

A qualitative study of the views of women aged 18-29 on over-the-counter availability of hormonal emergency contraception

Liz Folkes, RGN, BSc, MSc, *Research Associate, Department of Sociology*; Anna Graham, MRCGP, DFFP, *Clinical Research Fellow*; Marjorie Weiss, DPhil, MRPharmS, *Lecturer, Division of Primary Health Care, University of Bristol, Bristol, UK*

Correspondence. Dr Anna Graham, *Clinical Research Fellow, Division of Primary Health Care, University of Bristol, Canynge Hall, Whiteladies Road, Bristol BS8 2PR* Email: a.graham@bristol.ac.uk

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Abstract

Objective. *To explore women's views on the deregulation of hormonal emergency contraception (EC) prior to it becoming deregulated on 1 January 2001.*

Design. *Qualitative study using face to face, semi-structured interviews.*

Setting. *A NHS family planning clinic, a voluntary sector family planning clinic and a general practice in the South West region.*

Subjects. *Twenty-seven women aged 18 - 29 years.*

Results. *Most women were in favour of deregulation with over-the-counter provision perceived as quick, convenient and anonymous. Reservations regarding overuse and over-reliance upon EC mirror those of health professionals, although it was not felt that the increased accessibility of EC would lead to changes in sexual activity. Concerns that deregulation would promote an irresponsible attitude towards contraception were largely focused on younger women. Cost was generally regarded as a positive barrier to overuse. However, it was felt that the price should not be prohibitively high. A figure corresponding to the current prescription charge was most often cited. The pharmacy was the preferred choice of provider for most women.*

Conclusion. *Although most women in this study would prefer to obtain EC over-the-counter, the current charge of £20 is likely to prove a barrier.*

800 000 prescriptions for hormonal EC being issued in 1999/2000.¹ Clinical evidence supports the view that EC is a safe,² cost effective³ means of reducing unplanned pregnancy, with research linking the efficacy of EC to the intercourse-treatment interval.⁴

Throughout this paper 'over-the-counter' will be used specifically to describe the availability of Levonelle as a pharmacy (P) medicine, available without a prescription from a registered pharmacy. Supply as a P medicine is made under the terms of the OTC licence for the medicine. The Royal Pharmaceutical Society of Great Britain has issued guidance on best practice in relation to the supply of hormonal EC. This guidance states that a pharmacist must obtain sufficient information to assess the appropriateness of a supply of hormonal EC, advice on how it should be taken and advice to customers about side effects and additional counselling points.⁵

The potential for over-the-counter provision of EC has been discussed for over a decade.^{6,7} Last year saw the launch of five pilot schemes involving over-the-counter provision of EC through community pharmacies in England. These projects provide EC free to users through a group prescribing protocol, and are sited in areas with high rates of teenage conceptions and/or terminations. Demand for EC through these schemes has increased rapidly.⁸ Encouraged in part by the success of these pilots, approval was granted for a change from prescription only to pharmacy status for progestogen only EC, Levonelle-2, in July 2000. Deregulation of Levonelle-2 was effected from January 1 2001.

Previous studies conducted with GPs,^{9,10} family planning clinic staff¹¹ and pharmacists^{12,13} have revealed widespread misgivings amongst practitioners regarding the deregulation of EC. The principal concerns are the removal of the opportunity for ongoing contraceptive advice and fears that some women may 'abuse' EC. Less is known about the views of the consumer group themselves. Consumer consultation is playing an increasingly important role in the planning and implementation of health services.¹⁴ As such, a study exploring the consumer perspective is both timely and appropriate.¹⁵ This study uses a qualitative approach to explore women's views of over-the-counter availability of EC prior to it becoming deregulated on 1 January 2001.

Method

The study was conducted between August and November 2000. Ethical approval was obtained prior to the start of the

Key message points

- EC is a safe, cost effective means of contraception; improving the accessibility and availability of EC has been identified as a means of reducing unplanned pregnancies.
- Health professionals have expressed concerns that over-the-counter provision may lead to 'abuse' of EC by some women.
- Schemes piloting over-the-counter provision have reported considerable demand, however EC provided through these schemes has been free.
- Over-the-counter provision of EC is regarded by many women as a quick, convenient and anonymous solution to the problem of unplanned pregnancy.
- Women expressed concern that increased access to EC will result in irresponsible contraceptive practices-particularly by younger users.
- The price of EC will be an important factor in determining demand for EC at the pharmacy. The current cost of £20 may be a barrier for many women.

