

Emergency Contraception: Knowledge, Attitudes and Practices Among Brazilian Obstetrician-Gynecologists

By Loren Galvão, Juan Díaz, Margarita Díaz, Maria José Osis, Shelley Clark and Charlotte Ellertson

Context: *In Brazil, where emergency contraception could play a critical role in reducing unwanted pregnancies, the government has included the method in its family planning guidelines. Yet, little is known about its availability and provision.*

Methods: *A nationally representative, randomly selected sample of 579 Brazilian obstetrician-gynecologists responded to a 1997 mail-in survey on emergency contraception. The data yield information on these providers' knowledge about, attitudes toward and practices regarding emergency contraception.*

Results: *Nearly all respondents (98%) had heard of emergency contraception, but many lacked specific knowledge about the method. Some 30% incorrectly believed that emergency contraception acts as an abortifacient, and 14% erroneously believed that it was illegal. However, 49% of physicians who thought that the method induces abortion (which is largely illegal in Brazil) and 46% of those who thought that emergency contraception was itself illegal have provided it to clients. Most surprisingly, while 61% of respondents report having provided emergency contraception, only 15% of these physicians could correctly list the brand name of a pill they prescribed, the dosage and regimen, and the timing of the first dose.*

Conclusions: *Educational efforts that focus on specific prescription information and the introduction of a dedicated product would greatly improve women's access to this method in Brazil.* International Family Planning Perspectives, 1999, 25(4):168-171 & 180

Emergency contraceptives are methods that women can use after intercourse to prevent an unwanted pregnancy. Several methods of emergency contraception are safe and effective, including combined hormonal contraceptives taken in a dose higher than is used for regular contraception (the Yuzpe method*) and insertion of a copper IUD.¹ Another hormonal emergency contraceptive method, the levonorgestrel-only regimen, has been widely tested, with excellent results.² In addition to preventing pregnancy, emergency contraception can serve as a bridge into the health care system and a way to obtain an ongoing contraceptive method for women who do not have one.³ The World Health Organization recommends that reproductive health services offer emergency con-

traception as part of their routine services.⁴

In Brazil, where 26% of births in the early 1990s were unplanned and 22% were unwanted,⁵ emergency contraception could play an important role by averting pregnancies attributable to contraceptive failure, nonuse of contraceptives, lack of knowledge about or access to methods, or coercive sex. It also could reduce levels of unsafe abortion. In 1991, an estimated 1.4 million women in Brazil had an abortion, and many of these procedures were unsafe.⁶

Recognizing the potential contribution of emergency contraceptive methods, in March 1996, Brazil's Ministry of Health convened a national meeting, in collaboration with the Population Council, to discuss this issue. The main conclusions were that emergency contraception should be included in the ministry's official family planning program guidelines; that educational and dissemination activities should be developed for the general public and health providers; and that additional research was needed about emergency contraception in the context of Brazil.⁷ In March 1997, the Yuzpe regimen of emergency contraception was included in the family planning program guidelines.⁸

Although a levonorgestrel-only dedicated emergency contraceptive became available in Brazil in July 1999, at the time of the survey, women had to make up the

regimen using regular oral contraceptives. A number of pills potentially suitable for use as emergency contraception are available on the market (Table 1). However, because the various brands contain different dosages of active ingredients, they require different numbers of tablets to create a complete course of emergency contraception therapy, and this makes the method confusing for women. Furthermore, although pills are sold over the counter, obstetrician-gynecologists play a critical role in informing their clients about emergency contraception and in educating the public about the proper regimens. Presumably, even with a dedicated product available over the counter, obstetrician-gynecologists will continue to play a crucial role as educators.

Since obstetrician-gynecologists play a pivotal role in disseminating information about new reproductive technologies and providing family planning methods, participants at the national meeting recommended conducting a survey to assess their knowledge, attitudes and practices regarding emergency contraception, and to define the best strategies to improve access to this method.

