Author's response to reviews

Title: Policy Maker and Provider Knowledge, Attitudes regarding the Provision of Emergency Contraceptive Pills within Lao PDR

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Version: 3 Date: 1 April 2010

Author's response to reviews: see over
Answer to the reviewer’s Davida Becker

Title: Policy makers' and Providers' Knowledge and Attitudes Regarding the Provision of Emergency Contraceptive Pills within Lao PDR
Version 1: Date 7 January 2010

Minor Essential Revisions
1. There is no information discussing the study’s limitations. This should be added to the discussion section.

I added the study’s limitation as following:

This study applied a qualitative design to explore the perceptions of policy makers and providers on ECP, using in-depth interviews as the major tool. More focus group discussions or a triangulation of methods might have better highlighted this issue. It should be noted that the clients’ perspectives and experiences were not taken into account, and we acknowledge the need to explore this to capture the full picture of the provision of ECP.

Preconceptions of the interviewers, most of whom had medical backgrounds, may have affected the interpretation of data gained from the interviews. To control for this, group checking with the research team and professional colleagues was done after data collection to assess the trustworthiness of the interpretation of the data.

As for qualitative studies in general, our findings cannot be transferred directly to other settings. However, the study can give valuable insights to other researchers working in similar settings. The key informants were selected based on the diversity of the perspectives they could bring to ECP in the urban areas, but not in the rural areas; furthermore, rural health providers’ knowledge and attitudes related to ECP should be considered in additional studies of the issue.

2. The authors are inconsistent in their descriptions of the people they quote from. Sometimes they report the sex, age, sector of work (public or private), and job of the person (Ob/gyn, policymaker, etc.) but other times they only report some of this information. They should be consistent.

I modified the description of key informants more consistency according to your comments.

3. In the introduction, the authors’ mentioned that ECPs are not registered by the FDA in Lao PDR but it is unclear what this means in practice for the availability of ECP methods.

There are dedicated ECP products sold at some private pharmacies and clinics, but not yet in the public sector.

In Laos, some providers also prescribed women regular combined oral contraceptive pills in higher dosage which can be taken as emergency contraception, however, this was not very common practiced because the clients did not understand these hormonal pills and some providers know very little about emergency contraception.
4. In the section on study design, the authors describe the criteria they used to select public providers, but they do not describe their criteria they considered when selecting private providers and policymakers. This information should be added.

Yes, I added the information of the criteria they used to select private providers and policymakers as following:

Policy makers were purposively selected from the Ministry of Health and included the director of the Preventive and Curative Department, the director of the FDA, the director of the Maternal and Child Health Center (MCH), directors from six central hospitals. Public health providers were medical doctors and nurses working in family planning services, including obstetric-gynecology wards in the government sectors and private providers were chosen from those who opened their family planning private clinics, providing SRH health care services. The participants were selected to reflect the public and private sectors as well as SRH professional backgrounds.

5. A sentence on page 14 states that “The Ministry does not currently allow use of ECP in Lao PDR, and there is no policy for its use.” This sentence conflicts with information presented earlier in the paper which states that ECP has been included in the Ministry of Health plan since 2005 (page 5). Please clarify.

Yes, the information gained from the key informants contradicted the existing policy as some key informants did not know about the National Reproductive Health (NRH) Policy and they lack of awareness of the NRH policy.

6. On page 5, the authors state: “The additional methods were not suitable for implementation in the public sector and only available in some private clinics.” It is unclear why these methods were not “suitable.” Does this reflect a lack of supply? The wording should be changed to clarify the point.

I modified this paragraph as following:

Some other forms of contraception such as vasectomy were discussed but less practiced due to acceptability of methods. Additional methods such as implants, female condoms, diaphragms, and ECP have not been implemented in the public sector and are only available in some private clinics.

7. On page 15, in the section “availability,” the authors state “these policymakers and providers foresee no adverse effect of the use of ECPs on STIs.” This point conflicts with several of the earlier quotes in the paper which suggest several people interviewed had concerns that increasing ECP access would lead to more STIs. Please clarify.

As I mentioned that the policy makers and providers have ambivalent attitudes; however, the positive attitudes outweighed the negative effect of ECP. I should change the sentence almost all policy makers and health care providers hinted, through varying degrees, towards the negative effects of the general availability… to some policy makers…(page 18).
8. In the sentence on page 6, the authors should change their wording to:
“….encouraging approval of a dedicated ECP product by the Lao Food and Drug Administration”

Thank you for your comment. I modified its. .. encouraging approval of a dedicated ECP by the Lao Food and Drug Administration.

