Stakeholder and Provider Views Regarding Pericoital Contraceptive Pills in India and Uganda

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The development of pericoital contraceptive pills is under consideration to address unmet need for family planning, especially among women who have infrequent sexual intercourse. Pericoital pills, an oral contraceptive taken 24 hours before or after intercourse, would be a potentially desirable contraceptive option because it could provide convenience, discretion, and female control over contraceptive use. To gauge receptivity to pericoital contraception, a total of 49 in-depth interviews and 5 focus group discussions were conducted in India and Uganda with family planning providers and stakeholders. In India, the method was seen as filling a demonstrated need, based on perceived widespread and/or repeat use of emergency contraceptives. In Uganda, where emergency contraception has met strong opposition from conservative and religious leaders, respondents were more skeptical about the merits of the product. In both settings, using condoms consistently and taking oral contraceptives daily present challenges for consistent use, thus a new contraceptive method that is easy to use and under female control is likely to be appealing. (Studies in Family Planning 2013; 44[4]: 431–444)

Method choice—the number and variety of methods available—is considered one of the six fundamental elements of quality of care (Bruce 1990) and is a longstanding tenet of family planning best practice. Offering women a broad array of methods is associated with increases in overall contraceptive prevalence and decreases in contraceptive discontinuation (Jain 1989; Steele and Curtis 2003). At the heart of the commitment to expanded method choice is the recognition that what a woman desires and needs regarding a contraceptive method varies over her reproductive life course. Choice of method may change when a women marries or bears a child, when she separates from her husband as a result of migration, divorce, or death, or simply with aging as she experiences a natural decline in coital frequency. Introducing new contraceptive technologies that fit

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the diverse needs of women and couples over the life course reflects a commitment to the expansion of method choice.

Pericoital contraceptive pills—also known as “on demand” or “real time” contraceptives—are being considered for development to expand the method mix. This method may be especially appealing to women who have an unmet need for family planning and who are sexually active fewer than seven times per month. A substantial proportion of women in developing countries who have an unmet need for family planning cite “infrequent sex” as the reason for not practicing contraception. Depending on the country, 6–39 percent of women with unmet need in sub-Saharan Africa and 14–35 percent with unmet need in South and Southeast Asia do not use contraceptives because of the infrequency of their sexual activity (Sedgh et al. 2007). One study of unmet need in Southeast Asia, South Central Asia, and sub-Saharan Africa found that approximately one in four adolescent women (aged 15–19 years) with unmet need are not using a method because they have sex infrequently (Darroch, Sedgh, and Ball 2011). Among women who have sex infrequently, an oral contraceptive that is taken only at the time of intercourse may offer advantages over other methods with regard to convenience and ease of use. These advantages, together with discretion and female control over contraceptive use, may make the method appealing to other women as well. If such a method were introduced, women could take the pill within about 24 hours before or after intercourse.

The similarities between pericoital contraception and emergency contraception (EC) are that both methods are timed with instances of coitus and may employ the same active ingredient. A dedicated pericoital contraceptive product would, however, be labeled as a routine contraceptive method and marketed for use within 24 hours before or after sexual intercourse. Although repeated use of EC (containing levonorgestrel [LNG]) does not pose any known health risks, EC is not labeled for routine use or for use prior to sexual intercourse (WHO 2010). The recommended maximum number of administrations of pericoital pills per month will depend on its efficacy and side-effects profile, but an ongoing WHO clinical trial of pericoital contraception (using 1.5 mg of LNG) defines the appropriate coital frequency for study participants as six or fewer times per month.

Some women are already using EC off-label as an on-demand pill, suggesting latent demand for pericoital contraception (Lerkiatbundit and Reanmongkol 2000; Opoku 2010; Keesbury, Morgan, and Owino 2011). A survey of women in urban Nigeria revealed relatively regular and consistent EC use; women using EC did so on average five times during a six-month period (Chin-Quee 2012). Moreover, a study of Kenyan EC users found that those who have sex on a less frequent basis are particularly likely to use EC as their regular method (Keesbury, Morgan, and Owino 2011). These studies suggest that women have adapted an existing method to meet their need for a contraceptive method that is female-controlled, self-administered, and coitally related without interrupting sexual activity.

