

# Implementing an Advance Emergency Contraception Policy: What Happens in the Real World?

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**CONTEXT:** Advance provision of emergency contraception increases the likelihood of its use, yet little is known about the factors that influence successful implementation of an advance provision policy in publicly funded family planning clinics.

**METHODS:** Data on knowledge of, attitudes toward and use of emergency contraception were collected from 211 patients attending four Title X–funded clinics in Pennsylvania in 2001–2002. In addition, 22 staff from the four clinics were interviewed regarding barriers to and facilitators of advance provision in 2004–2005, and 111 staff from 46 clinics completed related surveys in 2005. Qualitative data underwent content analysis, and frequencies and bivariate associations between variables were calculated for the survey data.

**RESULTS:** Most patients said they would use emergency contraception (80%) and believed it should be easy to obtain (93%), although 46% thought it is a form of abortion. Patients' familiarity with the method, attitudes toward it and self-efficacy regarding its use were not associated with most demographic or reproductive health characteristics. While nearly all interviewed staff endorsed routine advance provision, only about half of survey respondents offered it "very often" at patients' initial or annual visits. Barriers to advance provision included staff prejudgment of patients' needs and ability to use the method, time constraints and inefficiencies in clinic procedures.

**CONCLUSIONS:** Strategies that may facilitate advance provision of emergency contraception include emphasizing the need for staff to offer it during all patient visits, providing patient-friendly information and streamlining clinic procedures.

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Emergency contraception is a safe, highly effective method of preventing unintended pregnancy. In 1997, the Food and Drug Administration concluded that the Yuzpe regimen of emergency contraception (two doses of combined estrogen and progestin taken 12 hours apart) is safe and effective in preventing pregnancy within 72 hours of unprotected sex or contraceptive failure; subsequent studies confirmed its effectiveness for up to 120 hours after sex.<sup>1</sup> The dedicated products Preven and Plan B were approved in 1998 and 1999, respectively.

Yet the availability of emergency contraception at pharmacies did not guarantee that women would be able to obtain it within the window of efficacy. Proponents of over-the-counter sales have argued that requiring a prescription limits women's access to emergency contraception, because some women do not know about the method, are reluctant to ask their health care providers for advance supplies or need it when their providers' offices are closed.<sup>2,3</sup> Furthermore, some clinicians typically discuss or provide emergency contraception only after patients request it or report having had unprotected intercourse.<sup>4</sup> The August 2006 approval of over-the-counter sales of Plan B for individuals 18 or older was hailed as an important step toward overcoming some of these barriers. However, for women who are younger than

18 or who cannot afford to buy emergency contraception, significant barriers remain.

One way of addressing disparities in access is to offer emergency contraception in advance of immediate need. Advance provision has been shown to increase the probability that this method will be used.<sup>5,6</sup> Because family planning clinics that are funded by Title X of the Public Health Service Act (the program that established federal funding for family planning) provide reproductive health services to approximately five million low-income women and adolescents annually,<sup>7</sup> these clinics could play a significant role in helping patients prevent unintended pregnancies by providing advance emergency contraception.

Title X–supported clinics and agencies are mandated to provide a broad range of contraceptive methods (including emergency contraception) and services to low-income clients for little or no cost according to their income and ability to pay. The majority of Title X–funded clinics educate clients about emergency contraception and dispense the method on-site or through prescription on an as-needed basis, and nearly half have a policy of providing advance supplies.<sup>8</sup> Although studies have examined patients' and providers' attitudes toward advance provision in general health care settings,<sup>4,9,10</sup> there has been

little research on how providers at publicly funded family planning clinics view advance provision.

This study explores staff and patient attitudes and behaviors in the context of a large Title X–supported network of diverse family planning service agencies that has a longstanding policy of providing advance emergency contraception. The Family Planning Council, the Title X grantee for southeastern Pennsylvania, instituted a policy of offering advance provision of this method in 1997, two months after the Food and Drug Administration endorsed the approach. This policy, recommended by the Council’s medical committee and approved by all affiliated agencies, stated: “All family planning provider agencies must offer prophylactic emergency contraception to all existing [female] patients (unless medically contraindicated).” According to the policy, patients are to receive information about emergency contraception, including when and how to use it and potential side effects. After signing a form requesting advance provision, women who do not have any medical contraindications receive emergency contraception to take with them; in accordance with Title X guidelines, the emergency contraception is provided free or at reduced cost.