Methodology

In August 1997, we conducted a mail-in survey of members of the Brazilian Federation of Societies of Gynecology and Obstetrics (FEBRASGO). More than two-thirds of the nation's obstetrician-gynecologists belong to FEBRASGO, so this study provides a fair-

Loren Galvão is program associate, and Juan Díaz is senior program associate, Population Council, Campinas, Brazil; Margarita Díaz is director of the Department of Education and Communication in Sexual and Reproductive Health, and Maria José Osis is director of sociomedical research, Center for Research and Control of Maternal and Child Diseases, Campinas, Brazil; Shelley Clark is staff program associate, Population Council, New York; and Charlotte Ellertson is director of reproductive health for Latin America and the Caribbean, Population Council, Mexico City. This study was conducted with the support of the U.S. Agency for International Development, the William and Flora Hewlett Foundation and the Robert H. Ebert Program. The authors thank the Brazilian Federation of Societies of Gynecology and Obstetrics for its logistical support in the study implementation; Schering/Brazil for providing the prize that was used as an incentive to participate in the survey; Beverly Winikoff and Martha Brady for technical support during the planning stages of the study; and the survey participants.

*The Yuzpe method consists of 200 mcg of ethinyl estradiol and 1.0 mg of levonorgestrel (or 2.0 mg of norgestrel), usually dispensed as four combined estrogen-progestin oral contraceptive tablets; two pills are taken within 72 hours of unprotected intercourse, and the remaining two are taken 12 hours later. (Source: Ellertson C, History and efficacy of emergency contraception: beyond Coca-Cola, *International Family Planning Perspectives*, 1996, 22(2): 52-56.) When the exact types of pills to make the Yuzpe regimen are not available, providers may substitute tablets containing 240 mcg of ethinyl estradiol and 1.2 mg of levonorgestrel, administered in two doses of four pills each, taken 12 hours apart. (Source: Hatcher R et al., eds., *Contraceptive Technology*, 17th ed., New York: Ardent Media, 1998.)

Table 1. Characteristics of selected brands of oral contraceptives available in Brazil that can be used for emergency contraception

Brand (and manufacturer)	Pills per dose	Hormonal content per dose		
		Ethinyl estradiol (µg)	Levonorgestrel (µg)	di-norgestrel (µg)
Anfertil (Wyeth-Ayerst)	2	100	0.0	1.0
Primovlar (Schering AG)	2	100	0.0	1.0
Evanor (Wyeth-Ayerst)	2	100	0.5	0.0
Neovlar (Schering AG)	2	100	0.5	0.0
Microvlar (Schering AG)	4	120	0.6	0.0
Nordette (Wyeth-Ayerst)	4	120	0.6	0.0

Note: The complete emergency contraception regimen consists of two doses taken 12 hours apart, and started as soon as possible, but within 72 hours after unprotected intercourse. Source: International Planned Parenthood Federation (IPPF), *Directory of Hormonal Contraceptives*, third ed., London: IPPF, 1996.

ly representative sample of all obstetrician-gynecologists in Brazil.

A structured questionnaire, including closed- and open-ended questions, asked physicians about their knowledge, attitudes and practices regarding emergency contraception. Population Council staff in Brazil, in collaboration with the Center of Maternal and Child Health of Campinas (CEMICAMP), prepared and pretested the questionnaire. Results from the pretest are not included in the analysis.

We randomly selected 10% of FEBRASGO's members (1,003 health care providers) to participate in the survey. FEBRASGO mailed these physicians a questionnaire, along with a letter explaining the objectives of the research and guaranteeing anonymity, and a prepaid return envelope addressed to FEBRASGO. Because mailed questionnaires have inherent limitations, to boost the response rate, we applied the total design method.⁹ We sent a second and, if necessary, third mailing to nonrespondents; after the third mailing, we attempted to reach nonrespondents by telephone. As an incentive to participate, we informed potential respondents that at the end of the study, one respondent would be randomly selected to receive a prize (a computer and printer).

Research staff reviewed each questionnaire, coded the open-ended questions and assessed if the questionnaire had been answered seriously. Fewer than 1% of completed questionnaires were rejected. Data from accepted questionnaires were entered twice, using a data entry program based on SPSSPC-DE. The data were analyzed using SPSSPC.

