Pharmacy Access to Emergency Contraception in California

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CONTEXT: *California is one of eight states that allow a woman to obtain emergency contraceptives from a pharmacy without a physician prescription. Because many women do not know about emergency contraception or direct pharmacy access, it is important to understand barriers to getting the method and women's reasons for choosing the pharmacy option.*

METHODS: *In a 2004 survey at 25 predominantly independent pharmacies across California that offered pharmacy access, 426 women completed questionnaires after obtaining emergency contraceptives. They were asked about their reasons for seeking the method, the time of unprotected intercourse, barriers to access, how they learned about pharmacy access and their reasons for choosing it. Chi-square tests and analysis of variance were used to assess differences between subgroups.*

RESULTS: *Eighty-six percent of women wanted emergency contraceptives for immediate use, and women obtained the method an average of 36 hours after unprotected intercourse. Those younger than 16, those who had had unprotected sex on the weekend and those who were embarrassed to ask for the method or who did not know about it all took a longer time to get the medication than did their respective comparison groups. Women who chose pharmacy access did so because they thought it was faster (54%) and more convenient (47%) than seeking a physician prescription. The majority reported that talking to a pharmacist was very helpful (84%) and that it was very important to be able to get the method directly from a pharmacy (81%).*

CONCLUSIONS: *Increasing women's knowledge about emergency contraception and its availability directly from pharmacies has the potential to improve the effectiveness of this contraceptive method by reducing the time interval between unprotected intercourse and initiation of treatment.*

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Emergency contraceptives—oral hormonal contraceptives taken after intercourse but before implantation to prevent pregnancy—are more effective the sooner they are taken after unprotected intercourse.[1] The method can prevent pregnancy when taken within 120 hours of unprotected sex.[2] When taken within 72 hours, progestin-only pills reduce the risk of pregnancy by 85%, and combined-hormone pills reduce the risk by 57%.[3] Because of the importance of timely access to the method, the manufacturer of Plan B, the only emergency contraceptive currently marketed in the United States, has applied to the federal Food and Drug Administration for approval to sell it over the counter.

Even before this application was filed, however, several states had enacted legislation or applied existing regulations to allow for the provision of emergency contraceptives directly through pharmacies without a physician prescription. In California, where the pharmacy access law became effective in January 2002,* pharmacists who choose to provide emergency contraceptives to women without a prescription from a doctor or clinic are required to obtain training in both clinical and counseling skills. These pharmacists work under a collaborative drug therapy agreement with an authorizing physician or under a protocol from the state's pharmacy and medical boards. They may dispense the method for immediate use up to 120 hours after unprotected intercourse, as well as for future use. Currently, about 1,200 of the state's approximately 5,500 retail pharmacies offer pharmacy access to emergency contraceptives in 49 of 58 counties.[4]

In California, a woman who needs emergency contraception for immediate or future use can visit a participating pharmacy to request it. The pharmacist reviews the woman's medical situation to assess the appropriateness of furnishing the method, provides information about it, dispenses the product and a state-mandated fact sheet (available in 11 languages) and makes referrals, if necessary, for services such as STD screening or ongoing contraceptive care. The client (or her insurance) pays for the medication and a maximum $10 pharmacist consultation fee.

By eliminating the requirement for a visit to a physician or clinic to get a prescription, pharmacy access has the potential to reduce the time it takes to obtain emergency contraceptives. Women trying to get the method through a doc-

*The other states with pharmacy access are Alaska, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico and Washington.

tor's office or clinic face a number of barriers. For example, among physicians listed on a national emergency contraception hotline and Web site as sources for prescriptions in 1999, one-quarter did not provide an appointment or a prescription within 72 hours.[5] In a 2001 California survey, a caller posing as a woman in need of the method found that 23 of 61 family planning providers participating in the state's Medicaid program offered neither emergency contraceptives nor a referral to another provider.[6] Thus, timely access to the method may be more likely through pharmacies than through clinics or physicians' offices, because pharmacies are more widely located and usually have longer business hours, including on weekends.