To assess consumer perspectives regarding a dedicated pericoital contraceptive product, we conducted a qualitative study of women and men in Kampala, Uganda and Lucknow, Uttar Pradesh, India and found that they were generally receptive to the concept of pericoital contraception (Cover et al. 2013). In particular, women embraced the idea of a female-controlled method that is less burdensome to use than a daily oral contraceptive, can be taken before or after sexual intercourse, and, especially in the Ugandan context, can be taken without a partner’s

knowledge. Most men also had a positive response to the method but asked more questions and expressed more concerns. Although these findings are promising for potential method introduction, understanding how receptive Ugandan and Indian family planning stakeholders and service providers would be to such a method is crucial for potential method introduction.

The family planning environment differs in the two countries, particularly regarding contraceptive prevalence, method mix, and supply source. In Uganda, modern methods are used modestly (26 percent), permanent methods (sterilization) are used minimally (3 percent), and injectables dominate the modern method mix (14 percent) among currently married women (UBOS and ICF International 2012). Seventy percent of married women are currently not using any method and 4 percent are using a traditional method. Nearly half of all contraceptive users (47 percent) and oral contraceptive users (46 percent) in Uganda rely on the public sector as their source of supply. In contrast, the modern contraceptive prevalence rate for married women in India is much higher (48 percent), permanent methods dominate the method mix (37 percent), and most couples using nonpermanent methods use condoms (5 percent) or traditional methods (8 percent). In general, Indian women wishing to space births tend to use methods that require male involvement (condoms, periodic abstinence, or withdrawal). The dominance of permanent contraception in the method mix results in Indian women's heavy reliance on the public sector for their source of supply (71 percent), given that approximately 84 percent of sterilizations take place there. Only 15 percent of oral contraceptive users in India rely on public sector sources (IIPS and Macro International 2007).

Policymakers' receptivity to EC also differs considerably in the two countries. When introduced in Uganda in 2001, EC faced enormous backlash because it was perceived as an abortifacient (New Vision 2001). (Abortion is illegal in Uganda except in instances where a woman's life is endangered.) EC is available in the private sector under the brand name Postinor 2, but resistance from conservative and religious leaders led to the banning of advertisements for the product. Although EC in Uganda is available only by prescription, women are able to procure the pill over the counter in private pharmacies.

In India, levonorgestrel was approved in 2001 for use as EC. Although originally available only by prescription, in 2005 EC was approved as an over-the-counter drug. EC is marketed by a variety of manufacturers in India and is available in more than 40 brands, with Unwanted-72, I-Pill, and Unwanted holding nearly 90 percent of the market share (Khan 2011). Access to information concerning EC has not been completely unimpeded. Advertising of EC was temporarily banned in India in 2010 in response to concerns regarding possible misuse or overuse, prompting the development of new advertising guidelines. EC use among women has increased substantially in recent years. Sales data suggest a tripling in sales between 2008 and 2010, from 5 million to 15 million packets sold (Khan 2011). The differing receptivity toward EC in India and Uganda is important for understanding how providers and stakeholders view the introduction of pericoital contraception.

This article details the challenges and opportunities of pericoital contraception introduction. We conducted a qualitative study of stakeholder and service provider perceptions in India and Uganda. We selected one country in South Asia and one in sub-Saharan Africa to achieve regional variation. India was chosen because of its vibrant commercial market, including a market for oral contraceptives and EC, and the potential to partner with local manufacturers

on production and distribution. Uganda was selected because of the dominant role the private sector plays in the provision of oral contraceptives and because of the recently renewed commitment to family planning by government leaders. Our intent was to assess the general appeal of and perceived need for pericoital contraception among these groups and to explore possible distribution channels. To that end, we conducted focus group discussions (FGDs) and in-depth interviews (IDIs) with family planning providers from the public, private, and retail sectors, and IDIs with senior-level family planning stakeholders.

