Identifying Barriers to Emergency Contraception Use Among Young Women from Various Sociocultural Groups in British Columbia, Canada

By Jean Shoveller, Cathy Chabot, Judith A. Soon and Marc Levine

Jean Shoveller is associate professor, and Cathy Chabot is project director, Department of Health Care and Epidemiology, Faculty of Medicine; Judith A. Soon is assistant professor, and Marc Levine is professor, Collaboration for Outcomes Research and Evaluation, Faculty of Pharmaceutical Sciences—all at the University of British Columbia, Vancouver.

CONTEXT: *Despite advances related to the provision of emergency contraception in Canada, particularly the granting of independent prescriptive authority to pharmacists in 2000, little is known about the ways in which women perceive potential barriers to using it.*

METHODS: *In 2004, an ethnically diverse sample of 52 women living in Greater Vancouver participated in interviews that were analyzed for an assessment of women's knowledge, attitudes and experiences related to emergency contraception, with particular attention to the ways in which ethnicity affected their stories.*

RESULTS: *Participants generally misperceived emergency contraception as an abortifacient, and often mistakenly thought that it has long-term effects on health and fertility. Knowledge gaps regarding reproductive physiology impeded clear understanding of when it is most effective. Participants also reported receiving subtle and sometimes overtly stigmatizing messages from providers when they sought emergency contraception. Asian and South Asian women were particularly concerned about negative interactions with providers; for example, they feared that female providers from their sociocultural community might recognize, chastise or gossip about them. Institutional policies (e.g., a Catholic hospital's refusal to provide the method), coupled with low awareness of pharmacists' prescriptive authority, also created barriers to use.*

CONCLUSIONS: *Women's ability to benefit from emergency contraception is hampered by lack of knowledge and conservative cultural or social mores. Serious contextual and structural shifts are required before woman-centered approaches to provision of the method become the norm.*

Perspectives on Sexual and Reproductive Health, 2007, 39(1):13–20, doi: 10.1363/3901307

On December 1, 2000, independent prescriptive authority was granted to certified pharmacists in British Columbia, Canada, to provide emergency contraception without requiring a physician's prescription. In 2000–2001, more than 1,500 pharmacists dispensed emergency contraception roughly 13,300 times in 415 community pharmacies.[1,2] Nevertheless, by 2002, women in British Columbia continued to require termination of unintended pregnancies at the rate of 17.7 per 1,000 women aged 15–44; this was the second highest rate among Canadian provinces, after that of Quebec.[3] As a point of comparison, the overall abortion rate in the United States in 2002 has been estimated at 20.9 per 1,000.[4]

In a survey of 2,648 women attending British Columbia abortion clinics in July–December 2002, we found that 82% of respondents knew of emergency contraception; of those, however, only 18% knew that it was available without a physician prescription.[5,6] Many (71%) of the respondents had been aware that they were at risk of pregnancy (e.g., had used no method of contraception, had had a condom break or had missed birth control pills) and therefore could have benefited by using emergency contraception. Nine percent of respondents who had known they were at risk had used it, but the method had failed.

The effectiveness of emergency contraception has been estimated at 75% for the Yuzpe combination hormonal regimen and 85% for levonorgestrel alone,[7] although the true effectiveness may be lower than these estimates.[8] Furthermore, the method is more effective the sooner it is taken,[7] so barriers that impede women's timely access to emergency contraception impede their effective use of the method. Despite important advances related to emergency contraception provision in Canada, little is known about the potential barriers to use that women perceive. Thus, we undertook a qualitative study in Greater Vancouver to investigate this issue.

METHODS

Sample Selection

In 2004, we conducted in-depth interviews with 52 women aged 15–29 chosen through purposive sampling. From our survey of abortion clinics, we knew that the proportion of women who know of emergency contraception is considerably lower among speakers of Hindi or Punjabi (25%), and among speakers of Cantonese or Mandarin (67%), than among speakers of English only (90%).[5] Thus, we recruited women who self-identified as Asian or South Asian (including new immigrants and women whose families had lived in Canada for multiple

generations). We recruited participants through advertisements at 35 sites, including immigrant services centers, university residences, health clinics, abortion clinics and bus shelters. In addition, service providers referred women to us; these women contacted us directly, to maintain their privacy. We fielded 123 telephone and e-mail requests from women wanting to participate. To be eligible, women had to be living in Vancouver, say that they could complete an interview in English and have heard of emergency contraception.

Initially, we focused exclusively on women who had used emergency contraception at least once. Our recruitment materials specified that we wanted to interview "women between 15–29 years who have used Emergency Contraception . . . from a variety of cultural backgrounds, particularly Indo-Canadian and Asian Canadian women, about their experiences with using emergency contraception pills." Thirty women were selected at this stage.