All affiliated agencies agreed to send the Council data from every patient visit, including whether emergency contraception was provided (either in advance or when needed). At monthly meetings of agency representatives, reports on the numbers of eligible women who received advance provision were distributed; in addition, the implementation of the advance provision policy and associated issues were periodically discussed. By 2005, the proportion of eligible women in the Council network who had received advance emergency contraception was still less than 25%, and ranged by clinic from 0% to 46%. Although the Council recognized that many women might not be interested in or might refuse advance emergency contraception, it also recognized a need to understand the views of patients, clinicians and counselors. Thus, this study collected information from patients and staff concerning advance provision—particularly with regard to barriers—with the goal of guiding efforts to improve clinic adherence to the advance provision policy.

## **METHODS**

### **Study Sites**

Like other Title X grantees, the Family Planning Council is the central source within its geographic service area for dispensing Title X funding, overseeing standards of care, purchasing supplies and developing policies to improve services. In 2006, its 29 subcontracted agencies and their 79 clinics provided contraceptive and other reproductive health services to approximately 134,000 female and 10,000 male patients; these clinics were run by teaching and community hospitals, affiliates of the Planned Parenthood Federation of America, public health departments, community health centers and other organizations (e.g., substance use treatment programs). Although affiliated

with the Council, these agencies maintain their own operational structure, management responsibilities and policies.

The data used in the present analysis were collected as part of a five-year longitudinal study designed to compare the frequency of emergency contraceptive use by women who have advance access with use by women who have only emergency access, and to identify factors associated with acceptance and use of the method.<sup>11</sup> The longitudinal study was approved by the Council’s institutional review board, and this approval was accepted by the affiliated clinics. Patient data were collected at four Title X–funded family planning clinics that were selected because they were willing to participate, had a large client pool and provided advance emergency contraception at levels similar to or above the Council network average. Two of the clinics were community health centers, and two were Planned Parenthood clinics. During the study period (2001–2005), the annual proportion of eligible women provided with advance emergency contraception at the four clinics ranged from 16% to 38%. The present study draws on data collected from 211 patients between June 2001 and July 2002, from 22 staff who were interviewed between November 2004 and February 2005, and from 111 staff who worked at 46 Council-affiliated clinics and who responded to a survey sent in November 2005.

### **Patients**

To be eligible for the study, patients had to be 15–39 years old, sexually active (or expecting to be sexually active within the next 12 months), neither pregnant nor seeking to get pregnant in the next 12 months, and not using sterilization, hormonal implants or an IUD as their primary contraceptive method. Interviewers approached women in the waiting rooms of the four clinics, described the project and invited them to participate. Interested women completed a self-administered screening survey consisting of 10 closed-ended questions. The interviewers then administered the intake survey to all eligible, consenting participants.\* The 26 intake questions were closed-ended and collected information on demographic characteristics (age, race and ethnicity, marital and partner status, education, occupation and the importance of religion in patients lives), sexual activity, opinions about becoming pregnant in the next year, contraceptive history and emergency contraception (whether the patient had ever used the method, whether staff had discussed and offered it at any previous clinic visit, and whether the patient had accepted it). These variables are defined in detail elsewhere.<sup>11</sup>

Women whose date of birth was an odd number were then selected to complete an in-depth survey. Together, the intake and in-depth surveys (completed before the patients met with clinicians or counselors) took

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\*All survey and interview forms are available on request from the authors.

approximately one hour to complete. Questions on the in-depth survey were closed-ended and related to the patient's access to and knowledge of emergency contraception; her and her partner's attitudes toward the method; her sense of self-efficacy about using emergency contraception; and her lifetime use of the method.

•**Access.** Using a five-point scale (from "strongly agree" to "strongly disagree"), respondents rated how much they agreed with the statements "It would be hard for me to pay for emergency contraception," "My clinic is too far away" and "It would be very hard to get an appointment."

•**Knowledge.** Using the same five-point scale, patients rated their agreement with the following: "I don't know enough about emergency contraception to be able to get it," "I would know enough about emergency contraception to decide if it was right for me" and "I would know how to get emergency contraception if I wanted it." In addition, respondents rated how familiar they were with emergency contraception ("not," "somewhat" or "very") and stated how long after having unprotected sex they believed that the method could be taken and still be effective in preventing pregnancy (options included four time intervals, ranging from "12 hours" to "one week," plus "don't know").

•**Attitudes.** Again using a five-point scale (from "strongly agree" to "strongly disagree"), patients rated their agreement with six statements: "Emergency contraception should be easy to get for any woman who wants it," "Emergency contraception is a better way to reduce unintended pregnancies than abortion," "Making emergency contraception easily available might encourage people to engage in risky, unprotected sex," "Some women might use emergency contraception as a regular, ongoing method of birth control," "Emergency contraception is a form of abortion" and "Taking emergency contraception is as safe for my health as taking birth control pills." After the patient provided her own views, all questions were repeated to ascertain the patient's perception of her partner's attitudes.