METHODS

To assess potential receptivity within the service delivery environment, we recruited family planning providers who directly interface with consumers. We sampled purposively to reach a broad spectrum of providers from both public facilities and the private sector—including NGOs and commercial outlets such as pharmacies—in Lucknow, Uttar Pradesh, India, and Kampala, Uganda. All providers who were invited to participate agreed to do so, although some in India requested permission from supervisors (which was sought and secured). Table 1 presents the number and type of interviews conducted in each country. In Uganda, family planning frontline providers participated in a total of 7 IDIs and 5 FGDs.[1] In India, all 10 interactions with family planning providers took the form of IDIs. Across the two country settings, 7 IDIs with family planning providers were conducted with pharmacists, 16 IDIs or FGDs were conducted with private-sector providers or NGO staff, and 45 IDIs or FGDs were conducted with public-sector providers (see Table 1).

TABLE 1 Number of participants, by occupation, according to country and mode of data collection, India and Uganda

	India	Uganda			
Occupation	IDI	IDI	FGD [a]	Subtotal	Total
Family planning provider	**10**	**7**	**51 (5)**	**58**	**68**
Pharmacist	4	3	0	3	7
NGO/private provider	4	4	8 (1)	12	16
Public provider	2	0	43 (4)	43	45
Key opinion leader	**10**	**21**	**0**	**21**	**31**
Donor representative	1	2	0	2	3
MOH planner/policymaker	1	6	0	6	7
Researcher	1	1	0	1	2
NGO/CSO/SMO representative	5	5	0	5	10
Professional association leader	0	1	0	1	1
University leader	2	1	0	1	3
Youth-serving organization employee	0	4	0	4	4
Parliamentarian	0	1	0	1	1
Total	**20**	**28**	**51 (5)**	**79**	**99**

IDI = In-depth interview. FGD = Focus group discussion. NGO = Nongovernmental organization. MOH = Ministry of Health. CSO = Capacity strengthening organization. SMO = Social marketing organization.
[a] Number in parentheses is number of focus group discussions conducted.

1 Where possible, the FGD approach was followed in Uganda (especially with public-sector providers) to maximize the number of participants, but in some instances conducting an in-depth interview was more practical. In India, FGDs were not perceived to be an appropriate approach for providers.

To assess the policy environment for method introduction, we conducted 21 IDIs with key opinion leaders (KOLs) in Uganda and 10 in India, targeting a wide range of individuals representing organizations active in family planning. These individuals were also sampled purposively and included local donor representatives, planners and policymakers from the Ministry of Health in Uganda and the Ministry of Health and Family Welfare in India, department heads at biomedical research organizations and universities, and representatives of social marketing and nongovernmental organizations, among others. All KOLs who were invited to participate agreed to do so. Participants in India were based in Delhi and Lucknow; those in Uganda were based in Kampala.

We developed discussion and interview guides that were consistent across the two settings. After pretesting in each country, we revised the guides to make them context-appropriate. Although some individual questions varied, the instruments addressed the same themes in both countries. Key opinion leaders and providers were given an overview of the concept of pericoital contraceptive pills, and their perceptions of the method were elicited with the following introduction: "Suppose there was a pill that a woman could take up to 24 hours before or after she has sex—so this pill is only taken on days when a woman has sex, instead of every day. It would be intended for women/couples who are not having very frequent sex. What is your impression of that method?"

We trained field teams on the intent and purpose of the study, research ethics, and use of the guides, and they demonstrated mastery of interviewing, facilitating, and note-taking skills prior to initiating data collection. FGDs and IDIs were conducted in the language (English, Hindi, or Luganda) preferred by the subject(s). FGDs and IDIs were one to two hours in length; in most instances they were audio-recorded. In the event that informants were reluctant to be recorded, the interviewers took detailed notes.

Country teams compared information from each FGD and interview transcript with findings from the other discussions, to identify themes that resonated across similar groups or individuals or that were distinct to a particular individual or group. Information coding followed an inductive approach, with codes and themes evolving organically from the transcripts or notes.

After confirming eligibility and explaining the purpose of the study, signed consent was obtained. The researchers stressed the voluntary and confidential nature of the assessment at the time of recruitment and again at the start of each FGD or interview. The Lucknow Ethics Committee in India and the Institutional Review Boards at Makerere University in Uganda and the Ugandan National Council for Science and Technology granted research ethics approval.