We wanted also to include women who had not yet used emergency contraception, since at least some may have wanted to access it but been prevented from doing so. Although we gathered information about each woman's sexual and reproductive histories (e.g., number of children, number of abortions and number of emergency contraception treatments), we do not have data on all participants' sexual experience; therefore, we cannot specify the proportion of women who had not yet had intercourse. Because our analysis of early interviews informed our ongoing sampling decisions, we focused subsequent interviews with never-users on the Asian and South Asian communities.

Unfortunately, only two of 16 South Asian participants had used emergency contraception, compared with 13 of 18 Asian participants and 15 of 18 participants of European or other backgrounds. The exploratory nature of our study, coupled with its time and resource constraints, prevented us from engaging further recruitment efforts to enhance our sample of South Asian women, limiting our data on this subgroup (one South Asian user reported having taken emergency contraception once, and the other reported having used it twice).

INTERVIEWS AND ANALYSIS

Female interviewers met with participants in university research offices and private meeting rooms at community centers, allowing for privacy, safety and comfort for participants and interviewers. We conducted 90-minute one-on-one interviews with 40 women and three two-hour focus groups with a total of 12 women; the group interviews followed similar methods to those of the individual interviews. Data from both sets of interviews are included in this article. Each participant received a $25 honorarium.

Tapes were transcribed, and personal identifiers were removed from transcripts. QSR NVivo was used to manage the coding. Transcripts were coded by research team members. In the analysis of the first six interviews, we assigned a code to each new idea represented in the raw data, using participants' language and avoiding, where possible, the imposition of preconceived theoretical constructs. For example, we used the code "information" to identify the points in the raw data where women described what they knew or thought they knew about emergency contraception. The data captured under this open code included myths and misperceptions that women believed to be facts about the method and their descriptions of where it is available. Using data from these six interviews, we developed 10 initial "open" codes.[9]

As additional interviews were completed, initial codes were regrouped into more abstract conceptual categories.[9] For example, the code "information" was reconfigured to focus on data regarding the provision of information about emergency contraception (e.g., sources of information). At this point, a broader code, "knowledge about emergency contraception," enveloped the codes "information," "technical aspects of its functions" and "perceptions of health risks." As subsequent interviews were completed and the analysis continued, we examined how social structures influenced key individual-level processes identified through the initial two stages of coding. We hypothesized about the ways in which the gender, cultural and social norms reflected in the data influenced individual experiences. We compared data from women of different ethnicities, ages and levels of experience with emergency contraception, and we contextualized individual items of data into more abstract and conceptual perspectives. Key concepts continued to be developed until no new ideas emerged and all the transcripts had been coded. In presenting our findings, we provide excerpts from interviews to help the reader relate to the women's experiences. We have attempted to represent the range of women's multiple standpoints (e.g., a woman as a sex partner, a daughter and a second-generation immigrant).

In addition to interviewing the women, we consulted five key informants: a physician specializing in youth and women's sexual health, who has been a consulting expert on numerous sexual health policy initiatives across Canada; a pharmacist who works at a 24-hour pharmacy that fills a large number of emergency contraception requests in Vancouver; and one counselor from each of three large abortion clinics in Vancouver that engage in advance provision of emergency contraception. Key informants provided supplemental information that offered insights into the later stages of our data collection and analysis (e.g., background regarding institutional policies related to emergency contraception provision that helped us contextualize our findings). We also drew on the theoretical and empirical literature, which helped us understand how our interview data related to other findings on barriers to using emergency contraception.

We recognize that our own identities, perspectives and experiences affected our study, including our interactions

with participants and our interpretations of the data and other aspects of the study's design and execution. Therefore, as in any rigorous qualitative investigation, it is important to clarify our various standpoints. Two research team members are internationally recognized pharmaceutical scientists who have been at the cutting edge of policy changes related to emergency contraception. The others, while new to emergency contraception research, are health and social science researchers who have worked extensively in youth sexual health and women's health. Given our privileged positions as academic researchers, we used the interviews with key informants as opportunities to challenge our assumptions about the experiences that women shared with us.

Ethics approval for this study was obtained from the University of British Columbia and the local health authority.

RESULTS

Study Participants

We interviewed 18 women from Asian backgrounds, 16 from South Asian backgrounds and 18 from other backgrounds (primarily European, but also Aboriginal, Middle Eastern or African). Four participants were international students, 20 were immigrants and 28 had been born in Canada. Thirteen participants reported a high school education or less, 30 reported 1–4 years of postsecondary education and nine had had more than four years of postsecondary education. Thirty-one women were full-time students, and eight were part-time students; 25 were not employed.