9. On page 16, the authors should reword their sentence: “providers cannot be relied upon to give accurate and consistent advice to potential clients.”

Thank your suggestion for y. I modified the sentence …these providers can not be relied upon to give accurate and consistent advice to potential clients.

10. There are a number of small problems with English in the paper:
   a. Page 4 “ Only a few methods were routinely practiced…” “Practiced” should be changed to “offered”

Since its implementation, only a few methods were routinely offered in hospitals and MCH clinics at the provincial and district level, including IUD insertion, sterilization (provincial hospital only), Depomedroxy-progesterone Acete (DMPA), condoms and oral contraceptives (OCs). Oral contraceptives and condoms are also available at the village level through mass organizations and from village health volunteers or committee leaders who have received basic training.

b. Page 5 “Emergency contraceptives are used to prevented” the sentence should say “prevent”

c. Page 6 change wording to: “The study was carried out in Vientiane, the capital city of the Lao PDR.”

Thank you for your comment. I changed it.

d. Page 6 change wording to: “ the total population of Lao PDR is 5.6 million. The country is divided into 17 provinces.”

Thank you for your comment. I changed it.

e. Page 8 change wording to: “The interviews were carried out face to face with the key informants.” Also, add “a” before “tape recorder.”

Thank you for your comment. I changed it.

f. There is a typo on page 9 where the authors report “nearly two-thirds had at least “nice” years of working experience.

Thank you for your comment. I changed it.
g. On page 17, the sentence should be changed to: “In Italy, where people are also poorly informed on the available methods.”

Thank you for your comment. I changed it.

Discretionary Revisions
1. If oral contraceptive pills are sold over the counter, educational campaigns could seek to teach women how to take regular combined pills as ECPs until a dedicated ECP product becomes available. This strategy has been used in other countries such as Mexico and may be relevant to Lao PDR. The authors may want to add this point to their recommendations section.

2. On page 14, the authors should consider changing their wording from “better, more sustainable methods” to “more effective, ongoing methods”

Thank you for your comment. I changed it.

3. The long quote on page 16 is difficult to follow and some of the English is confusing. I suggest editing it down.

Thank you for your comment. I changed it.
Answer to Reviewer's Margareta Larsson

Title: Policy makers' and Providers' Knowledge and Attitudes Regarding the Provision of Emergency Contraceptive Pills within Lao PDR
Version: 1 Date: 8 January 2010
Reviewer: Margareta Larsson

Reviewer's report:
This study is an investigation among policy makers and care providers in Lao PDR about ECP and it highlights the persisting gaps of knowledge and doubtful attitudes towards the method that still persist in many countries. It is a timely paper which contributes to the efforts of making this safe and well documented contraceptive method available in all countries. The study included a sufficient number of participants and the results and the discussion are well supported by the data. However, the manuscript needs some major revision before it can be published.

Major Compulsory Revisions

1. ECP currently exists also in a one dose levonorgestrel regimen and a new product containing 30 mg Ulipristalacetat is also available. This new regimen can be used up to 5 days after unprotected intercourse.

   Thank you for your comment. I added it.

2. The mechanism of ECP is mainly through inhibiting ovulation. Other mechanisms are questioned and should be omitted.

   Thank you for your comment. I deleted other mechanisms.

3. The legal framework for drug approval in Lao PDR remains unclear. Is ECP available or not? Is approval by the FDA a prerequisite for the drug to be provided through different channels or is it already available? Please clarify!

   A dedicated ECP is not available in the public sector; however, these drugs are available in the private sector. The approval by the FDA is a prerequisite for the drug to be distributed through different channel officially.

4. Participants were only recruited in the capital area. Why?

   Yes, Participants were recruited only from the capital area because it was the centre of education, commerce and business of the country and it has border with Thailand through the International Friendship. In addition, there was a rapid change in socio-economic development in the Capital City with technology, globalization of trade, urbanization and migration, changing family structure and dispersal of family members, the life styles of youth and the sexual norms which will influence on youth sexuality with an increased of unprotected sexual contacts.