•**Self-efficacy.** Using the same five-point scale, patients rated their agreement with several statements regarding self-efficacy: "I could keep myself from becoming pregnant by using emergency contraception," "I would think of emergency contraception as an option" and "I would take emergency contraception to prevent pregnancy." In addition, respondents answered two questions—"How effective do you believe emergency contraception can be in preventing pregnancy if used properly?" and "If you wanted to take emergency contraception, would it be easy?"—using a different five-point scale (from "very" to "not at all," plus "don't know").

We hypothesized that patients' personal characteristics and behaviors would be associated with three specific outcome variables: women's familiarity with emergency contraception, their attitude toward the method (whether they believed that emergency contraception is a form of abortion) and their self-efficacy (whether they would use

the method to prevent pregnancy). Explanatory variables included demographic factors and sexual and contraceptive variables.

### Staff

Staff data were collected from two cohorts using different methods.

•**Semistructured interview cohort.** Between November 2004 and February 2005, a trained interviewer invited counselors and clinicians to be interviewed about advance provision of emergency contraception. Each interview lasted about 20–40 minutes and was recorded. The 17 open-ended questions related to staff awareness of both the Council's and the clinic's own advance provision policy, staff decisions and attitudes about offering and dispensing advance emergency contraception, barriers and challenges to such provision (including reasons for patient refusal) and ways to address the barriers.

Following each session, interviewer notes were entered and summarized on an Excel spreadsheet, and tape-recorded interviews were transcribed verbatim. From the transcripts, two of the authors independently identified major themes related to barriers to advance provision and to suggestions for increasing or enhancing advance provision. Coding discrepancies were resolved through discussions between the authors.

•**Mail survey cohort.** The findings that emerged from the staff interviews were described at a meeting of agency representatives, who gave their support for a mail survey to determine the findings' relevance to the wider provider group, to further assess variations in advance provision and to obtain additional information for service improvement. A self-administered, 13-item survey consisting predominantly of closed-ended questions was then designed, drawing on responses obtained from the semistructured interviews. The time required to complete the survey was about 10 minutes. In November 2005, 79 Council-affiliated clinics received a mailing containing three surveys and stamped return envelopes. A cover letter described the purpose of the survey, and clinic managers were asked to choose three direct service staff to fill out the surveys. Clinics that had not responded after four weeks received telephone and e-mail reminders.

### Analyses

Data from both the patient and the staff surveys were entered, merged and analyzed using SPSS version 14. For the patient survey, associations between response variables and explanatory variables were assessed; for the staff survey, relationships between potential moderators (staff position and clinic type) and survey responses were assessed. Associations were evaluated using chi-square, t or nonparametric tests, as appropriate. Because of the large number of comparisons, we used a conservative significance level ( $p < .01$ ) to reduce the likelihood of obtaining statistically significant findings by chance.

## RESULTS

### Patients

Fifty-four percent of patients attended clinics located in urban areas, and 46% in suburban areas. Patients' median age was 23, and more than half were aged 20–29. Seventy-six percent were black, 19% white and 1% Hispanic. Most (82%) had a main partner, and 26% of these patients reported living with the partner. Nearly two-thirds (65%) had been pregnant before, and 58% said that getting pregnant within the next 12 months would be “bad” or “very bad.” When patients were asked how likely they were to get pregnant the next time they had unprotected sex, the median probability was 60%. Seventy-four percent had been sexually active in the past 30 days.

Patients' primary contraceptive methods were oral contraceptives (29%), condoms only (28%) and the injectable (21%). Twenty percent reported not using any method. Almost half (43%) of sexually active patients had had sex without birth control in the past 30 days. Twenty-eight percent of patients said that they were very familiar with emergency contraception, and 48% were somewhat familiar. Only 23% had ever used the method. Twenty-seven of the 211 respondents were new clinic patients; of the 184 returning patients, 58% recalled that staff had talked to them about emergency contraception, and 38% remembered being offered the method at a previous visit. Almost all women (96%) who remembered having been offered advance emergency contraception said they had accepted it.

