

Users' views of new providers of emergency contraception: a qualitative study

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Objectives: To explore users' views on increased availability of emergency contraception (EC) from two new providers of EC. **Context:** EC was previously available from general practitioners (GPs), Family Planning Centres, Accident and Emergency Departments and Brooke Advisory Centres. Recently, EC has also become available from pharmacies and Walk-in Centres (WiCs). **Design:** Qualitative study using in-depth interviews. **Setting and Participants:** Twenty-nine women from two (WiCs) and two pharmacies in Avon. **Results:** Women selected their provider on the basis of convenience and accessibility. WiC users valued the advice and personal nature of the contact with WiC nurses. Women who accessed EC from a pharmacy were amenable to answering questions to obtain EC but did not see this as a time to receive contraceptive advice. Women's attitudes to pharmacy supply of EC may be related to its associations as a place of business. Phrases such as over-the-counter may reinforce this notion, reflecting the business-like nature of the questioning and the impersonal nature of the interaction. While women considered the increased availability of EC to be generally positive, some had concerns about younger women accessing EC, particularly from a pharmacy. **Conclusions:** Women had a favourable view of their provider of EC, whether from a pharmacy or WiC. Concerns about pharmacy access may be related to its associations as a place of business where consumers have more power in the encounter. For some, this type of 'easier' access was considered inappropriate for younger users.

Key words: emergency contraception; increased access; patient choice; qualitative interviews

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Introduction

Emergency contraception (EC) has been available in the UK from doctors for over 20 years. This may include access from a general practitioner (GP), Family Planning Centre, Accident and Emergency Department or Brooke Advisory Centre. In 2001, EC became available over the counter from pharmacies. EC may also be accessed under a Patient Group Direction (PGD) at no cost from Walk-in Centres (WiCs), usually from nurses, or from a pharmacy. PGDs enable the supply or administration

of prescription-only medicines by health professionals who are not medically qualified (NHS Executive, 2000).

Increased access to EC has been advocated for many years. EC is thought more effective if given within 24 hours of having unprotected sexual intercourse. The 1999 Social Exclusion Unit Report commends over the counter availability of EC as having the potential to make a significant contribution to reducing unplanned teenage pregnancy and termination rates (Social Exclusion Unit, 1999). However, health care professionals have concerns about increased access to EC (Ziebland *et al.*, 1998; Blackwell *et al.*, 1999; Hinsliff, 2003) such that women may lose out on the benefits of a medical consultation, where future contraceptive needs can be discussed. Time and privacy may be particular

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issues with the access of EC from a pharmacy. In addition, some pharmacy users accessing over-the-counter medicines have been described as 'determined purchasers' – users who value being in control of the consultation and choose medicine access through a pharmacy because of their personal preference for managing personal health decisions themselves (Hassell *et al.*, 2000). How this relates to EC access is unclear but, if comparable to other over-the-counter consultations, such a user preference may exacerbate health care professionals' concerns about pharmacy access where there is potential for the control of the consultation to be in the hands of the customer.

From a patient perspective, in an interview study conducted by the authors prior to deregulation, most women were in favour of over the counter availability. However, like health care professionals, women had reservations about the dangers of overuse and over-reliance on EC by young people (Folkes *et al.*, 2001). The current study builds upon our earlier research by exploring the views of women now that deregulation has occurred. The specific focus of this research is to explore women's views on the increase in availability and range of service providers of EC.

Methods

The study population included women who purchased or received EC from pharmacies or WiCs in Avon. Of the three WiCs in Avon, at the time of the study only two supplied EC and both were recruited to the study. Pharmacies were recruited through a brief questionnaire survey asking for the number of EC packages sold per week. Preference for selection was given to those who supplied a larger number of EC packs as recruitment took place opportunistically in the WiCs and pharmacies. This was narrowed down further to the two pharmacies with an area away from the main purchasing counter where interviews could be conducted relatively privately.

Ethical approval was obtained to conduct in-depth qualitative interviews with EC users. The nurse or pharmacist from whom they had received EC gave potential participants a leaflet outlining the study. In the WiCs the interviews took place in a separate consulting room and in the pharmacies the dispensing area was used. Providers were

unable to hear the interviewer's discussions with users.

A semi-structured interview schedule was developed based upon our previous research and other research literature in the area. This included: discussing the characteristics of users of EC; views of users on increased availability of EC; and the influence of cost on women's decision making behaviour as well as the impact on their contraceptive and sexual behaviour. The use of a semi-structured interview schedule helped reduce interviewer bias.

