*Special Article*

# Please help, our condom tore last night

## A report on visits of fake clients, pretending to be in need of emergency contraception, to health facilities in Bulawayo, Zimbabwe

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**To identify bottlenecks in the delivery of comprehensive reproductive health care in Bulawayo, Zimbabwe's second city, a study was performed utilising volunteers pretending to be in need of emergency contraception. A total of 55 private, Zimbabwe National Family Planning Council, municipal and government health facilities were visited. These consultations resulted in 9 (16%) correct, 1 possibly correct and 15 wrong prescriptions for the morning-after pill (MAP); no treatment was prescribed in 30 instances. Public sector health personnel were very judgemental in their attitude toward sexually active teenagers. Although the Essential Drug List of Zimbabwe is quite clear about the MAP, many health providers are not aware of this, and others do not even have/use this book.**

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The morning-after pill (MAP) has been called the best-kept contraceptive secret. The public does not know about it and many pharmacists, nurses and doctors have forgotten what exactly it is and which reference book to check. Rape is reported to be on the increase, and the use of condoms (which can tear and slip) should be. We see patients who refuse any contraceptive other than the condom, because they fear that concurrent use of, for example, the pill might undermine their resolve to use the former, even if exclusively for HIV prevention. These women need emergency contraception (EC) if they have an accident with this barrier method. Knowledge of and access to EC especially among teenagers, who often have unplanned sexual intercourse, could substantially reduce the numbers of (clandestine) abortions[1] and/or ruined lives.[2] Contact with the health services for EC should then be used as an opportunity for discussion of more structured use of contraception and protection against sexually transmitted infections (STIs).

This study was performed in Bulawayo in December 1995 to assess attitudes and practices with regard to EC in order to plan appropriate educational interventions.

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## Methods

Six women, aged 16 - 26 years, were trained with the help of role-plays to present themselves convincingly with a fake problem to pharmacies, general practitioners' surgeries and clinics (municipality, central hospitals, Zimbabwe National Family Planning Council (ZNFPC) and one private mother and child health clinic). Twenty-two of the 23 pharmacies, 1 doctor at most surgeries, 6 of 17 municipal clinics and the outpatient departments of both government hospitals were visited as well as the 3 ZNFPC clinic, including the Youth Advisory Service. The study was terminated after no new insights had emerged for some time and detection of the 'fraud' through health networks seemed imminent. The two youngest fake clients made nearly all their visits together for moral support.

The women pretended to have been involved in an incident where a condom had torn the previous night. They would stress that they were not keen to be pregnant. They would reveal, if asked, that their last period had been a fortnight before and that they had a cycle of 4 weeks. If no solution were offered, they would say that they had heard about 'the morning-after pill'. After their visits they were debriefed with a checklist.

## Results

### *Attitudes*

As Table I shows, the women were treated politely and with enough privacy in most private surgeries. Some receptionists were very keen to know the reason for the visit. One proved to be an unsurmountable barrier. One doctor was so pleasant that she gave her home telephone number to use, even at night, for instant support. At one surgery, there was such a long wait before the doctor could escape from his government duties that the woman gave up.

**Table I. Attitude of the provider reported by the clients**

| | GPs | Pharmacies | Staff in clinics and hospitals |
|---|---|---|---|
| Concerned/friendly/ helpful/(very) nice/serious | 16 | 13 | 3 |
| In a hurry/not interested | 1 | 1 | 4 |
| Amused/shocked/nervous | 1 | 4 | |
| Condescending/ condemning/angry/ too much lecturing | 3 | 1 | 4 |
| Asked advice of others/ unsure what to do | | 3 | 1 |
| Total | 21 | 22 | 12 |

Most pharmacists were kind and supportive, but some would communicate loudly to a colleague so that other clients could hear: 'This girl comes for the morning-after pill'. In the municipal clinics the young teenagers were lectured extensively by the sisters, sometimes in a room

without much privacy. At one clinic the other patients laughed loudly when an unaccompanied 16-year-old left the building, without drugs but after a loud angry lecture. She was crying when she entered the car collecting her.

An 18-year-old girl was told at the municipal clinics that she was old enough and that it was about time she had a baby, anyway. ZNFPC clinic staff showed no concern and were not helpful. Table II shows the feelings of the clients during consultations.