Most patients thought that emergency contraception is very (60%) or somewhat (29%) effective in preventing pregnancy if used properly. Moreover, the majority agreed or strongly agreed that they could prevent pregnancy by using emergency contraception (81%), would think of it as an option if they had had unprotected sex (94%) and would take it to prevent pregnancy (80%). Cross-tabulation showed that these positive views were shared by both those familiar and those unfamiliar with emergency contraception. Most patients believed that they knew enough about the method to decide whether to use it (87%), and 75% knew that it is effective up to 72 hours after intercourse.\* Furthermore, nearly all patients (94%) said they knew how to get emergency contraception, and 84% agreed that obtaining it would be very or somewhat easy. One in three patients believed that it would be hard to pay for it, but relatively few said the clinic was far away (7%) or that getting an appointment would be difficult (11%).

Almost all (93%) patients agreed or strongly agreed that emergency contraception should be easy to get for any woman who wants it, and most (82%) believed their partners felt the same way. Almost half (47%) agreed or strongly agreed that the method is as safe as birth control pills. A similar proportion (46%) agreed or strongly agreed that “emergency contraception is a form of abortion”—a view common among both patients familiar (40%) and those unfamiliar (49%) with the method—and

an even greater proportion (56%) believed that their partners felt this way. Most patients agreed or strongly agreed that use of emergency contraception may encourage risky, unprotected sex (63%) and that some women might use emergency contraception as a regular, ongoing method of birth control (73%); again, these attitudes were shared by both those familiar and those unfamiliar with the method.

Familiarity with emergency contraception, attitudes toward it and self-efficacy were associated with only three demographic factors or measures of sexual behavior and contraceptive use. Self-efficacy and familiarity were positively associated with use of the method ( $p<.01$ ), and blacks were more likely than whites to be unfamiliar with the method (29% vs. 5%;  $p<.01$ ).

### Staff Interviews

Qualitative data were collected in interviews with 22 staff (12 clinicians and 10 counselors) out of the 24 who were providing services at the four clinics attended by our patient sample. (Two staff declined to be interviewed because of work and time pressures.) The median length of time staff had worked at their current clinic was 3.5 years. Twenty staff knew that their clinic had a policy of dispensing advance emergency contraception, but only 15 were aware of the Council's advance provision policy. All but one respondent thought that having an advance policy was good, great or excellent. When asked how they decide whether to offer emergency contraception, more than three-quarters said they offered it to all eligible women. Five said they offered it only if the patient was not using a regular method or if she asked for it. On average, staff estimated that 60% of patients who were offered the method accepted it (range, 25–90%).

•**Barriers to advance provision.** Most of the barriers cited by clinic staff fell into five categories: attitudes and judgment about offering emergency contraception; time constraints; clinic flow and procedures; the type of emergency contraception dispensed; and perceived patient reluctance to accepting advance emergency contraception.

Although the Council's advance provision policy called for offering emergency contraception to all women except those who had been sterilized, those using an IUD or the injectable, and those for whom the method was medically contraindicated, in practice a number of staff were interpreting the policy on a case-by-case basis using their professional judgment. Therefore, although they may have said they offered emergency contraception to all eligible women, their definitions of “eligible” differed from that contained in the Council's policy, and they were unlikely to discuss or offer the method as often as the policy instructed. By far the most frequently mentioned rationale for this decision was that the patient did not

\*At the time of the survey, it was not yet clear that emergency contraception is effective up to 120 hours after unprotected sex.

need advance emergency contraception because she was using an effective contraceptive method (especially the injectable, the pill or the patch). For example, one staff member said:

“There are patients out there...[who] take their birth control the way they’re supposed to. It’s almost offensive [to offer emergency contraception to these women]... I think that women are very intelligent, and...we need to...take that into consideration, that everyone doesn’t need it. And for those people who need it, it’s here; you can come get it.”—*Clinician*

On the other hand, some staff were reluctant to offer advance emergency contraception because they felt the patient might not understand how to use it or was irresponsible:

“The only time that I tend not to follow [the] protocol specifically is when I have repeat patients who have proven to me that they are not responsible enough to take that second pack...[when I] don’t feel like [my] patient is—I guess for lack of a better word—smart enough or knowledgeable enough to handle [her] own health.”—*Clinician*

This concern about lack of understanding was most often directed toward younger patients. One staff member noted:

“I’m afraid that if I have a young teenager in here...[she is] going to misuse [emergency contraception], if [she’s] very young. And when I say very young, I’m pretty much thinking 13, 14, maybe 15.”—*Counselor*

In a few instances, staff did not follow the advance provision policy because they disapproved of or misunderstood it (e.g., interpreting the policy as “If they don’t ask, we don’t give”) or because they did not understand the contraindications for taking the method.