In this article, we report on a survey of women who received emergency contraceptives at pharmacies with collaborative protocols. The survey was designed to examine women's experiences in obtaining emergency contraception and, particularly, whether direct pharmacy access shortened the time it took them to obtain the method following unprotected intercourse. We hypothesized that women who received emergency contraceptives directly from a pharmacy would experience shorter delays than women who first sought a physician prescription.

METHODS

Pharmacies for this study were drawn from 612 pharmacies listed as providing direct access to emergency contraceptives on a Web site (<http://EC-Help.org>) and toll-free hotline (1-877-EC-HELPS) maintained by Pharmacy Access Partnership, a nonprofit center of the Public Health Institute in Oakland, California. We excluded 130 of these pharmacies because they had not completed a survey conducted by Pharmacy Access Partnership in December 2003. To ensure that our survey reflected typical client experiences and included a representative sample of women, the probability of being selected was proportionate to a pharmacy's average weekly number of emergency contraceptive clients as reported in the 2003 survey.

In our initial random sample of 29 pharmacies, we found that pharmacists at chain stores had difficulty obtaining corporate approval to participate. Two of the 15 chain pharmacies and eight of the 14 independent pharmacies in this group agreed to participate in the survey. In light of the difficulties in securing participation from chain pharmacies, a second random sample included 27 independent pharmacies, 15 of which agreed to participate. Overall, 25 pharmacies participated—two chain and 23 independent pharmacies. They were located in rural and urban areas of Alameda, Humboldt, Los Angeles, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco and San Joaquin counties. Participating pharmacies were open an average of 6.1 days or 55 hours per week, whereas the average among all California direct access pharmacies is 6.3 days or 68 hours per week.*

Pharmacies participated in the survey for 1–10 weeks (mean, 5.5 weeks) during the summer of 2004 and were compensated between $200 and $400, depending on the duration of their involvement. In each participating pharmacy, all staff signed an agreement to abide by the survey protocol, including a confidentiality form, which was approved by the institutional review board of the Public Health Institute. Pharmacists asked all women seeking emergency contraceptives to fill out a one-page anonymous, confidential questionnaire after their request for the method was filled. Although females younger than 12 would not have been invited to participate in the survey, none were encountered at the participating pharmacies. Pharmacists were asked to maintain a log of all women seeking emergency contraceptives, including their age, race or ethnicity; the visit date and time; whether women had a prescription; and whether they agreed to participate in the study.

The questionnaire, which was available only in English, asked about women's demographic characteristics, their previous use of emergency contraception, the date and time of unprotected intercourse, their reasons for requesting the method and barriers to obtaining it. It also asked how women learned about direct pharmacy access and their reason for choosing this option, and included questions about their experience at the pharmacy, their knowledge about using the method and when they planned to take the first pill. Women sealed their questionnaires in the envelopes provided and returned them to the pharmacist or pharmacy staff. Participants received five-dollar Starbucks gift cards. Pharmacists returned the completed questionnaires to Pharmacy Access Partnership on a weekly basis in prepaid envelopes.

Analysis of variance was used to identify differences between subgroups in the time it took women to obtain emergency contraceptives. To assess these differences, we chose reference groups with characteristics that we hypothesized would be associated with fewer barriers to obtaining the method—women aged 30 or older, white women, those who used pharmacy access rather than first seeking a physician prescription and those who had unprotected intercourse between Monday and Thursday. To study the barriers to obtaining emergency contraceptives, we compared women who reported a specific barrier, such as not knowing the method exists, with those who did not report that particular barrier. Chi-square tests were used to assess the differences in knowledge between users of pharmacy access and prescription holders. All analyses were performed using Stata SE version 8.2.