5. The standardized guideline for the interviews is not presented.
I added the guideline of in-depth interview.

Annex 1: Guideline for in-depth interview

1. In your opinion, what are the different among Emergency Contraceptive Pills (ECPs), Post – coital pills and morning after pills?
2. Have you ever studied or heard about ECPs before? If yes, from where? What did you learn or heard? Are there any issues on this regard that you would like to know more? (Probe for indications of the use, side effects…) If you never learned or heard, what contents that you would like to learn more. What is the reliable source(s) of this information? Why?
3. Attitude of providers towards ECPs:
   - What is your opinion about telling potential users about ECPs as an emergency choice?
   - In case of providing ECPs for women as an emergency back –up method, what is your opinion about this idea?
4. ECPs services for a wider perspective:
   - What is your opinion towards ECPs as an emergency choice for women?
   - What organization should involve for appropriate ECPs’ use? What section in the health care facility that is suitable for integrated ECPs into the services. Why?
     Who should be the potential ECPs providers? Why?
     - Effect from the availability of ECPs towards casual sex or/and prevention? (probe for negative and positive effect to the user)?
     - Information dissemination to the public, what is the highlight information that should release to the public. What do we expect public to learn about ECPs?
5. Are there any ECPs available for women at your organization? If yes, what type of ECPs. If no, why ECPs doesn’t include in your organization?
   - Who should be the potential users?
   - How do you feel about women who used ECPs? Why the potential users could not reach ECPs? What are the barriers? (Probe for information and communication, culture, values and norms, time and transport, price…)
6. What are the appropriate means of information for ECPs users to strengthen the health services?
   - For service providers what are key messages and format?
   - Type of printed materials for ECPs users. What is it should be?

6. If a standardized guide leads the interview I would not call them in-depth but rather semi-structured interviews.

Thank you for your comment. I did a mistake. I used the guideline for the in-depth interview. It is not a standardized guide, but rather guideline for in-depth interview.

7. Was saturation reached and was the analysis and the data collection ongiong simultaneously as is often recommended in qualitative research?

Yes, the saturation was reached and the analysis was done after data collection simultaneously.
The authors claim to have used latent content analysis but looking into the data I would rather call it manifest, which is OK.

Thank you for your comment and I changed to latent analysis.

The categories presented are exactly the same as the topic areas presented in the objective. This is a circular process that should be avoided in qualitative interpretation. I suggest you go back into your data and reexamine what were your most prominent findings so categories emerge from your data instead of from your predetermined objectives. What did you find? Present that and label the categories according to your findings.

The main objective of this paper was to explore the knowledge, and attitudes of providers regarding ECPs. Because I am thinking how to match the objectives and the results, so why, I put the objectives the same as the categories. I tried to modify according to your suggestion by going back to my data and present the most prominent findings.

What measures were taken to ensure trustworthiness?

The first interview was coded together by four members of the study team to develop mutually agreed on definitions for each code and to establish examples of each code; codes were reviewed and revised. Each interview was then coded separately by two members of the study team. After coding, the two team members met to discuss the results; again, any disagreements in coding were resolved by consensus. Categories and themes were arrived at by consensus between the four authors.

Qualitative studies are not meant to be generalized but some discussion about the transferability is needed. How about providers from rural areas? Do you think they would differ?

As for qualitative studies in general, our findings cannot be transferred directly to other settings. However, it can give valuable insights to other researchers working in similar settings. The key informants were selected based on the diversity of the perspectives they could bring to ECP in the urban areas, but not in the rural areas; furthermore, health providers’ knowledge and attitudes related to ECP from the rural areas are needed to explore.

No discussion about limitations is included and needs to be added.

Thank you for your comment. I added the study limitations.

Methodological Considerations

This study applied a qualitative design to explore the perceptions of policy makers and providers on ECP, using in-depth interviews as the major tool. More focus group discussions or a triangulation of methods might have better highlighted this issue. It should be noted that the
clients’ perspectives and experiences were not taken into account, and we acknowledge the need to explore this to capture the full picture of the provision of ECP.

Preconceptions of the interviewers, most of whom had medical backgrounds, may have affected the interpretation of data gained from the interviews. To control for this, group checking with the research team and professional colleagues was done after data collection to assess the trustworthiness of the interpretation of the data.