RESULTS

Advantages of Pericoital Contraceptives Over Existing Methods

In both country settings, participants perceived that pericoital contraception offered women certain benefits: the ease of taking an occasional pill rather than a daily pill, better access via likely over-the-counter provision at pharmacies, and greater female control of fertility. Ugandan providers pointed out the distinct advantage of a pill that could be taken without a partner's knowledge.

> Because you do not have to go through the hassles of taking the pill every day, you do not have to go to the pharmacy for injection…. Anything that is user-friendly can be a good product. [KOL, medical research organization, India]

> It will be good. It will reduce the pill burden of swallowing every day and maybe you are not having sex every day.… This pill will help many women. [Public provider, Uganda, FGD]

> It will appeal definitely, because one of the drawbacks of OCs [oral contraceptives] is that clients forget. They forget one day and the next day they can have two tablets and then nothing…. Even literate people make mistakes, so I think this would be a very good thing. [Provider, NGO, India]

> In India, most women don't have the power in decisionmaking in when the couple has sex or if the husband is using a condom. So in those cases, it is a good option. [KOL, NGO, India]

> It can be used secretly…. It is going to empower the women whose husbands do not want them to use family planning. [Private provider, Uganda, FGD]

Expanding Method Choice

Some providers and stakeholders, particularly in India, observed that any method that increases the "basket of choices" available to women, prevents unplanned pregnancies, and increases family planning use would be a welcome addition to the method mix. Indian providers also observed that some women have adopted EC as a regular or routine method of family planning, suggesting that the need for a pericoital method exists.

> Any contraceptive that does not have very significant side effects is always useful for a woman.… The overwhelming majority of pregnancies in the country are unplanned.… Most sexual occurrences are unplanned.… So anything that provides an option of post-intercourse contraception is a good option. [KOL, NGO, India]

> I think this is how emergency contraceptives are being used right now; it is used 24 hours prior. So there seems to be an expressed need and I think that's evidence of that.… So, yeah, I think it fills in the gap. [KOL, NGO, India]

> [Pericoital contraception] will add to the product basket and will fill a gap.… [It] responds to key barriers as a woman does not need to go to the provider [if available over-the-counter]. Unmarried sexually active women are doing EC a lot already, showing an unmet need. [KOL, NGO, India]

In both countries, a few respondents noted that pericoital contraceptive pills could help reduce the number of unsafe abortions. In India, one respondent observed that EC is sometimes confused with abortion medication and that information and messages regarding pericoital contraceptives would need to be framed appropriately.

> I would be a promoter. I see the induced abortions, the perforated uterus. Anything that can reduce unplanned pregnancy without causing a lot of risks to the women is a welcome addition, because unplanned pregnancy causes death. [Ob/gyn, Uganda, IDI]

> Unsafe abortions have definitely gone down with the availability of medical abortion. Making this product available would definitely reduce the incidence of unsafe abortions in the country. [KOL, donor organization, India]

> EC pills are also confused with abortion pills. That needs to be addressed for this product as well. [KOL, NGO, India]

Skepticism Concerning Distinction between Pericoital Contraception and EC

Though some providers and stakeholders in both settings saw the advantages of pericoital contraception, the method was met with greater skepticism in Uganda. In particular, many Ugandan providers and family planning stakeholders did not see a distinction between pericoital contraception and EC and, therefore, saw limited need for a new method. Some individuals expressed specific concerns regarding this new use of EC. In India, only one or two individuals expressed the same reservation about EC already filling the niche for a pericoital contraceptive pill.

> The same as EC…; this time you are taking it before. That is all.…You are going to say use it before, the existing pill is use after. So what are the advantages of using it before?" [KOL, Ministry of Health, Uganda]

> It will be postcoital, it will not be pericoital.… Do you want to make Postinor [a brand of EC] a normal thing? It is going to be working as EC is working. [Pharmacist, Uganda]

> I am seeing like they are almost doing the same thing, but Postinor has advantages in that you take it when [sexual intercourse] has happened. However, the other one [pericoital pills], there are possibilities of even taking it and it does not happen.… [Pharmacist, Uganda]

> We are already having I-Pill and many others. So why are they introducing these? What is the reason for bringing this type of brand? [Provider, NGO, India]

A number of Indian providers observed the challenges of incorporating EC into the method mix as a regular contraceptive method, and recognize that pericoital contraception may fill a niche that EC does not. They stress the importance of marketing the method differently from EC. Ugandan stakeholders noted the importance of making the distinction between pericoital contraception and EC, but many seemed skeptical that a convincing distinction can be made, particularly in light of the reception that EC has received and the strong antiabortion sentiment in the country.