RESULTS

Sample Characteristics

Of 633 women who sought emergency contraceptives from participating pharmacies, 426 (67%) agreed to participate in the survey. The response rate was lower among Hispanics (48%) than among whites (82%), Asians or blacks (89% each). It was higher among women younger than 30 (72%) than among those 30 or older (52%).

*According to Pharmacy Access Partnership's directory of California pharmacies that provide direct access, 9% of independent pharmacies and 76% of chain pharmacies are open on Sundays. In our study, 17% of the independent and all of the chain pharmacies were open on Sundays.

TABLE 1. Percentage distribution of women seeking emergency contraceptives at California pharmacies, by selected characteristics, 2004

Characteristic	% (N=426)
Age	
13–15	1
16–17	12
18–19	16
20–24	37
25–29	17
≥30	15
Missing	1
Race/ethnicity	
Non-Hispanic white	45
Hispanic	33
Asian	11
Black	4
Native American	1
Other	3
Missing	2
Use of direct pharmacy access	
No	14
Yes	85
Missing	1
No. of times method previously used	
0	45
1	27
2	12
3	6
≥4	7
Missing	3
Day of unprotected intercourse†	
Sunday	19
Monday	18
Tuesday	12
Wednesday	14
Thursday	13
Friday	11
Saturday	13
Day of pharmacy visit	
Sunday	1
Monday	24
Tuesday	18
Wednesday	14
Thursday	14
Friday	14
Saturday	13
Missing	1
Reason for seeking method	
Unprotected intercourse	46
Condom failure	32
Uncertain about protection	8
For future use	7
Missing	7
Elapsed hours since unprotected intercourse‡	
≤12	11
13–24	29
25–36	15
37–48	19
49–60	11
61–72	10
73–120	4
121–165	1
Total	100

†Among the 356 women who wanted emergency contraceptives for immediate use and who reported the day of intercourse. ‡Among the 293 women who wanted the method for immediate use and who reported both the day and the time of intercourse. *Note:* Percentages may not total 100 because of rounding.

The mean age of participants was 23.4. Nearly one-third were younger than 20, about a third were 20–24 and the remaining third were 25–47 (Table 1). Five participants were younger than 16; four were 15, one was 14 and another was 13. Forty-five percent of the women were white, 33% were Hispanic, 11% were Asian and 4% were black, reflecting the racial and ethnic composition of the state's population.[7] Fourteen percent had a physician prescription, and 85% did not. There were no significant differences between these two groups in their demographic or behavioral characteristics.

Forty-five percent of respondents had never used the method before; 27% had used it once, 12% had used it twice, 6% had used it three times and 7% had used it four or more times. Forty-three percent had had unprotected intercourse over a weekend (Friday to Sunday). Sunday was the most frequently reported day for having unprotected sex (19%), and the least frequently reported for obtaining emergency contraceptives (1%). Twenty-four percent of women sought the medication from a pharmacy on Monday, and 18% did so on Tuesday. Overall, 9% of participants used pharmacies that were open five days per week, and 80% used pharmacies that were open six days per week (not shown). The remaining 11% went to pharmacies that were open every day.

The vast majority of women wanted emergency contraceptives for immediate use. Reported reasons were no protection during intercourse (46%), condom failure (32%) and uncertainty about protection at last intercourse (8%). Only 7% obtained the method for future use.

Women's Experiences in Obtaining Emergency Contraception

•*Elapsed time before obtaining emergency contraception.* Of the 397 women who wanted emergency contraceptives for immediate use or who did not disclose their plans, 356 reported the day of unprotected intercourse and 293 reported both the time and the day. Many of the remaining women gave general answers such as "in the morning," for which we could not calculate an elapsed time until receipt of the medication. Most women (95%) obtained the method from the pharmacy within the recommended 72 hours following unprotected intercourse; 11% received it within 12 hours, 40% within 24 hours and 74% within 48 hours. Four percent of women obtained it between 73 and 120 hours, and 1% after 120 hours. The time from unprotected intercourse to receipt of emergency contraceptives at a pharmacy averaged 36.2 hours, ranging from 15 minutes to 165 hours.