**Table II. Feelings of the clients during the consultation**

| | In the GP's rooms | In the pharmacies | In the clinics and hospitals |
|---|---|---|---|
| At ease/comfortable/ not bad | 17 | 12 | 2 |
| Not at ease/not taken seriously | 4 | 5 | 4 |
| Bad to horrible | — | 5 | 6 |
| Total | 21 | 22 | 12 |

## *Management of the problem*

Table III details the questions asked by the different groups of health workers. No doctor asked to do a vaginal examination. Some palpated the abdomen and some wanted to do a pregnancy test. Eleven of the 22 pharmacists gave drugs, only in 6 cases the correct ones. The corresponding figures for doctors were 14 of 21, correct in 3 cases (Table IV). Some remarks from health providers were peculiar. They are summarised in Table V. Only one doctor referred to the Essential Drug List of Zimbabwe, (EDLIZ) but could only find the 1989 edition. The 1994 edition has a description of the MAP. Of the 11 doctors who wrote an incorrect prescription, a few had it nearly right. One of the doctors prescribed 'MAP 2 stat PO'. The client would have had a 27% chance of visiting a pharmacy with the right information.

**Table III. Questions asked by the providers**

| | GPs (*N* = 21) | Pharmacy staff (*N* = 22) | Staff in clinics/ hospitals (*N* = 12) |
|---|---|---|---|
| Age? | 8 | 1 | 9 |
| Do parents know about visit? | 4 | | |
| Last menstrual period? | 19 | 4 | 10 |
| Regularity of period? | 14 | 1 | 1 |
| Ever used contraceptives? | 8 | 3 | 2 |
| Could you be pregnant now? | 7 | 1 | 1 |
| Any chance you have an STI? | 3 | | 1 |
| Offered pregnancy test | 1 | 3 | 2 |

**Table IV. Overview of the different prescriptions**

| | 21 GPs | 22 Pharmacies |
|---|---|---|
| Type of prescription (correct dosage) | | |
| Lo-femenal | 8 (3) | 5 (4) |
| Nordette | | 3 (1) |
| Demulen | | 1 (1) |
| MAP | 1 | |
| 'Injection to make the lining of the uterus loose' (Z$200) | 1 | |
| Ovrette | 1 | |
| Provera | 1 | |
| Norethisterone | 1 | |
| Trinovum | 1 | |
| 'Obecalp' | | 1 |
| Premarin | | 1 |
| Total | 14 (3) | 11 (6) |

**Table V. Reasons for not providing the MAP/general comments given**

| | No. of responses |
|---|---|
| Reasons given for not providing the MAP | |
| Not yet available in the country/Bulawayo/ still to go through Parliament | 4 |
| Illegal in Zimbabwe/we are not allowed to prescribe | 3 |
| Should have come in the morning/within 8 hours, it is now too late | 2 |
| Very expensive | 1 |
| Very dangerous | 1 |
| This pill is for nausea in pregnancy | 1 |
| The pill you take when you forget your regular FP tabs | 1 |
| Not efficient | 1 |
| MAP is still in experimental phase | 1 |
| General comments | |
| Have the baby/get married | 4 |
| Don't worry, this is not your fertile period | 2 |
| Sex is a crime at your age | 1 |
| He not only gave you a baby, but also AIDS | 1 |
| You should always shower after sex | 1 |
| Buy spermicide to kill the remaining sperm | 1 |
| Go to the UK for an abortion | 1 |
| Only a hysterectomy can help you now | 1 |

One ZNFPC clinic sister told our client that the MAP meant just that and that since it was now afternoon she could not be helped. At the municipal clinics the girls were advised to marry before the 'stomach showed', or that they were not only pregnant but must have acquired AIDS also. Municipal clinics had the right EDLIZ and used it, but sisters, often discussing the problem among themselves in the presence of the fake patient, did not feel authorised to dispense EC. A government hospital OPD referred clients to the ZNFPC clinic on its grounds and vice versa.

### *Side-effects*

Few prescribers explained about possible side-effects and what to do. Some prescribed anti-emetics. Few explained that the MAP could either cause early or late periods.