As for qualitative studies in general, our findings cannot be transferred directly to other settings. However, the study can give valuable insights to other researchers working in similar settings. The key informants were selected based on the diversity of the perspectives they could bring to ECP in the urban areas, but not in the rural areas; furthermore, rural health providers’ knowledge and attitudes related to ECP should be considered in additional studies of the issue.

Minor Essential Revisions

1. Change to past tense in the result section.

Thank you for your comments. I changed to past tense in the result section.

2. It would be good with a table showing the different steps in the analytical process with some example of meaning units, condensed meaning units, codes, categories and themes. That will guide the reader and strengthen the validity of the paper.

I presented the themes of analysis in the table:

Table 2: Summary of themes, categories and codes form analysis

<table>
<thead>
<tr>
<th>Codes</th>
<th>Categories</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Heard of ECP</td>
<td>Understanding of ECP</td>
<td>Knowledge of ECP</td>
</tr>
<tr>
<td>Lack of knowledge of mechanism</td>
<td></td>
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<td>Lack of knowledge of dosing</td>
<td></td>
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<tr>
<td>Lack of knowledge of timing</td>
<td></td>
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<tr>
<td>Lack of knowledge of side effects</td>
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<tr>
<td>Confusion the different names of ECP</td>
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<td>Training</td>
<td>Source of information</td>
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<tr>
<td>Media</td>
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<tr>
<td>Study tours</td>
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<tr>
<td>Mother &amp; Child Health Centers</td>
<td></td>
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<td>Colleagues</td>
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<td>Prescription</td>
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<tr>
<td>Agree to provide ECP versus disagree</td>
<td>Access to ECP services</td>
<td>Attitudes towards ECP</td>
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<td>Back up method</td>
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<td>Young people</td>
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<td>Rape victim</td>
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<tr>
<td>Married couples with occasional sexual intercourse</td>
<td></td>
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<tr>
<td>Everybody</td>
<td></td>
<td></td>
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<tr>
<td>Health care provider</td>
<td>Distribution channels</td>
<td></td>
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<tr>
<td>Media</td>
<td></td>
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<tr>
<td>Maternal and Child</td>
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<td>Obstetric-gynaecological wards</td>
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<tr>
<td>FDA</td>
<td></td>
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<tr>
<td>Positive effect</td>
<td>Effect of Availability of ECP</td>
<td></td>
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<tr>
<td>ECP encourage unsafe sexual behaviors</td>
<td></td>
<td></td>
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<tr>
<td>Negative effect</td>
<td></td>
<td></td>
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<tr>
<td>Outweigh of positive effect than negative effect</td>
<td>No registered drugs</td>
<td>Clandestine drugs</td>
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<td>-------------------------------------------------</td>
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<tr>
<td></td>
<td>Lack of information</td>
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<td></td>
<td>Barriers of use ECP</td>
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</tbody>
</table>

3. Some typos need to be corrected: page 9 "nine years of working experience". page 10 "after morning pills" should be changed to "morning after pills". Page 11. "providers never prescribed ECP".

Thank you for your comments. I changed according to your comments.

Discretionary Revisions

There are also other studies about advance provision showing that regular contraceptive use and sexual behaviour do not change even if ECP is provided to adolescents, one was performed in Sweden by Ekstrand M et al.

Thank you for your comments and I added in the reference list.
Answer of the Reviewer's Jane Harries

Title: Policy makers' and Providers' Knowledge and Attitudes Regarding the Provision of Emergency Contraceptive Pills within Lao PDR
Version: 1 Date: 26 January 2010
Reviewer: Jane Harries

Background

In this section it would be useful to provide more context as for many readers, myself included, very little is known about Lao and it health care system, though as a developing country there might be resonance with other developing countries in Africa and Latin America. This would provide some context as to why EC is unavailable in Lao and also the importance of this study.

Answer:
I added the background information on Health System in Laos as following.

The Public Health care system in Laos consists of three levels: central, provincial, and district levels. At the central level, Ministry of Health (MOH) is in charge of National Institute of Public Health, University of Health Sciences, Central pharamaceutical enterprise, central hospitals and nine centres, including Mother and Child Health Center (MCH). At the provincial level, services are coordinated by the provincial health office, and include service provision through provincial hospitals (45-240 beds) and supervising/supporting district health offices. District hospitals have between 15-25 beds and provide care for a population of about 300,000 people. The provincial health system is mirrored at the district level, where the district health office oversees services provided at the district hospitals and supports service delivery at the health post or dispensary level. In addition, there are village health volunteer at each village, who focus on health education, communication, hygiene and disease prevention (WHO, 2005).

