to the contraception methods that can be used by woman in the first few days following unprotected intercourse to prevent unwanted pregnancy.

2. **Unwanted pregnancy**: Is a pregnancy that has occurred when the woman doesn't want to have children, which may be because she already had the desired number of children or it mayn't be time.

3. **Mistimed (unplanned) pregnancy**: Is pregnancy which was unwanted during the time of conception. But, it doesn't imply unwanted or unloved child.

4. **Knowledge**: Knowledge of EC is awareness of the presence of contraception methods after unprotected sex, its sources and ability to identify when EC should be taken after unprotected sex, its side effect, its effectiveness, and whether it is effective after a lady has amenorrhea.

5. **Attitude**: Attitude is the study subject's opinion, outlook, position or ideas toward emergency contraceptive methods In what circumstances do users and providers feel EC is appropriate (in case of unprotected sex, contraceptive failure/condom breaking, rape)? Are there particularities about EC support of EC use for adolescents or particular scenarios when EC is deemed appropriate for adolescent use? Do users and providers believe EC increases promiscuous behaviors of its users? What are provider opinions and attitudes about repeat or routine use of emergency contraception?

6. **Practices:** have users ever got and used EC? Have providers ever distributed emergency contraception or EC-related counseling? Are they currently offering EC? How frequently are providers prescribing or selling EC?

Methods: To ensure a comprehensive collection of documented research, clear and concise steps were followed in searching and aggregating findings from the literature on access related barriers for emergency contraceptives. Starting from April 2012, a key word search of Google Scholar databases was conducted for identifying peer-reviewed relevant literature publications on terms like emergency contraceptives accessibility and providers to emergency contraceptives. The timeframe of articles selected for inclusion was between 1998 and 2011.

Findings: A total of 45 articles were included from Google Scholar database searches.

EC access and providers: As is common for any contraceptive method, EC access is a complex picture, with variables and influences affecting supply and demand, legality and regulations, as well as awareness and support among all stakeholders. Local and national policies affect EC availability by regulating whether public sector facilities are allowed to provide the method, as well as whether providers are trained on correct provision [7]. Ministries of Health revealed that, although EC is available in 80 percent of countries, only 46 percent of responding countries reported EC offered through public sector facilities [8]. In addition to regulating policies, religious, social and cultural influences affect provider beliefs and behaviors, and vary significantly across regions [7].

In Latin America, dedicated EC products are marketed in some countries, through public and private markets. Oral contraceptives are available in most Latin American countries, many times accessible over the counter, and other times requiring a prescription [7]. The prevalence of conservative cultural and religious norms affect service delivery policies, and EC provision is generally restricted to cases of rape or sexual assault. Social marketing activities in the early 2000s increased general awareness and distribution in Venezuela, Bolivia, Peru, Ecuador, and Argentina [9], and additional movements for improving restrictions on reproductive health products and programs are underway.

Across Africa, EC access is steadily increasing, with many governments integrating EC in national family planning service delivery policies and guidelines, and offering the method within public sector services

[7]. In Ethiopia, although NGO sector play a major role in addressing the demand for EC, NGOs accounted for only about 15 percent of all family planning services delivered. For most Ethiopians, therefore, EC still remained inaccessible: its provision did not appear in the standard training curricula for nurses, midwives, or other front-line health care workers, and no dedicated EC pills were available in the country. Access is increasingly focused on distribution through private market delivery mechanisms including pharmacies and medicine shops [10]. In Kenya, private sector pharmacies account for as much as 94 percent of EC sales [11]. A broad range of dedicated products are available across the continent, yet myths and misconceptions in the media have played a significant negative role in EC awareness and public approval. In Uganda, negative media actually resulted in illegalization of a once-approved EC method [12].

EC access across Asia depends greatly on product legality and registration and individual countries' incorporation of EC within national systems, as well as availability within private markets. India approved EC use in 2001, and multiple dedicated products are now available freely in government dispensaries, private markets, and pharmacies [7].

Many researches consulted in this review highlighted that EC access for most developing countries is still remain to be an important barrier besides provider and user related factors. When EC is supported by the government and well-known by the people attitudes tend to be more supportive to its utilization and distribution, yet hesitations and questions continue to raise concern among providers, policymakers, and women themselves [13, 24].

External influences, such as EC's legal status and policies regulating cadres of providers, dispensing the method, or requirements for prescription, certainly affect availability. Of greater interest now is identifying evidence of successful and efficient models reducing the various barriers to access and the most effective methods to overcome them, in order to ultimately increase access to emergency contraception around the world [15].

CONCLUSION: Based on those articles consulted in this review, it is possible to conclude that EC access to developing nations has not yet been fully succeeded.

However, barriers related to providers and users remain to be important factors for lower availability and utilization of emergency contraceptives among developing countries.

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