Thirty women had used emergency contraception: Eight had use it once, 10 twice, 10 between three and five times, and two 10 times or more. Together, they had used the method 98 times. Only three women had obtained emergency contraception directly from a pharmacist. Although the interviews took place nearly four years after the establishment of independent prescriptive authority for pharmacists in British Columbia, only five participants were aware that pharmacists have the authority to prescribe emergency contraception.

The interviews revealed that barriers to use of emergency contraception are related to four main themes: perceived vulnerability to pregnancy; knowledge about the method; experiences using it; and sociocultural and institutional factors. They also revealed that while participants who had used emergency contraception empathized with other users, never-users tended to identify users as being "irresponsible" or "careless" with respect to their reproductive health or sexual behavior. Never-users asserted, for example, that women resort to using emergency contraception because their "poor judgment" or "low character" leads them to have sex while drunk or high, or to be promiscuous. None of our questions probed this directly, and it is difficult to sort out whether these remarks are based on negative opinions of women who engage in such behavior in general or are more connected to beliefs about the kinds of women who use emergency contraception. Disturbingly, these moralizing remarks (and the spontaneity with which they were raised) suggest that stereotypes about women's sexuality persist. Moreover, they point to a potential barrier for a woman who is considering seeking emergency contraception—the fear of being stigmatized as "that kind of woman."

Perceived Vulnerability to Pregnancy

Many factors affect women's vulnerability to pregnancy (e.g., the menstrual cycle, contraceptive failure and unprotected intercourse). While participants knew that the menstrual cycle affects fertility, there was confusion or a lack of specific knowledge about when they are most fertile. Women who were deeply concerned about unwanted pregnancy (e.g., the unmarried) said that they worried "all the time" about getting pregnant, regardless of the stage of their menstrual cycle.

Others believed that a woman's vulnerability to pregnancy is related more to "luck" than to physiology. For example, when asked to estimate the likelihood of pregnancy after one sexual encounter without contraceptive use, a 21-year-old full-time student said: "If you were a really unlucky person, it could be 100%. For a lot of people, it's a gamble almost. I don't think there is any scientific percentage of whether it could happen." Notions of "bad luck" and poor understanding of reproduction did not vary substantially by ethnicity or previous use of emergency contraception.

When asked to describe specific situations in which they had felt most vulnerable to unwanted pregnancy, women commonly mentioned "broken condoms," "missed pills" and "didn't use a condom," as has been documented elsewhere.[10] However, these situations were perceived very differently. Stories about missed pills or nonuse of a condom were recounted as situations in which women should have been more responsible. However, in situations where condoms broke, stories of blame were absent. As the story of a 25-year-old Canadian-born Asian student illustrates, fear of being judged as irresponsible can prey on emergency contraception users' minds. The only time this woman had used emergency contraception, she had lied to her provider about the fact that she and her partner had not used a condom, saying instead that the condom had broken. She had done this because admitting that she had not used a condom would have made her look "careless" and "stupid." Our data do not reflect strong ethnic differences in relation to the ways that missing pills and not using a condom are perceived, compared with having a condom break.

We also asked about the ways in which relationship status might affect women's perceptions about their vulnerability to pregnancy. Longer-term relationships translated into less worry about pregnancy and reduced use of emergency contraception and other forms of contraception, as has been reported elsewhere.[11,12] However, one participant's story did not fit with this

general trend. This woman, a 23-year-old Euro-Canadian, had used emergency contraception 10 or more times and had recently separated from her long-term partner, who had repeatedly coerced her into using it near the end of their relationship. As their relationship disintegrated, her partner became increasingly worried about the chance that she would become pregnant. Unbeknownst to her at the time, her partner was in a relationship with another woman, which had recently resulted in an unplanned birth. This participant was the only woman in our study to describe being coerced into using emergency contraception, but her story highlights how partners' perceptions about vulnerability to pregnancy might affect use.

Women who had used emergency contraception . . .wished that their health care providers had explained how it works.

Knowledge of Emergency Contraception

•*Functional mechanism.* As in previous research,[12,13] participants across our diverse sample, including some who had used emergency contraception, mistakenly believed that it causes abortion. When we informed participants that emergency contraception is not an abortifacient, they expressed relief. For example, a 28-year-old married mother of two, who had immigrated from Pakistan and identified herself as a Muslim, recounted how other women in her community had reacted very negatively when they learned that a mutual friend had used emergency contraception; upon learning that her friend had not "done an abortion," this woman expressed immense relief. Never-users who had believed emergency contraception to be an abortifacient said that they would be more likely to consider using it, if the need arose, now that they understood how it functions.