> This is far better from 72 hours method. The product which we are already having, we are not able to make it as a 100 percent usable product. Until the time that EC is included in the bigger system, we won't reach anywhere. [Provider, NGO, India]

> You need to do something different from emergency pills. There should be no confusion, or else people would think this is the same as emergency pills. The 24-hours-before feature—you need to highlight that part more. [Provider, NGO, India]

> The values of this place will not allow us to work directly with EC. We have not marketed EC. We do not want to be seen, especially by religious leaders, promoting EC. Most individuals view it as some other form of abortion. We have kept away from that. [KOL, marketing CSO (capacity strengthening organization), Uganda]

> People think EC is an abortifacient. Of course, if this pill is associated with abortion, it will be very difficult. [KOL, Ministry of Health, Uganda]

Concerns Regarding Effectiveness

Although the level of method effectiveness for pericoital contraception will depend on the dosage and active ingredient, we queried stakeholders and providers about the acceptability

of potential effectiveness that is lower than that of oral contraceptives but exceeds that of condoms. In both country settings, family planning providers were concerned about pericoital pill effectiveness, observing that a more effective daily pill might be replaced with one that will have a higher failure rate. A number of Indian participants noted that a new method having greater effectiveness than condoms would be advantageous and well received, and an Indian stakeholder observed that side effects, rather than effectiveness, influences method choice most. Finally, a few comments by providers suggest that they may not know how effective different methods are, or may not conceptualize effectiveness in statistical terms.

> I would be worried that we are replacing things which are well known to be very effective, a combined oral contraceptive with a failure rate of 0.5 percent, and then we replace it with something whose failure rate is much higher …, then we get many unwanted pregnancies. I am worried about that type of problem. [Private provider, Uganda, IDI]

> If you are a married woman on regular coitus, we would want you to use an effective method of family planning, which would not be an EC pill. [Ob/gyn, Uganda]

> [Effectiveness] between condoms and OCs is fine because many people use condoms for their entire reproductive lives. [KOL, NGO, India]

> Effectiveness is not a huge issue.… Women usually give primacy to side effects in making a choice. [KOL, Ministry of Health and Family Welfare, India]

> If it's less effective than OC, why would they prefer it? It should be 100 percent effective, otherwise there are many other good methods in the market. Why would people take this? It's our duty to guide the people properly. We are not here for experiments. If the method is not good, then people would stop coming to the hospital. [Public provider, India]

Concerns Regarding Potential Side Effects

For all contraceptive methods, trade-offs exist between effectiveness and side effects. Although providers express concerns regarding effectiveness, not surprisingly they want a product that has few side effects. Anticipating that pericoital pills will have a higher hormone dose than a daily OC pill, providers and some stakeholders predicted that the magnitude and nature of the side effects would deter consumers. Others observed that those who use the method more frequently than recommended would experience excessive side effects.

> My worry would be about the strength of the hormones. How come every day you are swallowing, and yet this one you are going to swallow once? Is it not going to be having the side effects of the usual ones we are having? [Public provider, Uganda, FGD]

> Her period would be very irregular and this would be a new problem for her, and they won't take this again. Even we won't promote this again and we would suggest contraceptives other than this. [Public provider, India]

> If there are no side effects, then it would be better [than existing pills]. The main thing is there should not be any side effects. If bleeding would be more, then we won't recommend it. But yes, in everything there are some or other side effects. It is always there…. The only difference is in some tablet it's more or in some tablet it's less. [Pharmacist, India]

> Spotting would be bothersome, especially with irregular use, as it is not likely to go away with time as with OCPs [oral contraceptive pills]. [KOL, university, India]

> Say it is recommended for use four to five times a month but people are using it much more … then there would be side effects. Addressing those issues would be important. [KOL, social marketing organization (SMO), India]

> An irregular contraceptive like this might play havoc with the menstrual cycle, especially given the instance of use of ECs by the young population. [KOL, SMO, India]

The concerns of stakeholders, particularly in Uganda, extended to concerns that pericoital pills could cause infertility and possibly congenital birth defects.