Results

Sample

A total of 579 valid questionnaires were received, yielding a response rate of 58%. Virtually all respondents provided information about their background characteristics

(96% reported their gender, and at least 98% all other characteristics). Among those who reported their gender, 63% were male. Sixty-four percent of respondents lived in the country's southeastern region, which is the most highly developed and populated region and includes the largest cities, São Paulo and Rio de Janeiro. An additional 16% lived in the southern region, which is characterized by

a large European immigrant population and small-scale industry and farms. Only 20% came from the poorer and less-populated northeastern and center-northern regions. The sample is unbiased with respect to sex, but there are significant regional differences between respondents and nonrespondents. Physicians who did not return the survey were less likely than respondents to live in the southeast (54%) and more likely to live in the northeastern and center-northern regions (30%).

One-fifth (21%) of respondents had fewer than 10 years of professional work experience, while nearly half (47%) had 11–20 years; 24% had 20–30 years, and 9% had more than 30 years. Some 56% of respondents worked in state capitals, 37% worked in other cities or rural areas, and 7% worked in both state capitals and other cities.

Respondents who replied to the initial round of surveys were slightly but significantly more likely to have heard of emergency contraception than were those who needed to be prompted by a third round of surveys (98% vs. 92%; $p=.02$). This finding suggests that our results may overestimate obstetrician-gynecologists' knowledge of this method.

Knowledge and Attitudes

Awareness of the concept of emergency contraception was virtually universal; only 2% of respondents had never heard of it. All respondents who were familiar with emergency contraception were queried as to their knowledge about the method and their attitudes toward its use (Table 2).

Of those who knew of emergency contraception, 88% were aware that combined pills could be used for this purpose, and 26% knew that insertion of an IUD after intercourse could prevent pregnancy. Estrogen-only and progestogen-only pills were also mentioned often (19% and 15%, respectively). A small proportion of re-

spondents (4%) mentioned other methods, such as mifepristone and danazol, which are less widely available.

The vast majority of respondents (66%) correctly indicated that emergency contraception prevents pregnancy. However, 15% incorrectly thought that it induces abortion. Notably, respondents could indicate more than one mechanism of action, and 15% believed that emergency contraception both prevents pregnancy and induces abortion. Only 3% said that they did not know how the method works. (Although several possible mechanisms of action are being investigated, research shows that emergency contraception acts by preventing pregnancy and cannot interrupt an established pregnancy, which the National Institutes of Health¹⁰ and the American College of Obstetricians and Gynecologists¹¹ define as beginning with implantation. The

Table 2. Among obstetrician-gynecologists who have heard of emergency contraception, percentage who know about various aspects of the method, Brazil, 1997 (N=567)

Aspect	%
Methods used for emergency contraception	
Combined pill	87.6
IUD	25.9
Estrogen-only pill	19.2
Progestogen-only pill	15.3
Monthly injectable*	3.7
Three-month injectable*	1.8
Other	4.4
None	3.9
Mechanism of action	
Prevents pregnancy	66.2
Induces abortion	14.8
Prevents pregnancy and induces abortion	15.3
Don't know	3.0
Legal status	
Legal, not included in government family planning guidelines	37.0
Illegal	14.1
Legal, included in government family planning guidelines	11.6
Don't know	37.3
Best candidates	
Any women who have had unprotected intercourse	71.3
Adolescents	46.4
Women who have infrequent intercourse	35.7
Inconsistent method users	26.1
Women with multiple partners	9.2
Perimenopausal women	9.1
Other	15.5
Situations appropriate for use	
Rape	91.2
Condom breakage	82.1
Unprotected intercourse	75.9
Missed pills	38.0
Infrequent sexual activity	24.8
Other	7.4
None	3.7

*Effectiveness is unsubstantiated. Notes: Ns varied negligibly because not all respondents who were familiar with emergency contraception answered all questions. For some questions, respondents could indicate more than one answer.