We had anticipated that never-users would be relatively unlikely to know about how emergency contraception is thought to function, but that ever-users would have received relevant information when they had gotten the method. Ever-users cited a variety of reasons they had not obtained this information (e.g., they had felt rushed or embarrassed to ask questions). Having the opportunity to inform women about the functional mechanism of emergency contraception gave us some of the most important "teachable moments" during our interviews.

Of those who had even a basic understanding that emergency contraception prevents conception or implantation, most were unsure about how it is thought to work. Some women suggested that it acts as a spermicide or creates a toxic environment within the body to prevent conception or implantation. For example, a 27-year-old married woman from Mexico, who had been in Canada for two months and had never used emergency contraception, explained: "I heard something about the emergency contraception pill—it kills the sperm . . . [Emergency contraception pills] kill the environment, make a different environment to avoid the pregnancy." Previous research has also documented that large proportions of women, including ever-users, do not understand how emergency contraception is thought to function.[14]

Several women reported that walk-in clinics provided samples of oral contraceptives as a no-cost form of emergency contraception. This ad hoc strategy may contribute to confusion about emergency contraception's functional mechanism.

•*Perceived health risks.* Because participants had heard about health risks associated with long-term use of oral contraceptives, they worried that by taking emergency contraception, they might experience negative health outcomes. Women also frequently conflated their concerns about long-term pill use with their worries about using emergency contraception. They talked extensively of their concerns about ingesting a synthetic product, which they described as having the potential to interfere with "natural" processes, like menstruation. Participants further worried about using emergency contraception more than once or twice because they feared that repeated use could reduce their fertility or libido (problems they also associated with oral contraceptives). While these worries were most prevalent among Asian and South Asian participants, women of all ethnicities voiced similar concerns; this finding is consistent with findings from previous research.[15]

Experiences Using Emergency Contraception

The women who had used emergency contraception reported that they had felt immense relief once they had taken it. However, they also commonly reported embarrassment, shame or guilt. Furthermore, they wished that their health care providers had explained how it works and clarified that it is not an abortifacient. While they acknowledged that the circumstances within which they sought emergency contraception were often fraught with fear and stress, women said that knowing more about it would have helped to reduce their feelings of guilt and shame. A 21-year-old Aboriginal student who was in a long-term relationship had used emergency contraception twice and believed that it could cause an abortion. She also told us that she had *wanted* to believe that, so that she would feel terrible about having used it and discipline herself to "become more responsible" for her sexual behavior—a common theme among users. When our interviewer told this participant that emergency contraception does not cause abortion, she said that she felt that she had "wasted a lot of energies" by "worrying about the abortions."

Regardless of ethnicity or experience using emergency contraception, participants worried that health care providers would consider them irresponsible or promiscuous for requesting it, as demonstrated by an Asian woman's experience with a female pharmacist. This 20-year-old student, who had used the method twice, said she had felt "judged" and "scolded" when requesting it. She reported having felt that the pharmacist was thinking: "Oh you're another one of those who don't use a condom, and now you might have a baby, and you have to come and get your emergency contraception pill, and you're not

being safe." Women who had experienced judgmental interactions with providers said that as a result, they had questioned their morality and self-worth. One of our key informants, a physician specializing in adolescent and women's health, confirmed that service providers often view users of emergency contraception as irresponsible or promiscuous, and that such beliefs can be directly or indirectly communicated to patients, creating a barrier to use. Participants (even never-users) expressed concern that in addition to providers, their friends and family would regard them as irresponsible if they "resorted" to using emergency contraception.

When we asked ever-users to describe their physical reactions to using emergency contraception, half reported having experienced mild nausea and dizziness. They recounted suffering quietly through their symptoms to prevent others from discovering that they had used the method. It was especially important (and difficult) for unmarried women who still lived in their family homes to keep their symptoms secret. Some women said that they had not wanted their sexual partners to know, but others reported that their partners had helped them decide to use emergency contraception, accompanied them to access points or offered to share the cost.

Sociocultural and Institutional Factors

•*Provider gender and ethnicity.* Participants universally expressed discomfort at the idea of requesting emergency contraception from a male doctor or pharmacist, regardless of his ethnicity or clinical rapport. For instance, a 22-year-old Asian student who had used the method five times felt judged by male health service providers; she also often felt pressured to respond quickly to their questions. This was a problem for her because she speaks with clinicians in English (not her first language), and she feels that to avoid further embarrassment, she needs to formulate her responses carefully: "When I'm talking about this kind of thing, I answer slowly, . . . but it seems they just want your answer quickly." Although she clarified that it has been male health service providers' tone more than the content of their questions that has made her uncomfortable, her story illustrates the necessity of improving cultural and gender sensitivity within clinical interactions.