> What would be the side effects …? Won't it hinder in the future in case they wanted to have a baby …? I would not be happy if I am one of those who took it and the next time I look for a baby, a hundred years and the baby is nowhere to be seen. [KOL, Ministry of Health, Uganda]

> For my daughter, I was worried about safety … because my daughter at one stage she will need to have children. I do not want to say [the reason why she potentially could not have children] was that pill she took. [KOL, Ministry of Health, Uganda]

Concerns Regarding Promiscuity

Pericoital contraception was perceived by some respondents, particularly in Uganda, as a method that would increase sexual activity, especially among unmarried women. Providers reasoned that women who were equipped with an on-demand contraceptive would not think twice before having sexual encounters.

> Most of them who have been abstaining will stop abstaining because they think, "Even if I have sex, I have something that will prevent me from getting pregnant." [KOL, organization serving young people, Uganda]

> It is good but it might encourage prostitution.... The youth are the ones who will go for it because this generation is not the best. They just go and love anybody. [Public provider, Uganda, FGD]

> I do not think there will be a need, because there is a lot of abuse with those ECs. University students will go for sex anyhow and go and buy …, meaning that it will encourage them to go for risky behaviors.... They think, "I can't get pregnant because I have my emergency pill." [Pharmacist, Uganda]

> Strict regulation [will be needed] because young girls will misuse it. These secondary school girls will hear that there is a pill that protects against pregnancy. They need to put an age limit above 18. [Public provider, Uganda, FGD]

Impact on the Method Mix

Some stakeholders expressed the concern that the availability of pericoital contraceptive pills may decrease condom use, or that young women may be "coerced" into using the method in lieu of condoms. One stakeholder suggested that in light of the potential effect on condom use, unmarried individuals should not be a key target audience. Others suggested that the availability of pericoital pills might reduce reliance on long-term methods, which are heavily promoted in both countries.

> But [pericoital pills] might increase the perception among unmarried young couples that the girl can access this option so the boy doesn't need to use a condom.… So proper awareness

and advocacy are needed about the fact that the woman needs to take the pill and should not be softly coerced by the partner to use it as an alternative to condoms. [KOL, NGO, India]

The kind of people you like to use [pericoital pills]—those with infrequent sex—are often not married, are single, or are living separately from their partner, and that means the risk of HIV infection is possibly higher. It means the student population should be dropped because they have to prevent STIs and HIV. [KOL, donor organization, Uganda]

[Pericoital contraception] would deter [low-income women] from adopting a consistent long-term method … and they may not be able to understand it completely, leading to overuse/misuse. Just like EC pills, which are becoming a replacement for abortion, this would fall in the same bracket and could hinder adoption of longer-term, dependable contraceptives. [KOL, Ministry of Health and Family Welfare, India]

Distribute Broadly, Including Over the Counter

Perspectives vary regarding whether pericoital pills should be distributed over the counter (OTC) at pharmacies without a doctor's prescription. A number of Indian providers observed that requiring a prescription would increase costs to the user, either financially or in terms of opportunity costs. Two also noted that unmarried women are unlikely to procure contraceptives unless they can do so anonymously through a pharmacist. One respondent connected OTC access to the discretion this method offers to women who are hiding method use from their partners. These observations are consistent with the stigma associated with premarital sexual activity among Indian women.