Introduction

It is over 15 years since Schering PC4 was first licensed for use in the UK as an emergency contraceptive (EC). Annual figures have shown a steady increase in its use with nearly

study. Participants were recruited from three sites within an urban area in the South West of England reflecting the range of contraceptive service provision in the area. The sites chosen were the local health authority's principal family planning clinic; a Brook Advisory Centre, a non-profit making organisation providing family planning and sexual health services specifically targeted at the under 25s, and a general practice.

In order to obtain the views of a range of EC users and non-users from each site, a self-administered questionnaire was devised as a sampling tool. This questionnaire was issued to all women aged 16–29 years attending each of the sites over a 1-week period. Women under 30 years have been identified as the most frequent users of EC.¹⁶ Ethical concerns regarding parental consent determined the lower age limit of our sample as 16 years. Women unable to speak English were excluded from the study.

The respondents were asked to record their age, how many times, if ever, they had used EC, and which services they visited to obtain EC. The respondents were then provided with a brief description of the study and invited to give contact details if they were willing to be interviewed. The survey data were used to identify a purposive sample from each site to include women who had never used EC, those who had used EC once and those who had used EC several times.

The research team devised a semi-structured interview schedule informed by a review of the previous literature, and based upon the study's objectives. Interviews explored the women's current contraceptive practices, including her choice of service provider, past EC use, issues concerning availability and accessibility of EC and her views on deregulation of EC, including cost. The influence of increased access to EC on sexual behaviour was also discussed.

Interviews were conducted by LF. Interviews took place at the site where the women were initially surveyed and lasted between 20–40 minutes. The interviews were tape-recorded and transcripts analysed using QSR NUD*IST software.¹⁷ A coding frame identifying discrete themes, patterns and relationships within the data was developed through a detailed reading and re-reading of the interview transcripts. Each transcript was then coded by one researcher and a sample was independently reviewed by another. Any differences in the coding were discussed and the relevance of these clarified at regular meetings between all three authors. As identifiable themes emerged, constant comparison was used to explore similarities and differences within the data and to refine the coding process until a number of core categories evolved. Analysis took place concurrently with the data collection, which continued until no significant diversity of opinion was expressed by the informants concerning the key issues which had emerged.

Results

The survey was completed by 291 women: 131 at the Brook Advisory Centre, 57 at the family planning clinic, and 32 at the general practice. Twenty-nine women refused to complete a questionnaire and, due to issues of

confidentiality, 42 women attending with a male partner were not approached. This gave an overall response rate to the survey of 76% (220/291). Of the 220 women surveyed, 75 agreed to be interviewed. Using the survey data a purposive sample of 10 women from each site was identified to include women who had never used EC, those who had used EC once and those who had used EC several times. In all, 27 women were interviewed. Interviewees ranged in age from 18 - 29 years. Their use of EC ranged from never to nine times (Table 1). Seventeen of the women had previously used EC; 13 out of the 17 were under 19 years old when they had done so.

Few differences emerged in the views of women recruited from different sites. Neither age nor prior use of EC appeared to contribute to significantly different views on deregulation. The textual analysis can be summarised within four main themes: contraceptive methods and previous EC use; over-the-counter availability; sexual behaviour; cost.

Contraceptive methods and previous EC use

Interviews commenced with a discussion of the women's current contraceptive use. Over half the women (16/29) were currently using an oral hormonal contraceptive, four had been fitted with an IUD, two were on Depo-Provera[®] with the remainder either relying on condoms or reporting that they were not currently sexually active. All the women interviewed were content with their current contraceptive provider. Several women recalled negative encounters on previous occasions with doctors in other settings when attempting to obtain EC. One woman had been told that EC was 'no better than an abortion', others had been warned 'not to be so silly again' and 'made to feel looked down upon'. Fear of judgmental attitudes was a major factor in the choice of EC provider, especially as many of the women had used EC whilst still teenagers.

The women who had used EC were asked to recall what contraception, if any, they had been using when they had requested EC. Only two of the women said that they had told their doctor that they been using no other form of contraception at the time, the majority of the respondents reporting condom failure as the reason for their concern. It is possible that many do not admit to non-use of contraceptives in case they prejudice their request. Several women had been advised that repeated use of EC posed considerable health risks. No women suggested they would not use EC on medical or moral grounds.