A service provider's ethnicity was a particularly important consideration for newly immigrated and first-generation Asian and South Asian participants, who said that they would not feel comfortable requesting emergency contraception from a service provider of the same ethnicity. They would be afraid that the provider might recognize them (as a neighbor or member of their mosque, church or temple) and chastise them for using emergency contraception. These women also said that they would be especially uncomfortable accessing emergency contraception from a female provider who was a member of their ethnic community, because she might gossip about confidential information with other community members (although no one reported experience with confidentiality breaches). Asian and South Asian women said that they so feared having their use of emergency contraception disclosed, they avoided accessing it from providers of their ethnicity.

All participants wanted their providers to be knowledgeable, use nontechnical language, listen actively and respectfully, and, most important, provide assurances regarding confidentiality.[12,16] A 22-year-old Asian student who had used emergency contraception twice described a youth clinic as a place where she can feel comfortable accessing emergency contraception or other forms of birth control. She said: "I find that they don't judge you [at the clinic]. They're quite open to talking about whatever you feel like . . . whereas my family doctor doesn't." The clinic staff did not rush her; they provided continuity of care and helped her obtain the information she wanted. These factors not only made it easier for her to access emergency contraception, they also made her feel more comfortable discussing other sexual and reproductive health concerns.

The multiple facets of women's identity sometimes cause them to struggle with conflicting attitudes about emergency contraception. This was poignantly illustrated in our interview with a 27-year-old daughter of Chinese immigrants who is a medical student and has used emergency contraception. She spoke about the complexity of reconciling her "background and traditional values" with her medical training and simultaneously being deeply affected by her Catholic beliefs. She emphasized that as a clinician, she endeavors to separate her personal beliefs from "what is best for the patient." However, she also struggles to accommodate her identity as a sexually active woman and an emergency contraception user with the importance that she places on traditional values.

•*Place.* Place has both material and social effects on women's emergency contraception use. While Vancouver has extensive and affordable public transit, recent immigrants from Asia and South Asia described serious barriers to using public transportation to access emergency contraception (e.g., they did not know where to find outlets outside of their neighborhoods, or a family member often accompanied them in public). Moreover, they were very fearful that members of their social networks might see them accessing emergency contraception at doctors' offices or neighborhood pharmacies.

Some recent immigrants looked for a new doctor, rather than seeking out a pharmacy outside their neighborhood; this is not surprising, because most women in our study did not know that they could access emergency contraception directly from pharmacists. Others commented that pharmacies lacked confidential counseling areas and were wide-open, public spaces where clients' conversations with the pharmacist could be overheard. Participants, especially Asian and South Asian women, reported that a combination of material and social barriers contributes to their difficulties in gaining timely access to emergency contraception.

Women of European or Aboriginal descent who had grown up in rural communities noted that these places offered few options in terms of accessing emergency contraception; typically, a town had one hospital (if any) and only one pharmacy. These women found it difficult to travel to other communities, where they might enjoy a degree of privacy and anonymity.

•*Institutional policies.* As has been demonstrated elsewhere,[17] institutional policies on emergency contraception can directly affect women's access. While women might reasonably expect the method to be accessible from hospitals, the following story illustrates the influence of policies. Late one night, a 25-year-old Asian student had sought emergency contraception from the emergency room of a Catholic hospital because she believed that it was the only potential provider in her area at that hour. The woman, a first-time user, reported that "they don't have it there. . . . I guess because they're Catholic. They didn't want to talk about it. They said they didn't believe in it and they couldn't give me anything." She had then proceeded to a nondenominational hospital's emergency room (a 20-minute drive away), which had directed her to a 24-hour pharmacy; there, she was finally able to purchase emergency contraception.

When health care institutions "opt out" of providing emergency contraception, they create obstacles to women's ability to control their reproductive health.

This example demonstrates the perseverance with which some women seek emergency contraception. It also illustrates that when health care institutions "opt out" of providing emergency contraception, they create obstacles to women's ability to control their reproductive health. Also, as a form of health care management, the policy regarding pharmacists' prescribing authority may have had the unintended effect of unofficially "relieving" some health care settings of their duty to provide emergency contraception.

Health care is a provincial responsibility in Canada, and the provision of emergency contraception is the subject of ongoing debate in various provinces. We therefore asked study participants to express their perspectives on some of the evolving issues.* Regardless of ethnicity, women believed that the method should be available without a doctor's prescription. Nevertheless, in all ethnic groups and regardless of experience with the method, women expressed concern that over-the-counter availability might encourage "overuse." Notably, however, participants were primarily concerned about overuse by other women, who might come to rely on emergency contraception as their primary form of birth control, rather than themselves. Increased cost sometimes associated with over-the-counter provision was also viewed as problematic, although women said that they might go to great lengths to purchase emergency contraception (e.g., borrow money from friends or use a credit card).