Table 3. Among obstetrician-gynecologists who have prescribed emergency contraception, percentage who have prescribed the method in certain situations, and percentage distribution, by accuracy in describing the regimen (N=353)

Measure	%
Situations in which physician has prescribed	
Unprotected intercourse	75.4
Condom breakage	60.9
Rape	22.7
Missed pills	15.6
Other	4.8
Don't remember	1.4
Description of regimen	
Only name of pill was correct	42.8
Name and dose were correct	36.3
Name, dose and timing of first dose were correct	14.7
Not mentioned	4.0
Completely wrong	2.3
Total	100.0

Note: Respondents could indicate more than one situation in which they have prescribed emergency contraception.

method's ability to inhibit or delay ovulation has been demonstrated in several clinical trials¹² and is an important mechanism of action if emergency contraception is used during the first half of the menstrual cycle, before ovulation has occurred. Some clinical studies suggest that emergency contraception may make the endometrium less receptive to the implantation of a fertilized egg,¹³ although others have not found any effect on the endometrium.¹⁴ In addition, emergency contraception may prevent pregnancy by interfering with corpus luteum function; thickening the cervical mucus; altering the tubal transport of sperm, egg or embryo; or directly inhibiting fertilization.¹⁵

Many respondents (37%) did not know the legal status of emergency contraception in Brazil. An additional 37% believed that it was legal but not included in the national family planning guidelines, and 14% answered that the method was illegal. Only 12% correctly answered that emergency contraception was legal and included in the family planning guidelines.

When asked to identify all appropriate candidates for emergency contraception, 71% of physicians who had heard of the method declared that it should be offered to any woman who had had unprotected intercourse; 46% specifically mentioned adolescents. Providers noted that women who engage in intercourse infrequently or who use contraceptives inconsistently (for example, women who forget to take oral contraceptives) would be likely candidates for emergency contraception. Respondents also had the option to describe "other" candidates and most frequently mentioned women who have been raped.

Three-quarters of respondents (76%) believed that emergency contraception is appropriate after any act of unprotected intercourse. Nearly all respondents (91%) felt that this method should be used in cases of rape, and 82% believed that it should be used if a condom breaks.

To further examine knowledge and attitudes about the prescription of emergency contraception, the survey asked physicians how they would respond to the following hypothetical situation: An adolescent arrives for an appointment, saying that she had unprotected intercourse two days ago; she does not want to become pregnant and asks the doctor for guidance about how to prevent a pregnancy. Providers were given a list of alternatives and were asked to select one or more ways to advise this young woman.

The majority would give advice on how to use emergency contraception. About one-third (36%) identified the two correct descriptions of the Yuzpe regimen listed, and 22% selected one of the two correct single-hormone regimens described; 8% indicated that they would insert an IUD. Expressions of negative attitudes toward giving emergency contraception to this adolescent were rare: Seven percent of physicians agreed with the statement "I would not do anything because I am against abortion," and 3% indicated that they would "give [her] a serious reprimand and would tell her to come back for contraceptives, if she did not get pregnant."

Prescribing Emergency Contraception

Despite providers' largely favorable attitudes toward emergency contraception, they seldom inform their clients about this method or prescribe it. Of all physicians who responded to the survey, only 11% said that they inform all their female clients. Some 43% give information about emergency contraception only when clients request it, and 41% do not usually inform their clients. More than half (61%) have prescribed emergency contraception, mostly hormonal methods; fewer than 1% mentioned IUDs. In the last year, 75% of these providers had prescribed emergency contraception for women who had had unprotected intercourse, and 61% for women who reported condom breakage (Table 3). Rape was also a common reason for prescribing it (23%).

Physicians who have provided emergency contraception were asked the commercial name of the hormonal contraceptive they have prescribed, the dose and regimen prescribed, and the timing of the first dose after intercourse. Only 15% gave a completely correct prescription for the

Yuzpe regimen (Table 3). Almost half (43%) gave the correct name of a pill but failed to give the correct dosage and timing of the first dose. About one-third (36%) provided the correct name and regimen but gave an inaccurate answer for the timing of the initial dose. The majority of providers incorrectly thought that emergency contraception must be given within 24 hours after intercourse. This confusion may stem from the common usage of the term "morning-after pill," which implies that the method should be taken the next morning. A scant 2% gave completely incorrect answers, while 4% did not answer the question or mentioned only the IUD.