Respondents younger than 16 took 27 hours longer to obtain emergency contraceptives than did women aged 30 or older (Table 2). Women who had had unprotected intercourse between Friday and Sunday took six hours longer to get the method than did those who had had unprotected sex between Monday and Thursday. There was no significan difference between women who first got a physician prescription and those who went directly to pharmacies.

•*Barriers to getting emergency contraception.* To identify barriers to obtaining emergency contraceptives, we asked participants to choose from a list of factors that may have pre-

TABLE 2. Percentage distribution of women seeking emergency contraceptives, and difference in number of elapsed hours since unprotected intercourse, by selected characteristics

Characteristic	% (N=293)‡	Difference in elapsed hours
Age		
13–15	1	26.7*
16–17	11	0.8
18–19	16	7.4
20–24	41	–3.0
25–29	15	–0.8
≥30	16	ref
Race/ethnicity		
White	46	ref
Hispanic	32	6.2†
Other	22	–2.3
Use of direct pharmacy access		
No	11	4.5
Yes	89	ref
Day of unprotected sex		
Friday–Sunday	33	6.1*
Monday–Thursday	67	ref
Total	100	na

*Significantly different from reference group at p<.05. †Significantly different from reference group at p<.10. ‡Percentages are of women who wanted emergency contraceptives for immediate use and who reported the day and time of intercourse. *Notes:* Difference in elapsed hours was determined by analysis of variance. ref= reference group. na=not applicable.

vented them from getting the method sooner (Table 3). Four in 10 selected "not knowing which pharmacy provides emergency contraception." One in five women did not know of or could not find a doctor or clinic that provided it, and an equal proportion said that "having to go to a doctor or clinic for a prescription" slowed them down. More than a quarter of women (28%—not shown) said the lack of availability of the pharmacist (19%) or pharmacy hours (19%) prevented them from getting emergency contraceptives sooner.

Twelve percent of women said that being embarrassed to discuss the need for emergency contraceptives slowed them down, and these women took an average of 10 hours longer to get it than did women who did not select this reason. Ten percent said not knowing about the method slowed them down, and they took 11 hours longer to obtain it.* A quarter reported no barriers that slowed them in getting the method.

Women with physician prescriptions faced different barriers than those who went directly to pharmacies. A larger proportion of prescription holders than of direct pharmacy users said that having to go to a doctor or clinic for a prescription was a barrier (33% vs. 19%; p<.05—not shown). A higher proportion of these women also reported that embarrassment about discussing emergency contraception prevented them from getting the method sooner (25% vs. 11%; p<.01).

•*Insurance coverage.* Sixty-one percent of women paid out of pocket for their emergency contraceptives, while the remainder relied on insurance coverage. Twenty-three percent used Family PACT, California's Medicaid family planning waiver program for low-income women and men. Nine percent were covered by Medi-Cal, the state's Medicaid program, and another 9% used private insurance to pay for the method. A larger proportion of Hispanics than of other participants used the two state programs (48% vs. 32%).

•*Choosing pharmacy access.* Among women who used pharmacy access to get emergency contraceptives, the most-cited source of information about the method's availability directly from pharmacists was a doctor or clinic (39%—Table 4, page 50). Thirty-five percent of women found out about pharmacy access from a friend, and 14% from a pharmacist. The Internet was a source for 11% of women (6% used the EC-Help Web site). Telephone hotlines and schools were each cited by 7% as sources. Family and various media were each selected by fewer than 5% of respondents.