In addition, staff perceived that time constraints were a major reason for sometimes not discussing or offering advance emergency contraception during visits other than those specifically made for that purpose:

“We have a large [number] of patients that come in each day, and we have very, very little time to spend with them... We have so much information to go over...their history and birth control and their problems that they’re coming in with and counseling. Let’s say there’s violence or something like that that we have to counsel them about...It’s very difficult to make more time.”—*Counselor*

Some staff cited clinic flow as a possible reason for patients’ not receiving advance emergency contraception. For instance, one noted that advance provision was sometimes forgotten as patients moved through the various sections of the clinic:

“A lot of times...the counselors who first see [patients] say, ‘If you’d like to take the emergency contraception home with you today to have as a backup, you can do that.’ Then, by the time they see me, and then go to the checkout, something is lost and they don’t ask for it. Or it’s not offered again when they check out, maybe...”—*Clinician*

Shortages in the supply of emergency contraception were also mentioned as a barrier to adherence to policy. Although shortages were relatively rare, there was concern that advance provision to women who might not immediately need it could result in the clinic’s having an insufficient supply for women who needed emergency contraception right away.

Another barrier to advance provision concerned the multiple types of emergency contraception that the Council supplied to affiliated agencies. To reduce formulary costs, the Council recommended the use of less expensive forms of emergency contraception (repackaged combination pills) for advance provision so that Plan B (a progestogen) would be available for emergency visits. However, compared with progestogen alone, the combined formulations offer less protection against pregnancy (89% vs. 75% reduction in risk) and more frequently cause side effects—primarily nausea, vomiting and spotting.<sup>12</sup> (The current standard of care—guidelines for which were published after our survey had been completed—is to use the progestogen-only regimen.<sup>13</sup>) Some staff said that patient confusion about the various types, and about their side effects, made them reluctant to offer advance emergency contraception to their patients:

“We have two brands of emergency contraception. Plan B, we offer on request; the other brand, as advance emergency contraception. This one makes them sick. Patients are confused.”—*Counselor*

“I don’t really get concerned with giving out the emergency contraceptive pill, except—I just want to make sure that they understand how to use it. And sometimes that seems to be difficult because we have...three different kinds. Sometimes we have Preven [combined hormonal emergency contraception], sometimes we have Nordette [repackaged combined oral contraceptives], sometimes we have [Plan B]... And sometimes I think that even in explaining [the differences between the three types], and having [patients] restate to you what you’ve just told them, sometimes I don’t think that they completely absorb it.”—*Clinician*

In some instances, staff reported that they offered emergency contraception but patients refused it. When staff were asked why patients might decline advance provision, the most frequent responses were that patients believed that they did not need emergency contraception because they were using an effective regular method, that they would be more careful the next time they had sex, that they were considering or planning a pregnancy or that they had an aversion to taking pills. Other women were afraid of short- or long-term side effects, which staff attributed to experience or media reports about other medications, such as hormone replacement therapy. For example:

“The other day, I was reading [an article] in the paper—and if I’m reading it, so are patients—[and] it said something about birth control [being] not quite safe.”—*Counselor*

“They’re afraid of the side effects. That’s pretty much what I hear. And I do go over the side effects, which to some people may be scary and to others, it’s not even a thought.”—*Counselor*

“They are strongly against taking pills. And I tell them, this is just four pills: It’s different [from taking a pill every day]. But they still say, ‘No, I don’t want to take any pills.’”—*Clinician*

Patients’ confusion regarding the distinction between emergency contraception, abortion and mifepristone was also cited as an important reason for refusal to accept advance emergency contraception. As one staff member noted:

“People think it’s related to an abortion, rather than birth control. And even though you try to counsel people about that, it’s not always easy to get rid of that perception.”—*Counselor*

Finally, staff cited practical reasons why patients might decline advance emergency contraception. One was that some patients were in a hurry and did not have time to complete the education and consent forms that were required. Another was that many teenagers said they could not have the pills “laying around at home” for parents to find.

•**Facilitating advance provision.** Strategies for facilitating advance provision of emergency contraception can be grouped into three categories: education, staff endorsement, and clinic flow and procedures.