Prescriptions are barriers.… As long as people are aware of the side effects, there should be no reason for a prescription for such a product. [KOL, SMO, India]

This contraceptive shouldn't be from a doctor's prescription.… If someone has to take [it] after a doctor consultation from a long queue, then it is of no use. If this is through prescription then it's not possible, as people won't waste their entire day for a doctor's prescription. They can easily go to a chemist and they will get it from there. [Public provider, India]

Yes [over the counter] because many people don't want to go to the doctor. Unmarried couples won't go to a doctor. [Pharmacist, India]

Because it is a secret method, use needs secret access. The user will determine where to get it—normally a pharmacy, health center, or hospital. Women do not leave home saying they have gone for family planning methods; instead they give other reasons to leave home. Access is not that straight and open. [KOL, NGO, Uganda]

Family planning commodities are ideally prescription-only medicines.… However, it is not in the interest of the MOH because we want to increase uptake so we negotiate for exemption [with the National Drug Authority]. EC is not actually exempted, but the practice is that no one will touch you if you issue without a prescription. [KOL, Ministry of Health, Uganda]

Restrict Distribution to Settings Where Women Can Be Counseled

Stakeholders in Uganda and providers in both settings expressed concerns that pericoital pills offered without a prescription would be misused or overused, and that women need counseling from a trained family planning provider to contend with the side effects. They recom-

mended that pericoital pills be provided at health facilities where an informed individual can be consulted. Participant perspectives were mixed regarding whether pharmacists are sufficiently trained to provide adequate family planning counseling.

> [Pericoital pills should be available only at] health centers where there is qualified staff, not in a shop because in a shop everybody will just come and buy and they will not buy [just] one. At the health center, we try and explain all the side effects. Pharmacies … are on a commercial basis. If someone says I want a full box, they just give. [Public provider, Uganda, FGD]
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> It should be distributed through people who have gone through family planning training. It should involve high provider–client interaction.… I would hate the idea of giving a product over the counter, because as I told you we need to examine the women first. [KOL, capacity strengthening organization, Uganda]
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> To me it will be abused.… Pills are first of all cheap and used by almost all women, but from what I have seen with Postinor [EC brand], it is abused. It should be prescription only, but oftentimes it is over the counter. You know the way we dispense here, somebody comes and says, "I want Postinor, how much?" You have not even asked why.… The guy dispensing just gives and pockets the money, whether it is for this young girl or for the mother. When she gets out, then people start discussing…. It is that bad. [KOL, National Drug Authority, Uganda]
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> It is incredible how much consultation takes place at the pharmacy counter.… [Pharmacists] recommend in one way or another professionally [and] can talk about alternate methods.… They can easily dispense. [Private provider, Uganda, IDI]
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> This should be gotten from a hospital only and not from a medical store.... In the hospital, after counseling, that is the best way. [Public provider, India]
>
> [It should be available only] as a prescribed product because with a prescribed product then a doctor is already there…. No drug should ever be given OTC. [Provider, NGO, India]

Target Audiences

In both countries, key opinion leaders viewed young unmarried women as a likely target audience for this method. In Uganda, where premarital sex is fairly commonplace, this finding is not surprising, but it is somewhat surprising in India, where premarital sex occurs less frequently and remains highly stigmatized.

> I can see it working best for students. Most students do not have regular sex. These are people who most times plan for their sex. [Private provider, Uganda, IDI]
>
> I see people that do not have regular partners, probably youngish people. They just want to have a good time for a short time without any ties or something like that. [KOL, Ministry of Health, Uganda]
>
> Urban kids and young adults … especially as the marriage age is increasing in India for women. [KOL, NGO, India]

In addition to unmarried women, respondents identified the following as likely clients: educated women, older women, and women whose husbands travel. In both contexts, key opinion leaders did not see this method as particularly appropriate for less-educated and/or rural women, presumably reflecting the concern that they would not use the method correctly.

In general, key opinion leaders in India tended to list a much wider range of potential users, though one or two in Uganda also envisioned a broad appeal.

> You are looking at high-class women for this method. What about women down in the village? Those who spend the day digging …; it is difficult. [KOL, Ministry of Health, Uganda]

> Educated women will be able to understand the product, while uneducated might not. [KOL, university, India]

> Literate, educated women in periurban or urban areas would be open to it. Couples who meet once in a while, due to distance or travel, would also have need for it. [KOL, donor organization, India]

> Any age group can go for it …; it is a one-time shot, why not? If my husband goes away for six months, he is saying, "I am coming on Friday" …, why not? [KOL, Ministry of Health, Uganda]

> Everybody! But specifically, women above 35 whose sexual behavior would be sporadic and young unmarried women. [KOL, university, India]