In general, physicians' knowledge, attitudes and practices did not differ significantly by their sex, region or residence. However, women were significantly more likely than men to give a completely correct prescription for hormonal emergency contraception (20% vs. 11%; $p < .05$).

Considerable discrepancies exist between beliefs about emergency contraception and actual practices. For example, not understanding the correct mechanism of action does not imply an unwillingness to prescribe emergency contraception: Forty-nine percent of doctors who believe that emergency contraception acts as a means of abortion provide it, even though abortion is legally restricted in Brazil. Either these doctors disregard the Brazilian abortion law and provide what they incorrectly consider abortions, or they draw a distinction between emergency contraception and abortions. Moreover, only 16% of physicians who think that emergency contraception induces abortion stated that they would never provide it for that reason. Similarly, nearly half (46%) of physicians who believe that the method is illegal have prescribed it—a considerable proportion, albeit much lower than the proportion among providers who know that it is legal (71%).

Discussion

Our survey followed on the heels of several major initiatives to inform health care providers about emergency contraception. A few months before the survey, the proceedings from a national meeting on emergency contraception were published in FEBRASGO's official journal,¹⁶ which is distributed free to all its members, and another highly circulated scientific journal.¹⁷ In addition, many physicians and institutions throughout Brazil received the government's family planning guidelines, which included guidelines on emergency contraception.

These dissemination efforts may partly

explain the high proportions of respondents to our survey who had heard of emergency contraception and who knew how it works. Nonetheless, many physicians held inaccurate beliefs about the method and its legal status, and lacked specific knowledge about the correct prescription.

Although this survey did not ask providers about their awareness and recall of recent publications on emergency contraception, the abundance of misinformation evident in their responses calls into question the adequacy of traditional information dissemination systems to change attitudes and ensure high-quality practices. Obstetrician-gynecologists clearly require additional education on several aspects related to emergency contraception in Brazil. These interventions should also aim to debunk myths and allay concerns about the method. For example, studies from other countries clearly indicate that women are not likely to "misuse" emergency contraception or substitute it for their regular method; a landmark study revealed that Scottish women who were given the therapy to keep on hand in case of need were no more likely to use it repeatedly than women who had to go to the clinic to get the pills when they were needed.¹⁸

Educational campaigns should emphasize that no evidence indicates that this method is unsafe even when women use it repeatedly. Emergency contraception pills have a very short duration of exposure, and their total hormone content is far lower than the estrogen levels experienced during pregnancy. Physicians should also be encouraged to inform all potential users about emergency contraception and be willing to prescribe the method to all women, including adolescents, in need of a postcoital contraceptive. Finally, educational interventions should be evaluated after their implementation to help identify effective ways to disseminate information to obstetrician-gynecologists on the use of the Yuzpe regimen with the currently available brands of combined pills.

Additional studies on emergency contraception would aid the development of these educational interventions. The results of this study suggest a couple of areas that require further investigation. For example, female physicians were significantly more likely than their male counterparts to prescribe the Yuzpe regimen accurately. This issue deserves further exploration and special attention when educational strategies are being designed. Furthermore, it would be advisable to examine the knowledge and practices of other health providers, such as nurses,

who may offer emergency contraception. Also, since women in Brazil are often able to buy oral contraceptives over the counter without consulting a physician or other health care provider, studies that evaluate the knowledge and attitudes of pharmacists, as well as pilot studies of clear and adequate instructions for consumers, could greatly enhance awareness of and access to emergency contraception.

Finally, given the scant knowledge about the correct prescription of the currently available pills, the recent introduction of a dedicated product in Brazil could greatly improve women's access to safe and effective emergency contraception. Although the ultimate impact of this dedicated product is yet to be determined, such a product may also help decrease the number of unwanted or unplanned pregnancies and subsequent abortions, reduce the hospital costs associated with abortion complications and act as a bridge to reproductive health services. International experience suggests that approval of specially packaged and labeled emergency contraceptive pills with clear instructions for providers and clients helps legitimize the method; makes existing regimens much easier to administer and use; and promotes safe, effective and appropriate use.¹⁹ Furthermore, by widely advertising their commercial products, companies can help inform the public about this contraceptive option.