The majority of respondents felt that education—for staff, patients and the public—was the key to increasing the provision and acceptance of emergency contraception. Diverse approaches would help to increase knowledge, understanding and the translation of information into practice. Suggestions for staff and patients included the following:

“Educate the new staff...so that they can be knowledgeable about emergency contraceptives and understand the importance of offering it to patients and the consequences of not offering it.”—*Clinician*

“Use every family planning visit [to discuss]...how [emergency contraception is] used, how [it is] supposed to be used and...the role that [it is] really supposed to play in managing your reproductive behavior.”—*Clinician*

“[Provide] more eye-catching patient information about [emergency contraception]... We give them an FAQ [frequently asked questions] sheet about it...but it’s very long...and I don’t think a lot of patients take the trouble to read it. So...I don’t think a lot of them really know what emergency contraception is. If we had a little card, or a little pamphlet or something...”—*Counselor*

“Because [advance emergency contraception is] for future use, I try to have some instructions to stick in the little container, so [that patients will] have the instructions when they need to use [it].”—*Clinician*

Staff members also suggested that the general public be educated about emergency contraception, perhaps through advertisements in books and magazines and on television, and through information campaigns in

schools. Staff recommended that these advertisements and campaigns explain that emergency contraception is not the abortion pill and will not terminate a pregnancy.

In addition, staff endorsement of the advance provision policy was perceived as vital to its implementation. For example, when asked, “Why do you think that some family planning clinics are more likely to offer advance emergency contraception to patients than other clinics?” one staff member responded:

“The main thing is really having a supportive staff, and [also that] the provider has [sufficient time to implement the policy].”—*Clinician*

Several respondents suggested that improving clinic flow and procedures would facilitate advance provision. Specific suggestions included giving patients written information about emergency contraception to read before they see the counselor or clinician; streamlining the advance provision process by approving emergency contraception access for repeat visits; and ensuring that clinic forms include a reminder for staff to discuss the method during routine visits and a place to check off when it has been discussed. For example:

“We started to put emergency contraception on all of the forms...so [clinic staff]...remember to ask the patient about emergency contraception. And since we started to put that [reminder] on the forms,...staff are providing more emergency contraception than before.”—*Clinician*

Staff also suggested that time constraints could be addressed by assigning certain staff to do most of the emergency contraception counseling and to process the required forms. To address patients’ time constraints, the explanations could be tailored according to the patients’ availability and need; patients would receive a phone number for someone in the clinic and assurance that they could call if they needed additional information.

#### **Staff Mail Survey**

Of the 79 clinics that received the survey, 46 (58%) responded; overall, 111 staff completed the survey. Responding clinics did not differ from nonresponding ones in type (community-based, hospital or Planned Parenthood) or size; however, the weighted proportion of patients to whom advance emergency contraception was dispensed was greater at responding clinics than at nonresponding ones (19% of eligible patients vs. 16%).

Sixty-five percent of responding staff were clinicians, 30% were counselors and 5% were medical assistants. Except where indicated below, responses to specific survey items did not differ by clinic position or type. Respondents had worked at their clinic for a median of 4.6 years. On a scale of 1 (“not comfortable at all”) to 10 (“very comfortable”), respondents’ median comfort level with offering advance emergency contraception to all eligible patients was 10, indicating that most staff were very comfortable with offering the method. Although comfort levels did not differ between clinicians and counselors, seven clinicians but none of the counselors

**The majority of [providers] felt that education... was the key to increasing the provision and acceptance of emergency contraception.**

**TABLE 1. Percentage distribution of family planning clinic staff, by how frequently they had offered and provided advance emergency contraception in the past six months, according to visit type, southeastern Pennsylvania, 2005 (N=111)**

Visit type	Very often	Often	Rarely/ never	Total
<b>Emergency EC</b>				
Offered	83	13	4	100
Provided	72	23	5	100
<b>Initial</b>				
Offered	49	31	20	100
Provided	30	35	35	100
<b>Annual</b>				
Offered	48	31	21	100
Provided	25	35	40	100
<b>Pregnancy test*</b>				
Offered	41	31	28	100
Provided	30	33	37	100
<b>STD test</b>				
Offered	28	35	37	100
Provided	18	33	49	100

\*Includes only visits that yielded negative tests. Note: EC=emergency contraception.

reported a comfort level of 5 or below. Most staff indicated that more than half of the patients would accept advance emergency contraception if offered.

•**Barriers to advance provision.** Like the staff who were interviewed from the four clinics, respondents often interpreted the advance emergency contraception policy using their professional judgment. For example, only 83% indicated that they offered advance emergency contraception (in addition to pills for immediate use) very often to women who came seeking the method (Table 1). About half (48–49%) said they offered advance provision very often at patients’ initial and annual visits, but just 28% said they offered it at STD visits. About a third (28–37%) of clinicians stated they rarely or never offered emergency contraception to women who were visiting for pregnancy or STD tests.