### *Future contraception*

Even without the MAP the chance of becoming pregnant after one act of unprotected intercourse at the time of ovulation is only 20 - 30%; this is reduced to 5 - 7% with the MAP.[3] Few clients were counselled about future contraceptive options, although private doctors might have intended to initiate this discussion at a suggested follow-up visit. Municipal and even ZNFPC clinics did not raise this subject. The mother and child health clinic sister wanted to, but finally did not, prescribe the pill because our client refused vaginal examination.

### *Sexually transmitted infections*

Only 3 doctors asked if STI treatment could be necessary after the condom mishap. Another doctor wanted to give a series of penicillin injections regardless. HIV screening of both partners was never suggested.

## Discussion

Probably few members of the public know about EC, but apparently the medical, nursing and pharmaceutical professionals are not at all ready for requests for the MAP.

An article about condoms in Bulawayo's *The Chronicle* of 1 November 1995 and in the Matabeleland AIDS Council newsletter of January 1996 specifically mentioned the MAP in relation to ruptured condoms. This should have prompted some research by health workers in the city. With 30% of the antenatal clinic patients in Bulawayo HIV-positive, one would expect increased use of condoms and therefore more demand for the MAP in the future. Any random (un)wanted pregnancy has a 12% chance of ending in a vertically HIV-infected child and an 18% chance of resulting in an orphan-to-be.[4] It therefore seems quite reasonable to prevent unwanted pregnancies.

Nobody offered to insert an intra-uterine contraceptive device (IUCD), which is more effective and can be applied longer after the mishap than the MAP. Combined with antibiotics this would be the best option in countries where access to safe, affordable abortion is restricted, and the very effective MAP, RU486 (mifepristone) cannot be used because it is unavailable.

The legal situation worried some personnel, but because the mechanism of action (delaying ovulation, interfering with the corpus luteum and preventing implantation[3]) is, at worst, similar to the action of a (legal) IUCD, this should be of no concern. Even the Vatican has recently approved the use of the MAP in the case of rape.[5] One pharmacist, worried about the law, prescribed tablets recognisable as Trinovum in the wrong dose and labelled them Obecalp (which can be understood if it is read backwards).

It was disappointing to see that the EDLIZ, a product of the best medical and pharmaceutical minds in Zimbabwe, was used so little by everybody apart from the municipal nursing sisters. Local doctors see this book as being 'just for sisters'.

## Conclusion and recommendations

This study found that most health providers know little about EC but that municipal nursing sisters can find the information. Staff in the public sector tend to be very unfriendly to sexually active girls, even when specially recruited to advise young people. Private doctors were found to be friendly and understanding, but should consider reading the EDLIZ or the future South African equivalent.

All opportunities should be used to educate health providers and the public about the MAP. Posters and discussions in health facilities and schools, and inserts in or, still better, printed on the combined oral contraceptive packet itself (together with instructions about what to do when pills are forgotten) should spread the word about the MAP. It could even be argued that condom manufacturers should legally be obliged to suggest the MAP in case of failure of their product. The MAP should be available without prescription as suggested in the UK,[6] so that clinic sisters feel confident about dispensing it. Police personnel should be informed about the EC option after rape and should be urged to take the victim to a health facility in time. Readers should ensure that EC is available at their own medical facility for, for example, a case of rape, even after hours and on weekends.

IUCDs have lost some ground in Zimbabwe since the (re)introduction of injectables and Norplant and since the advent of HIV, but they still have a place in emergency situations, particularly while menstruation regulation and induced abortions are illegal and mifepristone unobtainable.

Discussions at the World Health Assembly in May 1995 indicate that the message about prevention of teenage pregnancy is at long last getting across. Education about and provision of EC should be an integral part of that effort.[7] Thousands of unwanted pregnancies that end in ruined lives happen every day because so few teenagers in this part of the world protect themselves at the time of first sexual intercourse. EC can give them a second chance.

Thanks to Kelly, Nelly, Thembi, Natalie, Varda and Nienke, who were so brave. Thanks also to the health workers who unwittingly provided the data for this study, participated in a friendly feedback meeting after its completion, and agreed that the result of these shock tactics was that they were unlikely to forget how to handle EC again.

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