In addition to public health facilities, there are more than 900 private clinics, most of which are located in the capital, Vientiane, and almost 2,000 registered pharmacies, located mostly in urban areas in close proximity to district or provincial hospitals (WHO, 2005). The private clinics play an important role in providing accessible SRH services in the urban areas and would help improve quality of health care.

Why investigate providers and policy makers attitudes towards a product that is not available or FDA approved in the country.

Answer:
This study investigated providers and policy maker’s attitudes towards a product that is not available or FDA approved in the country because ECP included in the National Reproductive Health Policy. Thus, there is a need to explore knowledge and attitudes of policy makers and providers in order to prepare to introduce ECP and encouraging approval of a dedicated ECP in the country.

Why focus on this particular method of preventing an unplanned pregnancy and not another?

Answer:
Because this method is the back up method for preventing unplanned pregnancy and there was shown that this method will reduce the unplanned pregnancy about 60% (Grossman, 2001). The other reason is that EC is included in the National Reproductive Health Policy, but lack of supply and implementation the EC in the government sector.

There are many unanswered questions or provision of background that would make the paper and research more compelling. For example:

What are attitudes towards childbearing, what role does the state play?

Answer:
Overall, the attitudes of providers towards childbearing are positive if women are married and have someone to responsible for their childbearing. If the childbearing without father, women felt more stigmatized and discriminated from the family and society.

What are the predominant methods of contraception and are they readily available – are they provided free in the public health care sector.

Answer:
I put in the background about the predominant methods of contraception. The most popular method currently use for married women is the pill (16%), followed by the injection (10.6%).

Are abortions legal in Lao etc all this would provide some backdrop to providers attitudes towards EC which in many countries is viewed as an abortifacient – (bearing in mind that EC is not an abortifacient yet these views also do emerge in this study) and thus would be interesting to know status of abortion in Lao and predominant religious beliefs of respondents and countrywide.

Answer:
In the Lao PDR, abortion is illegal and highly restricted; the vast majority of procedures are clandestine, and high proportions are unsafe. The legal status of abortion is permitted only to save the life of pregnant women; however, there are no clear criteria established regarding termination and there is very limited data on the incidence of abortion. These measures often involve clandestine abortions performed under unsanitary conditions and by unskilled practitioners using dangerous techniques (MOH, 2005).

Methods
Study setting
This is unclear- a detailed explanation of the study sites needs to be provided What is provided on page 6 under study site is a description of the formal health system in the country and not where the interviews were conducted – how does this relate to the various study sites in Vientiane City?
Answer:
I try to add to the study site.
The study was carried out in Vientiane Capital City of Lao PDR between March and June of 2007. Vientiane has a population of 464,000 and has the highest population density in the country. Compared with other parts of the country, the capital city has both higher levels of education as well as income and is the center of culture, commerce and administration in Laos. There are 108 private clinics in Vientiane Capital City, of which 82 private clinics provided Sexual Reproductive Health Services (SRH). The prevalence of contraceptive use is 41% in VTE City (VTE Health Office, 2009). The rapidly changing economic has the impact upon the sexuality of young people: high levels of internal migration place many young people far away from their villages and cultural norms, with an increased risk of unprotected sexual contacts.

Study participants needs to be defined and included in the methods section

Answer: Thank you for your comment, I included.

The target group of this study was policy makers, health providers, and staff of private clinics. Policy makers were purposively selected from the Ministry of Health and included the director of the Preventive and Curative Department, the director of the FDA, the director of the Maternal and Child Health Center (MCH), directors from six central hospitals. Public health providers were medical doctors and nurses working in family planning services, including obstetric-gynaecology wards in the government sectors and private providers were chosen from those who opened their family planning private clinics, providing SRH health care services. The participants were selected to reflect the public and private sectors as well as SRH professional backgrounds.

Socio demographic information in a uniform manner needs to be provided so that the reader has a clear idea who was interviewed, from which site, and what their position was i.e. health care provider (public or private) and policymaker and what kind of policy maker?