When asked why they came to the pharmacy directly instead of first going to a doctor or clinic for emergency contraceptives, 54% of participants said that it was faster. Forty-seven percent said the pharmacy location was more convenient to their home, work or school, and 25% said it was "more comfortable going to a pharmacist than a doctor." Twenty percent said they could not get an appointment at a doctor's office or clinic, and 18% cited the convenience of pharmacy hours on nights, weekends and holidays as an incentive for choosing pharmacy access. Sixteen percent thought it would be cheaper than getting the method from a doctor or clinic. More than one in five women reported that they did not have health insurance (13%), did not have a regular doctor (12%) or both (4%).

Among the 54 women who came to a pharmacy with a prescription, 65% reported that they did not know that women in California could get emergency contraceptives directly from a pharmacist without first getting a prescription from a doctor or clinic (not shown). Most of the 34 women (82%) who had a prescription and did not know about direct pharmacy access said that if they had known

TABLE 3. Percentage of women indicating that selected barriers impeded their access to emergency contraception, and difference in number of elapsed hours since unprotected intercourse for women reporting each barrier

Barrier	% (N=293)†	Difference in elapsed hours
Not knowing which pharmacy provides it	39	1.7
Not knowing/finding a provider	22	3.5
Having to go to a doctor/clinic for a prescription	20	3.4
Limited availability of the pharmacist	19	6.1
Pharmacy hours	19	2.1
Embarrassed to discuss need	12	10.2*
Not knowing it exists	10	10.7*
No barriers/nothing slowed getting it	26	–4.4

*Significantly different at p<.05. †Percentages are of women who wanted emergency contraceptives for immediate use and who reported the day and time of intercourse. *Notes:* Difference in elapsed hours was determined by analysis of variance. Comparison groups were women not reporting each barrier; comparison group for the "no barriers" category was women who reported any barrier.

*There were significant racial differences in knowledge; 25% of black women and 20% of Hispanic women said that not knowing about the method slowed them down, compared with 5% of white women.

TABLE 4. Percentage of women seeking emergency contraceptives, by responses to selected questions about pharmacy access to the method

Question	%
Source of information about pharmacy access	(N=358)
Doctor/clinic	39
Friend	35
Pharmacist	14
Web site	11
Hotline	7
School	7
Family	4
Ad	3
Magazine/newspaper	2
TV	1
Reason for choosing pharmacy access	(N=358)
Takes less time than going to a doctor/clinic	54
Convenience of pharmacy location to home/work/school	47
More comfortable going to a pharmacist than a doctor	25
Could not get an appointment with a doctor/clinic	20
Pharmacy open on weeknights/weekends/holidays	18
Cheaper than going to a doctor/clinic	16
Do not have health insurance	13
Do not have regular doctor/clinic	12
Helpfulness of talking to pharmacist	(N=426)
Very	84
Somewhat	9
Not	0
Did not talk to pharmacist	2
Missing	5
Importance of direct pharmacy access	(N=426)
Very	81
Somewhat	13
Not	2
Missing	3

Note: Women could choose multiple responses for source of information and reason for choosing pharmacy access.

this earlier, they would have gone directly to a pharmacy for the method.

•*Satisfaction with pharmacy access.* Overall, a majority of women (84%) said that talking to a pharmacist about emergency contraception was very helpful, and 9% said it was somewhat helpful. Two percent reported that the pharmacist did not talk to them. When asked whether they thought it was important to be able to get the method directly from a pharmacist, 81% said it was very important and 13% said it was somewhat important, while only 2% said it was not important.

The majority of women expressed interest in receiving other reproductive health services directly from pharmacies (not shown). Eighty-five percent were somewhat or very interested in direct pharmacy access to hormonal contraceptives, and 75% were somewhat or very interested in pharmacy-based testing or treatment for STDs.

Women's Knowledge About Using Emergency Contraception

To assess women's knowledge about using the method, we asked them to respond to three true-false statements regarding its use (Table 5). Most women correctly agreed that "the earlier the first tablets are taken the more likely they are to work." The proportion who responded correctly was significantly higher among women using pharmacy access (92%) than among women with prescriptions (73%). Three-quarters of women knew that emergency contraceptives "may make you feel nauseous," and nearly nine in 10 knew that it "does not protect against sexually transmitted infections." Responses to the last two statements did not vary significantly between women with physician prescriptions and those who used pharmacy access.