*The status of emergency contraception provision has changed significantly since 2000 in Canada—and it seems set to change again soon in many provinces. As of April 2005, pharmacists in all provinces have the authority to dispense Plan B without a written prescription from a physician; regular oral contraceptives are still available only by doctor's prescription. Within British Columbia, pharmacists still dispense the method through pharmacist-initiated prescriptions under the legislation implemented in 2000. In January 2006, the College of Pharmacists of British Columbia wrote a letter to the provincial government recommending that Plan B become an over-the-counter, nonprescription drug. (Source: College of Pharmacists of British Columbia, Minutes, January 20, 2006, <http://www.bcpharmacists.org/resources/councilcommittees/pdf/20_Jan_2006_Council_mtg_minutes.pdf>, accessed Oct. 21, 2006.) As of October 2006, the government was still considering this recommendation.

DISCUSSION

Emergency contraception remains one of reproductive medicine's "best kept secrets."[18] The experiences recounted during our interviews suggest that the establishment of pharmacists' prescriptive authority has not been enough to change this; rather, social marketing efforts need to be undertaken in conjunction with legislative and policy changes related to the method's provision. The very low levels of awareness regarding pharmacists' prescriptive authority four years after it had been initiated reveal a serious knowledge-based barrier. Moreover, in our study, emergency contraception was often misperceived as an abortifacient and was mistakenly thought to have long-term effects on health and fertility. Despite considerable research indicating that there are no contraindications to taking emergency contraception for the majority of women,[19–22] this message does not appear to be reaching everyone.

Major knowledge gaps appear to impede the likelihood of knowing when emergency contraception can be most useful. This has serious public health implications: On the basis of the day in the menstrual cycle on which women in British Columbia obtained emergency contraception from pharmacists in 2001–2002, Soon et al. have estimated that 550 pregnancies would have been expected among these women.[2] Because of the inherent failure rates of the Yuzpe and levonorgestrel regimens in reducing the risk of pregnancy, and the time between unprotected intercourse and when the women received emergency contraception, an estimated 300–400 of those pregnancies could have been prevented through its use.[2]

Although Cohen et al.[23] found that pharmacists generally treat women seeking emergency contraception with respect, the women in our study reported receiving subtle and sometimes not-so-subtle messages about their sexual "choices" when they sought it. While some participants may have misread a provider's body language or comments, their reports reflect their perspectives, which we suggest require more attention vis-à-vis the impact that provider-patient interactions can have on emergency contraception provision. The Canadian Contraception Consensus Guidelines state that "women and men of reproductive age should be counseled about emergency contraception" and that "women should be offered a prescription in advance of need";[24–26] nevertheless, we documented numerous reports of negative interactions with providers. Although the letter of the Consensus

Guidelines may be implemented at many (but not all) access points, the spirit in which provision occurs sometimes lacks a "woman-centered" approach.

Even in contemporary Canadian society, women's sexuality is scrutinized, and this helps to create situations in which some women judge and blame themselves for needing to use emergency contraception.[27] Myths about emergency contraception appear to reinforce the stigma associated with its use, contributing to the set of social relations that exacerbate power imbalances between women and others (e.g., health care providers, sex partners or family members). For example, women's suggestion that over-the-counter provision would encourage overuse speaks to deeply ingrained biases about women's abilities and rights to make informed choices about their reproductive health. A variety of situations lead women to use emergency contraception,[28] and "overuse" is a relative term. As women internalize stigma associated with emergency contraception use, it is worth considering how women might censor their efforts to seek it (e.g., how they might believe that it causes abortions and therefore might decide against seeking it because they or their family or peers are against abortions). Furthermore, these myths are juxtaposed with other myths regarding women's sexuality (e.g., a woman who is perceived to be knowledgeable about contraception may be assumed to be promiscuous). Together, these social forces foster a patriarchal and sometimes coercive set of structures that negate women's rights to control their reproductive health, which ultimately affects the overall health and social well-being of our society.

Roadblocks and detours in seeking emergency contraception can translate to delays in using it, which have an impact on its effectiveness. Being turned away and redirected to alternative access points might also put a woman at risk of giving up on seeking emergency contraception, which elevates the likelihood that she will need to use abortion services or will carry through with an unwanted pregnancy. Furthermore, anecdotal evidence suggests that there is a widespread, but erroneous, lay understanding that emergency contraception is available only at hospital emergency rooms, perhaps because hospitals were traditionally places where women could access the method after hours and because some people believe that emergency rooms have it "on reserve" for use by victims of sexual assault. It is also problematic that women receive messages that they may not be able to depend upon emergency rooms to respond to their urgent health needs.