Educational interventions that reach all health professionals, further studies on the provision of emergency contraception and the widespread availability of a dedicated product would significantly improve the quality of reproductive health services by offering this method in the context of free and informed choice. Our study shows that obstetrician-gynecologists in Brazil are prepared to support expanded access to emergency contraception, but will need further information to do this well.

References

- Berer M et al., Consensus statement on emergency contraception, *Contraception*, 1995, 52(4):211-213.
- World Health Organization Task Force on Postovulatory Methods of Fertility Regulation, Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception, *Lancet*, 1998, 352(9126):428-433.
- Grossman RA and Grossman BD, How frequently is emergency contraception prescribed? *Family Planning Perspectives*, 1994, 26(6):270-271.
- Van Look P and Von Hertzen H, Emergency contraception, *British Medical Bulletin*, 1993, 49(1):158-170.
- Sociedade Civil Bem-Estar no Brasil (BEMFAM) and Macro International, *Pesquisa Nacional Sobre Demografia e Saúde*, 1996, Rio de Janeiro, Brazil: BEMFAM; and Calverton, MD, USA: Macro International, 1997.

6. Alan Guttmacher Institute (AGI), An overview of clandestine abortion in Latin America, *Issues in Brief*, New York: AGI, 1996, pp. 1-6.

7. Lebardone A et al., A anticoncepção de emergência: um grupo de consulta para o seu uso no Brasil, *Femina*, 1996, 24(6):567-570.

8. Ministério da Saúde, *Normas para a Assistência ao Planejamento Familiar*, Brasília: Ministério da Saúde, 1996, pp. 121-125.

9. Dillman DA, Mail and other self-administered questionnaires, in: Rossi PH, Wright JD and Anderson AB, eds., *Handbook of Survey Research*, Orlando, FL, USA: Academic Press, 1983, pp. 359-377; Dillman DA, *Mail and Telephone Surveys: The Total Design Method*, New York: Wiley-Interscience, 1978; and Dillman DA et al., Increasing mail questionnaire response: a four state comparison, *American Sociological Review*, 1974, 39(5):744-756.

10. 45 CFR 46.203.

11. Hughes EC, ed., *Obstetric-Gynecologic Terminology*, Philadelphia, PA, USA: F.A. Davis Co., 1972.

12. Swahn ML et al., Effect of post-coital contraceptive methods on the endometrium and the menstrual cycle, *Acta Obstetrica et Gynecologica Scandinavica*, 1996, 75(8):738-744; Ling WY et al., Mode of action of dl-norgestrel and ethinylestradiol combination in postcoital contraception, *Fertility and Sterility*, 1979, 32(3):297-302; and Rowlands S et al., A possible mechanism of action of danazol and an ethinylestradiol/norgestrel combination used as postcoital contraceptive agents, *Contraception*, 1986, 33(6):539-545.

13. Ling WY et al., 1979, op. cit. (see reference 12); Kubba AA et al., The biochemistry of human endometrium after two regimens of postcoital contraception: a dl-norgestrel/ethinylestradiol combination or danazol, *Fertility and Sterility*, 1986, 45(4):512-516; Ling WY et al., Mode of action of dl-norgestrel and ethinylestradiol combination in postcoital contraception. II. Effect of postovulatory administration on ovarian function and endometrium, *Fertility and Sterility*, 1983, 39(3):292-297; and Yuzpe AA et al., Post coital contraception—a pilot study, *Journal of Reproductive Medicine*, 1974, 13(2):53-58.

14. Swahn ML et al., 1996, op. cit. (see reference 12); and Taskin O et al., High doses of oral contraceptives do not alter endometrial $\alpha 1$ and αv - $\beta 3$ integrins in the late implantation window, *Fertility and Sterility*, 1994, 61(5):850-855.

15. Glasier A, Emergency postcoital contraception, *New England Journal of Medicine*, 1997, 337(15):1058-1064; and Ling WY et al., Mode of action of dl-norgestrel and ethinylestradiol combination in postcoital contraception. III. Effect of preovulatory administration following the luteinizing hormone surge on ovarian steroidogenesis, *Fertility and Sterility*, 1983, 40(5):631-636.