> Pericoital contraception would have universal demand. It would be an appropriate product at different points in the reproductive lifecycle of a woman. [KOL, medical research organization, India]

DISCUSSION

Our interviews and discussions with stakeholders and providers suggest that receptivity toward pericoital contraception is context specific. In India, where EC has been, until recently, widely advertised and commonly available (at least in urban areas), most stakeholders and providers see the product as filling a demonstrated need, based on their experience with widespread and/or repeat use of EC. They expect that the availability of pericoital contraceptives would encourage more proactive, rather than reactive (reliance on EC and abortion pills), family planning. In Uganda, where EC has met strong opposition, providers and stakeholders alike are more skeptical about pericoital contraception's merits and possible market niche, particularly given concerns about method efficacy, possible side effects, and promiscuity.

In both settings, stakeholders and providers recognize that consistent use of daily oral contraceptives and condoms presents challenges and that easy-to-use methods that are under female control are likely to have considerable appeal. We also heard that unmarried women are a promising target audience for pericoital contraceptives because they often lack access to family planning and are at risk of unintended pregnancy and abortion. Provider and stakeholder perceptions reflect what we heard from consumers in both countries: an occasional or on-demand pill is easier to remember and less burdensome than a daily pill, and particularly welcomed in the context of less frequent sexual activity. Our consumer study also revealed that, particularly in Uganda, the ability to hide method use from a partner was important to women and that young, unmarried women viewed themselves as potential clients (Cover et al. 2013).

The concern expressed among stakeholders in both settings—that pericoital pills could replace condoms, leading to higher rates of STI exposure—merits further attention. The same concern regarding condom replacement was voiced for EC but has generally not been borne out by the evidence. A randomized trial found that adolescent women using EC were not less likely to use condoms (or oral contraceptives), nor were they more likely to contract an STI (Gold et al. 2004). The possibility of condom replacement would need to be evaluated for pericoital contraception as well.

The risk of condom replacement should also be viewed in the context of male condoms being a method over which women have minimal influence. As observed by one Indian stakeholder: "In India, most women don't have the power in decisionmaking … or [over whether] the husband is using a condom.…" Uganda is likewise a male-dominated culture, and condom use tends to be stigmatized in the context of steady relationships, where condoms carry the connotation that one of the partners has been unfaithful (Pool et al. 2000). Moreover, the fact that unmarried women in both contexts tend to be infrequent and inconsistent condom users is worth noting (Nalwadda et al. 2010). Although data are limited, apparently relatively few young, unmarried Indian women are exposed to pregnancy risk. But among those who are sexually active, condom use is rare. A recent study of premarital sexual activity among young people in six Indian states found that only 7 percent of sexually active young women had ever used a condom (Santhya, Acharya, and Jejeebhoy 2011). For young women, in particular, the challenges involved in negotiating condom use and using condoms consistently necessitates the development of contraceptive choices that are readily available and female-controlled.

Determining whether the availability of pericoital contraceptives might deter women from using more effective and/or long-term methods is important and should be researched in the context of a rigorous acceptability study to inform method introduction. That said, family planning programs are charged with helping women select the method that is most appropriate to individual circumstances. As others have noted, the frequency of sexual relations is a factor that is seldom considered during family planning consultations but is relevant for method selection (Blanc and Rutenberg 1991). As evidenced by a recent study that found that 5 percent of sterilized women of reproductive age in India regret having undergone sterilization (Singh et al. 2012), diverging from standards for quality of care that necessitate a full range of contraceptive options may come at a high price.

In presenting pericoital contraception to study participants, we identified a potential target audience as women who have less frequent sex. Our framing, although intended to situate the method as one that would address unmet need in this population, created a study limitation. Respondents may have been unduly concerned that other women might use the method as well, and may have interpreted such use as ill-advised.

Whereas the finding that receptivity to pericoital contraception is context-specific is not surprising, the varied views of stakeholders and providers reminds us of the importance of targeted advocacy and information as a key step in method introduction. Clearly, prior experience with the introduction of other contraceptive technologies shapes stakeholders' views of new technologies. Having standard, accepted, global guidelines and country-specific messages and approaches is therefore vitally important.

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