Because women may have to overcome numerous barriers even to ask for emergency contraception, we argue that every woman presenting at any access point should receive it, if she meets the medical criteria for its use. Furthermore, providers need to be educated to use opportunities that emerge in routine visits to facilitate better access to emergency contraception (e.g., by providing the method in advance). Although new policies that are intended to enhance the availability of emergency contraception continue to unfold, the challenge of promoting accessibility remains primarily a socially constructed problem. Despite evidence that women's sexual behavior does not vary according to the method's accessibility,[29–32] the myth that better access to contraception contributes to women's promiscuity persists, perhaps deterring some women from seeking emergency contraception.

Our findings highlight the need for women to receive information about emergency contraception, stressing confidentiality and privacy.[23,33] Moreover, despite a diversity of opinions about provision, there is a high degree of agreement regarding the need to keep the costs low.[34] Sociocultural norms that can create access barriers (e.g., restrictions on some South Asian women's ability to travel unaccompanied) need to be addressed through culturally sensitive initiatives that promote gender equity and women's right to control their reproductive health.

Provider ethnicity and gender exert complex influences on women's experiences with emergency contraception. Although study participants preferred female providers, Asian and South Asian women expressed an additional layer of anxiety. Our study provides insights regarding the multiple ways in which sociocultural forces affect preferences related to provision. A focus on the delivery of emergency contraception services represents an important new avenue for interdisciplinary public health research teams, including social scientists, epidemiologists, health services researchers and clinicians.

Strengths and Limitations

Like all qualitative researchers, we inevitably needed to make judgments and decisions during our sampling and analysis. These decisions require justification and explanation. While self-reported data are often presumed to be vulnerable to recall bias and memory loss, we were interested in describing women's diverse perceptions and insights. The way in which women recalled their experiences or described their knowledge and attitudes has inherent value because it reveals the meanings that they attach to their stories.

The insights gained have resulted in rich descriptions of the women's perspectives, which can be further investigated. While diverse, our sample does not reflect the experiences of all women, particularly with respect to age, ethnicity, social standing and place of residence. The design, size and resources of this study limit the generalizability of our findings and require us to acknowledge that we did not reach full theoretical saturation.

Conclusion

Drawing on the findings of the current study, we hope that more woman-centered approaches to emergency contraception provision will be adopted. While progress is being made in Canada and elsewhere to generate awareness, dispel myths and promote advance provision,[35] women's ability to benefit from the method is

hampered by complex, socially determined barriers, including social mores regarding women's control over their sexuality and reproductive health. Serious contextual and structural shifts are required before such "upstream" forces can be addressed fully.

REFERENCES

1. Soon JA et al., Provision of emergency contraceptives by pharmacists, *Canadian Pharmaceutical Journal*, 2004, 137(6):23–29.

2. Soon JA et al., Expanding access to emergency contraceptives in British Columbia, *Canadian Medical Association Journal*, 2005, 172(7):878–883.

3. Statistics Canada, *Canadian Vital Statistics: Birth Database and Stillbirth Database, Pregnancy Outcomes, by Age-Group, Canada, Provinces and Territories*, 2002, Ottawa: Statistics Canada, 2002.

4. Finer LB and Henshaw SK, Estimates of U.S. abortion incidence in 2001 and 2002, New York: The Alan Guttmacher Institute, 2005, <http://wwwguttmacher.org/pubs/2005/05/18/ab_incidence.pdf>, accessed May 25, 2006.

5. Soon JA, Levine M and Schmidt T, Use of emergency contraceptives in women presenting for abortion in British Columbia: differences and similarities across major language groups, paper presented at the annual meeting of the National Abortion Federation, Seattle, Apr. 5–8, 2003.

6. Soon JA and Levine M, Barriers to the use of emergency contraception in British Columbia, *Canadian Journal of Clinical Pharmacology*, 2003, 10(1):32.

7. 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.

8. Trussell J et al., Estimating the effectiveness of emergency contraceptive pills, *Contraception*, 2003, 67(4):259–265.

9. Strauss A and Corbin J, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, second ed., London: Sage, 1998.

10. Pyett P, Postcoital contraception: who uses the "morning after pill"? *Australian and New Zealand Journal of Obstetrics and Gynecology*, 1996, 36(3):347–350.

11. Kershaw TS et al., Misperceived risk among female adolescents: social and psychological factors associated with sexual risk accuracy, *Health Psychology*, 2003, 22(5):523–532.

12. Free C, Lee RM and Ogden J, Young women's accounts of factors influencing their use and non-use of emergency contraception: in-depth interview study, *BMJ*, 2002, 325(7377):1393–1397.

13. Aneblom G et al., Women's voices about emergency contraceptive pills "over-the-counter": a Swedish perspective, *Contraception*, 2002, 66(5):339–343.