To examine whether respondents understood that they are supposed to take the first tablet as soon as possible after unprotected intercourse, we asked women who obtained the method for immediate use when they intended to take their first pill. Overall, 96% said they would take the pill within one hour. The proportion giving this response was significantly higher among women using pharmacy access (97%) than among women who had physician prescriptions (88%).

DISCUSSION

Lack of awareness of emergency contraceptives and where they can be obtained continues to be a significant barrier to getting the method in a timely manner. A California survey conducted between 1999 and 2001 found that 38% of women aged 18–44 knew about the method.[8] Hispanic, foreign-born, older and poor women, as well as women without a high school education, all had low levels of knowledge about emergency contraception. Another study found that only 9% of all Californians knew that it is directly available in participating pharmacies.[9] We found that women who did not know about the method experienced significant delays in obtaining it. Wider publicity of the availability of emergency contraception through education campaigns, Web sites and hotlines may increase women's access and reduce the time it takes to obtain the method.

This study indicates a continued need for physicians, clinics and pharmacists to inform their patients about emergency contraceptives and to provide the method. A Kaiser

TABLE 5. Percentage distribution of women seeking emergency contraceptives, by responses to selected questions about use of the method, according to use of pharmacy access or physician prescription

Question	Total (N=409)	Pharmacy access (N=353)	Physician prescription (N=56)
The earlier taken, the more effective			
True	89	92	73*
False	11	8	27
May create nausea			
True	75	75	77
False	25	25	23
Does not protect against STDs			
True	85	84	89
False	15	16	11
How soon woman plans to take†			
Within 1 hour	96	97	88*
>1 hour from now	4	3	12
Total	100	100	100

*Significantly different from pharmacy access users at p<.05. †Among women who wanted emergency contraceptives for immediate use.

Family Foundation survey conducted in 2003 found that only 12% of women in California had learned about the method from their health care provider, and that television news was the leading source of information.[10] In our survey, negligible proportions of women who actually obtained emergency contraceptives had heard about pharmacy access through television or print news, while 39% had learned about it from a doctor or clinic, and 14% from a pharmacist. One explanation for why we found no significant difference in elapsed time since unprotected intercourse between women who had a physician prescription and those who went directly to the pharmacy is that many of the latter women reported that limited pharmacy hours and pharmacist availability had slowed them down. Until knowledge of pharmacy access for this contraceptive method is widespread, the full time savings of direct pharmacy access will not be realized.

Currently, the Food and Drug Administration is considering dual label status for Plan B, by which women 16 or older can obtain it over the counter, but those 15 or younger must first get a physician's prescription. Our study found that women younger than 16 experience delays of more than 24 hours in obtaining the method, even without the need for a physician prescription. Requiring younger women to find a doctor who will write a prescription before they go to the pharmacy may further delay their use of the method. If such dual label status is established, permitting pharmacists to initiate a prescription under pharmacy access protocols will become an even more important clinical service in the prevention of unintended pregnancy, especially for the youngest women and for women who cannot show proof of their age.

Another issue related to over-the-counter status is health insurance coverage of the method. Nearly a third of women we surveyed used public health care programs to pay for their emergency contraceptives. If the medication becomes available over the counter, both Family PACT and Medi-Cal should continue to cover its cost, or lower income women will have to bear the economic burden. We found that few women used private insurance to pay for emergency contraceptives, although private plans are required to cover it under the state's Contraceptive Equity Act. Women's concerns about confidentiality or a lack of knowledge of covered benefits may explain the low utilization of private insurance. Health plans that cover the cost of abortions and births would benefit from publicizing their coverage of emergency contraception and so avert some of the costs of unintended pregnancy.