More than three-quarters indicated that they only occasionally or never offered advance emergency contraception to women who used the injectable as their main

method (Table 2). In addition, some staff said they only occasionally or never offered advance provision to women who did not ask for it (33%), those in a long-term relationship (32%) and those with children (24%). Seventeen percent of staff reported that they occasionally or never offered advance emergency contraception to patients younger than 18, but this proportion differed between community-based clinic staff and Planned Parenthood staff (32% vs. 6%—not shown).

Other barriers to offering advance provision fell into two categories: logistic issues and staff perceptions of patient characteristics. More than one-third of respondents (38%) indicated that time and staffing constraints were very important barriers, whereas few (11%) felt that the supply and cost of emergency contraception presented a major barrier. As found in the staff interviews, the most common reason perceived by staff for patients’ refusing advance emergency contraception was that the latter thought their regular contraceptive method was sufficient (67%); less commonly cited reasons were that patients did not mind becoming pregnant (19%), objected to emergency contraception for religious reasons or equated it with abortion (10%), or were concerned about side effects (8%). In addition, almost half (45%) of the surveyed staff believed that patients would misunderstand the effects of emergency contraception or would not follow instructions.

•**Facilitating advance provision.** Staff suggestions for fostering advance provision largely mirrored the interview findings. Two-thirds of staff indicated that the most important way to improve adherence to the advance provision policy was to make the offer of advance emergency contraception a routine part of the patient visits. Other frequent suggestions included improving staff training on how to offer advance provision of the method (45%)—an approach favored by 56% of clinicians but only 22% of counselors—and providing patients with more educational materials (52%).

**DISCUSSION**

The vast majority of patients in this study believed that emergency contraception is effective, that they knew enough about it to decide whether to use it and that they would take it to prevent pregnancy. Nearly all who had been offered advance emergency contraception had accepted it. However, almost half of patients thought it is a form of abortion. Despite their reservations about advance provision—that some women might use this method instead of regular birth control and that it could encourage unprotected sex—nearly all felt that women should have easy access to emergency contraception.

Only a few published studies have examined patients’ responses to advance provision of emergency contraception. A study of patients attending a primary care clinic found that attitudes toward emergency contraception were extremely favorable,<sup>4</sup> even though women’s knowledge of and experience with the method were less than those of patients in our study. Moreover, our

**TABLE 2. Percentage distribution of family planning clinic staff, by how frequently they had offered advance emergency contraception in the past six months, according to selected patient characteristics**

Characteristic	Always	Usually	Occasionally/ never	Total
Frequently has unprotected sex	71	23	7	100
Condom is main method	54	34	12	100
Used emergency contraception in past two months	52	33	15	100
Younger than 18	46	36	17	100
Has ≥1 child	34	42	24	100
In a long-term relationship	29	39	32	100
Does not ask for emergency contraception	28	39	33	100
Injectable is main method	4	18	79	100

Note: Percentages may not total 100 because of rounding.

findings that women have predominantly positive attitudes and high levels of self-efficacy regarding emergency contraception echo findings from a study of clinic clients in California.<sup>6</sup> However, in contrast to our study and the primary care study, only a small minority of the California patients felt that advance provision of emergency contraception encourages nonuse of other methods and increases risky sexual behavior. These patients were assessed after an intervention that included information about emergency contraception, suggesting that clinic education can dispel negative attitudes toward the method. Like our study, neither of these studies identified any patient characteristics that were associated with attitudes or beliefs regarding advance provision.

Our interview and survey data revealed that clinic staff, like patients, had highly favorable attitudes toward emergency contraception and the advance provision policy. Nevertheless, staff frequently did not offer advance emergency contraception to patients who were medically eligible. The major reasons were staff perceptions of patients' reproductive lifestyle (e.g., women who used an effective regular method were frequently not offered emergency contraception) and clinic logistics. Attitudes regarding provision to teenagers varied by clinic type, suggesting that the agency "mission" can be a relevant factor. Furthermore, staff thought that most patients would refuse emergency contraception because they relied on their main method; in reality, nearly all patients said they would consider using emergency contraception if they had unprotected sex.