Answer:

The majority of key informants were male (7 males in 10 policy makers, 13 in 22 public providers; 6 in 10 private clinics). Among the policy makers, three from the MOH, four from central hospitals, one from the Mother and Child Health Center, one from the military hospital and one from the police hospital. The policy makers were the Directors of the Departments of the MOH and the hospitals. Ten of public providers were medical doctors and twelve were nurses who worked in the gynecology-Obstetric wards and Mother and Child unit which provided sexual reproductive health services; the ten private care providers worked in obstetrics-gynaecology and family planning programs and operated their clinics after working hours in the government sector. Nearly two-thirds of them had at least nine years of working experiences.

What kinds of clinics were these – were they primary health care clinics, family planning clinics providing SRH health care services or hospitals?

Answer:
The clinics were the family planning which provided SRH health care services.

Why were private clinics included in this study and what role does private health care play with regards to SRH and contraception or provision of EC in this setting?
The private clinics were included in this study because they play an important role in introducing ECPs as ECPs are available in some private clinics and some pharmacies. In addition, the private clinics can help to increase the coverage and quality of sexual reproductive health services, through its resources, expertise, and infrastructure.

Women felt shy and embarrassed to access contraception in the public sector; however, private clinics provided ECP to clients.

Research instruments

What were these guidelines – what were the issues explored?

Answer:

Annex 1: Guideline for in-depth interview

7. In your opinion, what are the different among Emergency Contraceptive Pills (ECPs), Post – coital pills and after morning pills?
8. Have you ever studied or heard about ECPs before? If yes, from where? What did you learn or heard? Are there any issues on this regard that you would like to know more? (Probe for indications of the use, side effects…) If you never learned or heard, what contents that you would like to learn more. What is the reliable source(s) of this information? Why?
9. Attitude of providers towards ECPs:
   • What is your opinion about telling potential users about ECPs as an emergency choice?
   • In case of providing ECPs for women as an emergency back –up method, what is your opinion about this idea?
10. ECPs services for a wider perspective:
    • What is your opinion towards ECPs as an emergency choice for women?
    • What organization should involve for appropriate ECPs’ use? What section in the health care facility that is suitable for integrated ECPs into the services. Why?
      Who should be the potential ECPs providers? Why?
      • Effect from the availability of ECPs towards casual sex or/and prevention? (probe for negative and positive effect to the user)?
      • Information dissemination to the public, what is the highlight information that should release to the public. What do we expect public to learn about ECPs?
11. Are there any ECPs available for women at your organization? If yes, what type of ECPs. If no, why ECPs doesn’t include in your organization?
    • Who should be the potential users?
    • How do you feel about women who used ECPs? Why the potential users could not reach ECPs? What are the barriers? Describe? (Probe for information and communication, culture, values and norms, time and transport, price…)
12. What are the appropriate means of information for ECPs users to strengthen the health services?
    • For service providers what are key messages and format?
Type of printed materials for ECPs users. What is it should be?

Please expand what is meant by standardized guidelines page 8.

Answer:
I think that it is not standardized guideline; however, it is a semi-structure guideline.

This is unclear – Please expand how was data collected what were the selection criteria and did all those approached agree to participate

Answer:
The first author (VS) initially contacted the key informants through colleagues in the Ministry of Health, central hospitals and private clinics. Three of the interviewees were senior specialists and another three were public health backgrounds. In-depth interviews were carried out face to face with the key informants such as 10 policy makers, 22 public providers (12 medical doctors and 10 nurses), and health providers at 10 private clinics. Participants were interviewed in a private office at the Ministry of Health, hospitals and private clinics by the trained interviewers.

The selection criteria were providers in both public and private who provided SRH services, including contraception. For the policy makers, they were directors of the Department of Curative; Department of Health Prevention; Department of FDA; MCH centre, four central hospital, one military and one Police hospitals.

Who analyzed the data?

Answer:
The first interview was coded together by four members of the study team to develop mutually agreed on definitions for each code and to establish examples of each code; codes were reviewed and revised. Each interview was then coded separately by two members of the study team. After coding, the two team members met to discuss the results; again, any disagreements in coding were resolved by consensus. Categories and themes were arrived at by consensus between the four authors.

Who conducted the interviews and what training did they have? This is important to know –

Answer:
The interviewers were from the Faculty of Postgraduate Studies & Research and they had the medical backgrounds.

Ethical clearance-how was confidentiality ensured – it is not mentioned – what steps if any were in place to ensure anonymity?

