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

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

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

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

**Prescribing Emergency Contraception**

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

Physicians who have provided emergency contraception were asked the commercial name of the hormonal contraceptive they have prescribed, the dose and regimen prescribed, and the timing of the first dose after intercourse. Only 15% gave a completely correct prescription for the Yuzpe regimen (Table 3). Almost half (43%) gave the correct name of a pill but failed to give the correct dosage and timing of the first dose. About one-third (36%) provided the correct name and regimen but gave an inaccurate answer for the timing of the initial dose. The majority of providers incorrectly thought that emergency contraception must be given within 24 hours after intercourse. This confusion may stem from the common usage of the term “morning-after pill,” which implies that the method should be taken the next morning. A scant 2% gave completely incorrect answers, while 4% did not answer the question or mentioned only the IUD.

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

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

**Discussion**

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