14. Aneblom G et al., Knowledge, use and attitudes towards emergency contraceptive pills among Swedish women presenting for induced abortion, *British Journal of Obstetrics and Gynaecology*, 2002, 109(2):155–160.

15. Ziebland S, Maxwell K and Greenhall E, "It's a mega dose of hormones, isn't it?": why women may be reluctant to use emergency contraception, *British Journal of Family Planning*, 1996, 22(2):84–86.

16. Simonds W and Ellertson C, Emergency contraception and morality: reflections of health care workers and clients, *Social Science and Medicine*, 2004, 58(7):1285–1297.

17. Brening RK, Dalve-Endres AM and Patrick K, Emergency contraceptive pills (ECPs): current trends in United States college centers, *Contraception*, 2003, 67(4):449–456.

18. Hatcher RA et al., *Emergency Contraception: The Nation's Best Kept Secret*, Decatur, GA: Bridging the Gap Communications, 1995.

19. Abuabara K et al., As often as needed: appropriate use of emergency contraceptive pills, *Contraception*, 2004, 69(4):339–342.

20. Grimes DA and Raymond EG, Emergency contraception, *Annals of Internal Medicine*, 2002, 137(3):180–189.

21. Malleson R, Emergency contraception: a simple, safe, and effective approach to preventing pregnancy after unprotected intercourse or contraceptive failure, *BC Medical Journal*, 2002, 44(1):30–35.

22. Trussell J et al., The role of emergency contraception, *American Journal of Obstetrics and Gynecology*, 2004, 190(4 Suppl.):S30–S38.

23. Cohen MM et al., Using a secret shopper to evaluate pharmacist provision of emergency contraception, *Canadian Pharmaceutical Journal*, 2004, 137(1):28–33.

24. Black A, Francoeur D and Rowe T, Canadian contraception consensus: SOGC clinical practice guidelines, *Journal of Obstetrics and Gynaecology Canada*, 2004, 26(2):143–156, <http://sogc.medical.org/guidelines/pdf/ps143_1_3.pdf>, accessed Apr. 1, 2006.

25. Black A, Francoeur D and Rowe T, Canadian contraception consensus: SOGC clinical practice guidelines, *Journal of Obstetrics and Gynaecology Canada*, 2004, 26(3.):219–254, <http://sogc.medical.org/guidelines/pdf/ps143.2.pdf>, accessed Apr. 1, 2006.

26. Black A, Francoeur D and Rowe T, Canadian contraception consensus: SOGC clinical practice guidelines, *Journal of Obstetrics and Gynaecology Canada*, 2004, 26(4):347–387, <http://sogc.medical.org/guidelines/pdf/ps143.3.pdf>, accessed Apr. 1, 2006.

27. Holland J et al., *The Male in the Head: Young People, Heterosexuality, and Power*, London: Tufnell Press, 1998.

28. Keogh LA., A qualitative study of women's use of emergency contraception, *Journal of Family Planning and Reproductive Health Care*, 2005, 31(4):288–293.

29. Folkes L, Graham A and Weiss M, A qualitative study of the views of women aged 18–29 on over-the-counter availability of emergency contraception, *Journal of Family Planning and Reproductive Health Care*, 2001, 27(4):189–192.

30. Gold MA et al., The effects of advance provision of emergency contraception on adolescent women's sexual and contraceptive behaviors, *Journal of Pediatric and Adolescent Gynecology*, 2004, 17(2):87–96.

31. Graham A et al., Improving teenagers' knowledge about emergency contraception: cluster randomized controlled trial of a teacher led intervention, *BMJ*, 2002, 324(7347):1179–1185.

32. Raine TR et al., Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs: a randomized controlled trial, *Journal of the American Medical Association*, 2005, 293(1):54–62.

33. Gainer E et al., Bringing emergency contraception over the counter: experiences of nonprescription users in France, Norway, Sweden and Portugal, *Contraception*, 2003, 68(2):117–124.

34. Bissell P and Anderson C, Supplying emergency contraception via community pharmacies in the UK: reflections on the experiences of users and providers, *Social Science and Medicine*, 2003, 57(12):2367–2378.

35. Fairhurst K et al., Emergency contraception: why can't you give it away? qualitative findings from an evaluation of advance provision of emergency contraception, *Contraception*, 2004 70(1):25–29.

Acknowledgments

The authors acknowledge the support of the British Columbia Ministry of Health and the Michael Smith Foundation for Health Research. They also thank Tessa Graham for requesting that this study be undertaken, Denise Canso for research assistance and the organizations that facilitated recruitment.

Author contact: *jshovell@interchange.ubc.ca*