Answer:
All the information gained from the study participants were to ensure confidentiality and they could withdraw their participation anytime during the interview. Pseudonymous was used to ensure anonymity.
Why were in depth face to face interviews chosen – why was this deemed important?

Answer:
I used to write face-to-face interview or just write in-depth interview. In-depth interviews are usually conducted face-to-face and involve one interviewer and one participant.

Results

This section needs to be tightened up – as it reads it is very descriptive

Page 11
Attitudes towards ECP
These subheadings
Access
Target population
Distribution channels
Might be more useful

Answer:
Thank you for your comment. I added like your suggestion.

Overall not clear what the difference if any was between policy makers and providers and between public and private providers knowledge and attitudes towards EC – it might be useful to provide a paragraph summing up what the differences were if any between these different stakeholders.

Answer:
Thank you for your comments. I summarized the difference between policy makers and public and private provider’s knowledge and attitudes towards ECP as following:

Policy makers lacked of knowledge of details information related to ECP; while public and private providers had some misconceptions of ECP. Few private providers had more knowledge on ECPs due to prescribing a higher dosage of the regular combined oral contraceptive pills. Regarding their attitudes, most policy makers and providers agreed to introduce ECP in the public sector by convincing positive effects outweighed the negative effects. Some public health providers were more likely to incline there was some negative effects of the availability of ECP than those private providers.

General comments
It would have provided more strength to the study if women or potential recipients of EC had been interviewed and a possible limitation to the study-

Answer:
This is a limitation of the study. I also did interviewed women and men who are the potential users of ECP which is presented in separate paper.

There are no stated limitations to this study and these needs to be discussed.
Answer:
I added the limitation

Methodological Considerations

This study applied a qualitative design to explore the perceptions of policy makers and providers on ECP, using in-depth interviews as the major tool. More focus group discussions or a triangulation of methods might have better highlighted this issue. It should be noted that the clients’ perspectives and experiences were not taken into account, and we acknowledge the need to explore this to capture the full picture of the provision of ECP.

Preconceptions of the interviewers, most of whom had medical backgrounds, may have affected the interpretation of data gained from the interviews. To control for this, group checking with the research team and professional colleagues was done after data collection to assess the trustworthiness of the interpretation of the data.

As for qualitative studies in general, our findings cannot be transferred directly to other settings. However, the study can give valuable insights to other researchers working in similar settings. The key informants were selected based on the diversity of the perspectives they could bring to ECP in the urban areas, but not in the rural areas; furthermore, rural health providers’ knowledge and attitudes related to ECP should be considered in additional studies of the issue.

In view of the fact that this article is in the Health Services Research BMC journal more should be discussed in terms of recommendations or suggestions as to how EC can be rolled out in Lao and if so how it can be integrated into other health services including perhaps private and or sexual assault services.

Answer:
Thank you for your comments. This is an early stage to integrate EC into other reproductive health services including private and or sexual assault services in Laos, since a dedicated product had not been introduced yet.


Thank you for suggestion this book

This manuscript needs to be checked for numerous typos.

Clarifications and minor essential revisions
1. Page 4 last paragraph : what are these natural methods?
Answer:
The natural methods included calendar and withdrawal.

What are these other forms of contraception?
Answer:
Some other forms of contraception such as vasectomy were discussed but not practiced due to acceptability of methods.

2. First sentence page 5 what are these additional methods? And why where they not available in some private clinics.
   Answer: The additional methods were implant, female condom, diagphragma, and ECP were not implemented in the public sector and only available in some private clinics due to lack of supply in the public sector.

3. Page 5 Need clearer descriptions of different EC methods see WHO Guidelines
   Answer: Thank you for your comments.

4. Last sentence page 5 suggest replace ignorance with poor levels of knowledge
   Answer: Thank you for your comments.

5. Page 6 Methods Study setting. The first sentence needs to be re written to read
   The study was carried out in Vientaine the capital city of Lao PDR.
   Thank you for your comments.

6. Page 8 Second paragraph should read
   In -depth interviews were carried out face to face with the key informants…….
   Thank you for your comments.

7. Page 9 – First word should read Ethical clearance. Second paragraph under Results should read nine years of working experience ( not nice years)
   Thank you for your comments.

8. References page 21 [16] Abuabara et al typo should read as often as needed: appropriate use of emergency contraceptive pills
   Thank you for your comments.