16. Lebardone A et al., 1996, op. cit. (see reference 7).

17. Lebardone A et al., Relatório final da I oficina Brasileira sobre a anticoncepção de emergência: um grupo de consulta para o seu uso no Brasil, *Reprodução Climatério*, 1996, 11(2):75-76.

18. Glasier A and Baird D, The effects of self-administering emergency contraception, *New England Journal of Medicine*, 1998, 339(1):1-4.

19. Senanayake P, Emergency contraception: the International Planned Parenthood Federation's experience, *International Family Planning Perspectives*, 1996, 22(2): 69-70.

Resumen

Contexto: En Brasil, donde la anticoncepción de emergencia podría jugar un importante papel en la reducción de los embarazos no deseados, el gobierno ha incluido este método en

(continued on page 180)

Emergency Contraception...

(continued from page 171)

sus normas sobre planificación familiar. Sin embargo, se sabe muy poco acerca de la disponibilidad y provisión de este método.

Métodos: Una muestra representativa a nivel nacional que fue seleccionada en forma aleatoria constó de 579 obstetras y ginecólogos brasileños; dichos médicos respondieron a una encuesta sobre anticoncepción de emergencia, realizada por correo en 1997. Los datos aportaron información acerca de su conocimiento, sus actitudes y sus prácticas relacionadas con la anticoncepción de emergencia.

Resultados: Casi todos los entrevistados (98%) habían oído hablar de la anticoncepción de emergencia, pero muchos no tenían un conocimiento específico de este método. Aproximadamente el 30% creía erróneamente que la anticoncepción de emergencia funciona como un abortivo y el 14%, también en forma errónea, creía que este método era ilegal. Sin embargo, lo ofreció a sus pacientes el 49% de los médicos que pensaban que el método induce el aborto (el cual es ilegal en el Brasil) y el 46% de ellos pensando que el método mismo era ile-

gal. Más sorprendente aún, resultó que en tanto que el 61% de todos los entrevistados indicaron que habían recetado la anticoncepción de emergencia, solamente el 15% de ellos podían indicar en forma correcta la marca de la píldora que habían recetado, la dosis, el régimen y el momento en que las pacientes debían tomar la primera dosis.

Conclusiones: Podría mejorar en gran forma el acceso de la mujer al considerado método en el Brasil si se introduce en el país un producto determinado para fines de anticoncepción de emergencia, y se realizaran trabajos de educación para informar a los profesionales sobre cómo recetar el método.

Résumé

Contexte: Au Brésil, où la contraception d'urgence pourrait jouer un rôle critique dans la réduction des grossesses non désirées, le gouvernement a inclus la méthode dans ses normes de planification familiale. L'on en sait toutefois peu sur la disponibilité et la prestation du service.

Méthodes: Un échantillon national aléatoire de 579 obstétriciens-gynécologues brésiliens a répondu à une enquête menée par courrier en 1997 sur la question de la contraccep-

tion d'urgence. Les données recueillies renseignent sur les connaissances, les attitudes et les pratiques de ces prestataires à l'égard de ce type de contraception.

Résultats: Presque tous les répondants (98%) avaient entendu parler de la contraception d'urgence, mais beaucoup n'en possédaient pas une connaissance spécifique. Environ 30% croyaient, à tort, qu'il s'agissait d'une méthode abortive, et 14% pensaient, à tort aussi, qu'elle était illégale. Quarante-neuf pour cent des médecins selon lesquels la méthode provoquait un avortement (généralement illégal au Brésil) et 46% de ceux selon lesquels la contraception d'urgence était en soi illégale l'avaient toutefois prescrite à leurs clientes. Plus étonnant encore, alors que 61% des répondants déclaraient avoir presté des services de contraception d'urgence, 15% seulement pouvaient citer correctement la marque, la dose, le régime et le moment de la première dose d'une pilule prescrite.

Conclusions: Les efforts de sensibilisation axés sur une information de prescription spécifique et l'introduction d'un produit spécial permettraient d'améliorer grandement l'accès des femmes à la contraception d'urgence au Brésil.