Although little has been published about the relationship between advance provision and the attitudes and behaviors of staff in publicly funded family planning clinics, advance provision has been studied in general health care practice. Fairhurst and colleagues reported that many general practitioners in Scotland believe that advance provision undermines the use of regular birth control and that some women should not use the method.<sup>2</sup> These views and assumptions were associated with reduced distribution of advance emergency contraception.<sup>10</sup> Moreover, these researchers found that general practitioners were reluctant to offer advance provision of the method, a finding that was also reported in a study of family planning and gynecologic providers in California.<sup>14</sup> Sable and colleagues noted that only a minority of faculty physicians (predominantly family practitioners, obstetrician-gynecologists and pediatricians) at four universities strongly intended to prescribe emergency contraception to teenagers,<sup>15</sup> whereas our data showed that although there was some concern about teenagers' understanding of the method, the vast majority of respondents felt that advance provision was appropriate for them. Another study found that although most primary care physicians supported advance provision, their attitudes regarding patient knowledge and the need for emergency contraception by women using effective contraceptive methods were similar to those of our clinic staff.<sup>4</sup> However, clinicians in that study were considerably more concerned than staff in our study about the repeated use of

emergency contraception and a potential increase in the rate of unprotected intercourse. In agreement with our findings, Fairhurst and colleagues also reported that provider time constraints were a barrier to advance provision.<sup>2</sup>

### **Limitations**

The limitations of our study include the fact that patient data were collected several years before the staff interviews and surveys were conducted, and there may have been staff turnover during that period. Furthermore, our approach of using qualitative (interview) data to illuminate quantitative (survey) data has both advantages and disadvantages. One disadvantage is that self-reports may conform to expectations; however, an advantage is that because the quantitative and qualitative arms of the study were seeking similar information, the findings may be confirmed in both. Finally, the staff who completed the surveys were predominantly a convenience sample, and results may not be generalizable to other geographic areas or health care systems, such as general health clinics.

### **Implications**

This study found that both staff and patients at publicly funded family planning clinics strongly supported the policy of offering advance emergency contraception. However, the policy was not fully implemented by staff, largely because of clinic logistics and because they sometimes overlooked eligibility criteria and decided that some women were not suitable candidates for using emergency contraception. Some logistic barriers can be overcome by streamlining clinic flow procedures and offering emergency contraception at all routine visits. Fiscal and time constraints are more difficult to address. Useful long-term goals would be to provide one type of emergency contraception (progestogen-only) to all patients and to employ more counselors to assist in patient education. A short-term and more feasible goal would be to provide patients with basic, easy-to-understand information about emergency contraception before they see a staff member. Staff training programs on improving documentation, contraceptive supply and clinic flow may also be needed.

Our study shows that offering and providing advance emergency contraception needs to be a regular part of office visits (including annual, STD and negative pregnancy test visits) for all patients (regardless of age, contraceptive use and relationship status), so that staff do not feel that they should make judgments about when and to whom emergency contraception should be offered. This practice can be supported through additional education and training: Chuang and Freund demonstrated that a single educational intervention made physicians (predominantly internal and family medicine practitioners) more likely to prescribe advance emergency contraception.<sup>9</sup> In addition, technical assistance (provider education and training, plus information and promotion materials concerning emergency contraception for clients) at top family planning clinics in California increased the proportion of providers

who offered emergency contraception prescriptions in advance of need from 22% to 34%.<sup>14</sup>

To improve staff adherence to a policy of providing advance emergency contraception, we recommend periodic training for all new staff and refresher sessions for others. Besides reviewing basic information, training would include guidance—perhaps through “targeted discussions”<sup>15</sup>—on offering emergency contraception as a backup method to women already using effective contraception, assessing patients’ knowledge about the method and addressing various misconceptions, such as the belief that emergency contraception is an abortifacient.

It is unclear how the advent of over-the-counter availability of emergency contraception, which was approved subsequent to this study, will affect the use of this method, attitudes regarding the method and the role of family planning clinics in providing it. Some insight can be gained from studies of women who have had over-the-counter access to emergency contraception. In a randomized controlled trial, U.S. women who had access to advance emergency contraception were more likely to use it than those who could obtain it without cost at a pharmacy.<sup>5</sup> In a prospective, population-based study in France, where emergency contraception is available without prescription, Goulard and colleagues concluded that prior detailed knowledge increased the likelihood of subsequent use, and recommended that information be provided through physicians and public information campaigns that target all women at risk for unintended pregnancy, including those in stable relationships.<sup>16</sup>

In the United States, public advertising and educational messages to “back up your birth control” have been effective,<sup>17</sup> but such campaigns are expensive, and funding from private sources has not materialized. Political controversies, misconceptions and the public’s lack of knowledge regarding emergency contraception have increased the confusion among women who might have an immediate need for the method. This confusion suggests that the role of family planning clinics as educators has not diminished and, in fact, may have grown. In addition, to the extent that this study’s patient population is representative of the clientele of other family planning clinics, the need for access to emergency contraception appears particularly critical for the large proportion of women who do not use contraceptives at all or who rely solely on condoms. Finally, publicly funded family planning clinics can continue to play a vital role in serving patients (particularly low-income women and teenagers) for whom cost is a major barrier to access.

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