Over-the-counter availability

Deregulation, including a description of the pharmacy consultation process, was explained to the women, who were then asked for their views. Although only one respondent was entirely opposed to the idea, most women were cautious in their welcome of over-the-counter availability. There were no differences between previous users and non-users of EC in terms of how they perceived the advantages and disadvantages of pharmacy provision, and all the interviewees recognised the positive advantages of greater accessibility such as a reduction in unplanned

Table 1 Characteristics of the interview sample (n = 27)

Setting	Number of interviews	Mean age	Age range	Mean EC use	Range of EC use
Brook Advisory Centre	10	24	19 - 29	2.1	0 - 6
Family planning clinic	7	25	18 - 29	3	0 - 9
General practice	10	24.9	21 - 28	1.1	0 - 4
Total	27	23.8	18 - 29	1.8	0 - 9

pregnancies and avoidable abortions. On a personal level most of the women identified convenient locations, more flexible opening times and speed of consultation as of likely benefit to them. All the women felt it was 'easier' to visit the pharmacy. However, this perceived ease was the focus of many of the interviewees' reservations. Frequently these concerns mirrored those expressed within the studies of health professionals, particularly in terms of the implications for regular contraceptive use. Concerns about the spread of sexually transmitted infections were related to a decrease in condom use, rather than the loss of the opportunity for detection that a medical consultation (potentially) affords (Box 1).

Box 1 Over-the-counter availability

I'm more worried about the younger girls really and how, you know, it will just make everything too easy. Too easy to not worry about using a condom. 'Cos I think that what girls are probably more worried about is getting pregnant than catching a disease. I think everything's just, you know, it doesn't make them really think hard about what they're doing before they do it.
(24-year-old, family planning clinic, used EC twice)

But just mainly because I think that people would use it as a form of contraception rather than emergency contraception and just young girls who don't really know about these things, being able to just go in and, and buy it over-the-counter. I don't know, it's a bit worrying. I think for, for older women it's a good idea and maybe there should be an age limit on it.
(22-year-old, Brook Advisory Centre, used EC twice)

The Department of Health has already indicated that pharmacists should not supply EC to girls under 16, with many of the women recognising the problems that this will present to the pharmacist. Although several women acknowledged that pharmacists were highly qualified professionals, there were perceptions of pharmacists as 'white coated shop assistants'. The majority of respondents endorsed specific training prior to dispensing EC. A lack of privacy and the potential for embarrassment were also remarked upon.

Sexual behaviour

Despite assurance that their use of EC had been, or would be, an informed choice, none of the women interviewed expressed an unqualified faith in the ability of other women to do the same. Teenagers were identified as needing additional support and advice. There was a prevalent belief that there were women 'out there', typically characterised as young girls, who would be tempted not to bother with 'proper' contraception. It was widely felt that these young girls, predisposed to act impulsively and irresponsibly, would simply abandon planned contraception. Many participants were willing to forgo the personal convenience of over the counter provision in order to enforce responsibility on these girls for the consequences of their actions (Box 2).

Although it was felt that contraceptive practices might change with the deregulation of EC, none of the women endorsed the view that sexual behaviour would be affected. The notion that promoting contraception implicitly encourages promiscuity was discounted by all. It was casual contraception rather than casual sex that comprised the women's main reservation. No participants suggested that improved access would result in an increase in their own use of EC, and only one woman considered that she might buy it in advance of intercourse. Despite their reservations as to whether pharmacy provision was in everyone's best interest, most of the women stated that they would use the

Box 2 Sexual behaviour

I'd probably be happy buying it but I think as a general thing, for younger people, it's more important for them that they do it right, otherwise it's a bit too easy to do. I think with people my age, in their twenties I don't think they want to go in and get a lecture, I think basically the chemist would just have to be, you know, a bit of a judge of character and, you know, speak when it's necessary rather than lecturing everybody.
(21-year-old, Brook Advisory Centre, used EC twice)

I think to make my life easier, because I'm older and responsible, it would be great. However, I think we need to put younger people who are less aware and less experienced and less knowledgeable about how these things work first, because I think they're more important and I think I can put up with a bit of, like, faffing around for the sake of some kids not getting pregnant cause they're told the wrong thing. Good and bad, good for me, bad for them, good for them, bad for me so I still think put them first. Make them go down and get it, make them sit there and be told how it works and why they shouldn't keep doing it that way..... it's a lot to do with responsibility the availability of things like that. I think it's the irresponsible, less experienced people you actually need to make the rules for, because the older people can sort themselves out.
(21-year-old, Brook Advisory Centre, used EC once)

pharmacy as their first choice. Prior use of EC was not a factor in this choice, with similar numbers of previous users and non-users favouring this method.