Encouraging advance provision of emergency contraceptives is an important way to prevent unintended pregnancy. Several studies have shown that women who had the medication at home were more likely to use it after unprotected intercourse than were those who had to have a prescription filled.[11] However, we found that fewer than one in 10 women sought emergency contraceptives for future use. Given the apparent lack of demand for advance provision, pharmacy access may be the most direct route to getting the method, short of making it available over the counter. Nine states introduced pharmacy access legislation for emergency contraceptives in 2005, two of which enacted laws.* As pharmacy access becomes more widespread and women become more aware of this option, the elapsed time from unprotected intercourse to getting the method may be shortened, thus increasing its effectiveness and reducing the incidence of unintended pregnancy.

At a time when media attention has been focused on pharmacist refusals to stock or dispense emergency contraceptives, this study found pharmacists to be an important source of information and education about the method and its availability. Participants acknowledged the helpful role that pharmacists played and the importance of being able to get the medication directly from a pharmacy. Women also expressed support for pharmacy access to hormonal contraceptives and to testing for STDs. These findings complement national data showing women's interest in pharmacy access for contraceptive pills, patches and rings.[12] Investing in pharmacists and pharmacies as a critical source for information on and provision of emergency contraceptives, as well as other reproductive health services, can expand women's options and access to methods of pregnancy prevention and improve women's health.

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Limitations

Our study may not have identified all the barriers that women face in obtaining emergency contraceptives in pharmacies. The survey was administered only to women who had successfully obtained the method at a pharmacy employing a pharmacist who had been trained and authorized to provide it directly to women without a physician prescription. We did not collect data for women who went to a pharmacy that did not provide similar access, or for women who requested the medication but did not obtain it. Because our survey was conducted in English, we also could not assess the experiences of non-English speakers.

Another limitation is that our survey included only two chain pharmacies, as it was difficult for pharmacists to get permission from their headquarters to participate in the study. Unfortunately, this shortcoming skewed our sample toward independent pharmacies. Corporate chains make up 56% of all California pharmacies that offer pharmacy access to emergency contraception,[13] but only 8% of the pharmacies in our sample. Because our survey was conducted predominantly in independent pharmacies, and because these pharmacies on average have shorter business hours and are open fewer days per week than chain pharmacies, the women in our study likely experienced greater delays in getting their medication than does the average California woman seeking it. Our reliance on independent pharmacies may have contributed to the finding that the least common day for a pharmacy visit was Sunday. Furthermore, the fact that many of the pharmacies in our study were not

*The nine states are Illinois, Kentucky, Maryland, Massachusetts, New Hampshire, New York, Oregon, Texas and Vermont. New Jersey introduced legislation in 2004 that is still pending.

open seven days a week may have resulted in the lack of time difference to obtain the method between women with physician prescriptions and women using direct pharmacy access.

Conclusions

Women who used pharmacy access to get emergency contraceptives believed it was faster, more convenient and less expensive than seeking a physician prescription. Surprisingly, although the public setting and potential lack of privacy at the pharmacy counter might deter women from directly requesting the method, one in four women said they chose pharmacy access because it was "more comfortable" than visiting a doctor or clinic. A majority of the women who did not use pharmacy access reported that they would have done so had they known it was an option.

Given that the most common day for unprotected intercourse among women in our study was Sunday, and that almost half reported unprotected sex between Friday and Sunday, we believe there is a substantial need for weekend access to emergency contraceptives. Yet the advantages of pharmacy access will not be fully realized until many more women become aware of the method and learn which pharmacies provide direct access. Even if it becomes available over the counter under the proposed dual label status, pharmacy access can provide a critical route to getting the method for the youngest women. Because of the convenience of pharmacy locations and extended hours of operation, as well as women's high levels of satisfaction in talking to pharmacists about the method and the desire to obtain it directly from them, pharmacies have the potential to make emergency contraception and other reproductive health services more readily available.

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