Cost

Women were asked what they regarded to be a 'reasonable cost' to pay for EC. Of the 25 women prepared to name a price, 18 mentioned a figure somewhere between five and ten pounds, with 10 of these suggesting a figure equating to the current prescription charge (£6). Four women felt that ideally EC should be free or 'a couple of quid at the most'. Only one woman was prepared to pay over £15 with many expressing concerns that making EC too expensive would deter the very people that over-the-counter availability might benefit most. Even those who suggested that in an ideal world EC would be free could perceive advantages to attaching a cost. Many women saw cost as a positive deterrent. Suggestions were made that the cost 'should be enough that people noticed', 'enough where you wouldn't want to be buying it every week' and 'a price where people have to think about it, that it's not to be taken lightly, that it's going to cost them at the end of the day'.

Linked to this was a feeling that people should be prepared to pay for their mistakes, planned or otherwise. The abiding image of an EC user for most women was someone who had deliberately engaged in sex without contraception, regardless of their own personal experiences of split condoms and missed pills (Box 3).

Discussion

This qualitative study explored women's views on the deregulation of EC. Despite reservations about a scheme whereby EC was universally available, the majority of women in this study felt that they could, and would, use this service. Previous studies with consumers and health professionals show less equivocal support. In the 1996 survey by Smith¹⁸ only 36.1% were in favour of over-the-counter availability. It is possible that as publicity about the availability of EC has become more widespread, acceptance of over-the-counter provision has also increased. Equally this could reflect bias in our sample, a problem which is inherent in using small, voluntary samples.

The pharmacy pilot schemes have provided a useful indication of demand for over-the-counter availability of EC. However, in all of these schemes EC has been provided

Box 3 Cost

It would be best to stop unwanted pregnancies but practically, obviously a small charge would be okay and also, perhaps, as a sort of deterrent, you know, to use other forms of contraception that are free instead.

(23-year-old, general practice, never used EC)

I mean if they're trying to help out people who had an accident or anything, then, you know, then that isn't helping them at all really is it, because very few people could afford twenty pound for it.

(23-year-old, family planning clinic, used EC five times)

I think it is a bit much 'cos lot of women I'd think would not bother taking it if they thought they had to pay like ten or twenty pounds for it, I think a lot of women would just leave it, just take the chance.

(23-year-old, general practice, used EC once)

free. Our study suggests that cost will be an important factor in this decision, with the current £20 charge likely to be present a barrier to many women. This supports previous findings. In Glasier's self-administration study, 68% were willing to pay £3 but this fell to 42% willing to pay £5.¹⁹ The figure regarded as a reasonable cost by most of our participants was the prescription charge (£6). This is the price at which EC is available over-the-counter in France. The Department of Health has been careful to portray deregulation as a complement to existing contraceptive services.²⁰ The new NHS Walk-in Centres, where EC may be available free under a patient group direction, could provide an attractive alternative for many women.

The deregulation of Levonelle-2 has the potential to change the way that EC is obtained within the UK. If over-the-counter provision of EC is to have an impact on unplanned pregnancies, it must not simply be made more available, but more accessible. Ziebland²¹ identified appropriate advice and a sensitive, non-judgmental approach on the part of the provider as the essential foundation of any contraceptive service. Women in this study recognised the barriers created by stigma and embarrassment. Within a social context that implicitly condones certain types of sexual activity whilst censoring others, there is a deeply held association between responsible sex and responsible contraception, suggesting the devaluing of both these activities if unplanned.

Conclusion

Obtaining EC to prevent an unplanned pregnancy is a profoundly rational act and yet it is construed as feckless, shameful and irresponsible behaviour by the very women

who have used EC themselves. Protestations that a woman requesting EC should be provided with the confidence that she will be treated with respect, 'as a responsible adult who is making a responsible health care choice'²² seem to have done little to alter the prevailing attitudes. Increased availability of EC has been greeted by predictable moral outrage.²³ On the same day a spokeswoman for the Royal Pharmaceutical Society described the over-the-counter provision of EC as 'a sort of normalised, non-stigmatised healthcare intervention'.²⁴ This research suggests that it is not only health providers who would hesitate to endorse this statement, but consumers too.

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