Women aged 16–35 years who had obtained EC at the two WiCs and two pharmacies were interviewed immediately afterwards by RL. The interviews took place between November 2002 and April 2003. They were tape recorded and transcribed. Fieldwork data was collected until categories or data themes were saturated within the context of the study objectives. Data were coded under identified categories, the transcripts re-read and the categories refined further. Emerging themes and contradictory cases were actively sought. The process of data analysis was both descriptive and explanatory in trying to identify potential theories to elucidate respondent's narratives. Deviant cases which did not fit emerging explanations were sought and explanations amended or discarded. The overall process of data analysis followed the approach described by Strauss and Corbin (1998). The qualitative computer software package Atlas.ti was used to aid data manipulation and analysis. All transcripts were analysed by RL and MCW.

Results

The pharmacies included in the study were both part of a large chain, one based in an out of town shopping complex (Pharmacy 'A') and the other in a city centre (Pharmacy 'B'). Both pharmacies estimated sales of EC of approximately 10 packets per week, with EC free to under 21s under a PGD. The two WiCs were diverse with respect to their surrounding location and likely population served and also numbers supplied. One WiC is based in a city centre and provides approximately 10 packets of EC per day, and the other is in a poor residential area supplying approximately five packets per week. Both supply EC at no charge.

Twenty-nine women were interviewed by RL, immediately following supply of EC, 16 at a
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pharmacy and 13 at the WiCs. Women under 16 years old were not included in the study as they were not included within the original ethical submission. Forty-two women were asked to take part. Two were excluded as they were under 16 years old, nine agreed but RL was unable to interview them as when they were available to be interviewed she was already doing interviews with other participants. Two other women refused to take part. The interviews took place on the weekend ($n = 20$), a Bank Holiday Monday ($n = 3$) or a weekday ($n = 6$). Ten respondents were recruited from Pharmacy A and six from Pharmacy B. Eleven respondents were recruited from the City Centre WiC and two from the WiC located in the residential area.

Characteristics of the interviewees

The median age of the women recruited to the study was similar in both the pharmacies (25 years) and WiCs (24 years). The two groups of women were also similar in their range of age (pharmacy users aged 16–35 years and WiC users aged 17–34 years) and previous use of EC. WiCs were only slightly more likely to be first time users of EC. Pharmacy users tended to be older, with four women in their 30s in the sample, and have slightly more experience of EC having used EC more often (see Table 1).

A range of themes emerged from the data. These are organized under the headings of the nature of the interaction, cost and influence on women's behaviour.

Nature of the interaction

Overall women chose their EC provider, whether pharmacy or WiC, because it was accessible and convenient. Providers were chosen because they were near their home or because it was open at the weekend when they needed it. Other convenience-related reasons included the speed of the service,

the availability of car parking spaces, the provider was on a local bus route and the provider was within the shopping precinct where they were shopping anyway. All of the respondents valued a friendly, non-judgement manner from their EC provider and all felt they had received this in their current provision. In general, women were not choosing between a pharmacy and a WiC but rather on the basis of what was available and convenient for them on the weekend.

Four of the 11 WiC users phoned NHS Direct and were advised that EC could be obtained (out of hours) from a pharmacy or WiC. These four decided to go to the WiC because they wanted to get some advice (on whether or not EC was needed or because they were a first time user). The WiC was perceived as being more 'personal'. During the interview, all were told that EC was now available from pharmacies; none of the WiC users had previously obtained EC from a pharmacy. When asked if she was comfortable with EC being available in some supermarket pharmacies, one WiC respondent said:

No, I don't think it should be [available in supermarkets]. I think you need advice on these things ... in the pharmacy it is very impersonal.

(Interview 2A, WiC user)

Another WiC user preferred obtaining her EC from a WiC:

I would probably still come here because you can get the advice that you can't when you get it over the counter, can you? It's more personal.

(Interview 3A, WiC user)

Use of words such as 'impersonal' and 'lack of advice' may reflect associations with the phrase 'over-the-counter' in relation to pharmacy availability. This phrase conveys an image of a conversation over a pharmacy counter which, given the demands of the commercial environment, may be overheard and would necessarily have to be brief. This association with the commercial environment may have led two respondents to view the WiC as a place which was 'more medical':

I would rather come here [in preference to going to the chemist's] because I have never

Table 1 Characteristics of interviewees

	Walk in centres ($n = 13$)	Pharmacies ($n = 16$)
User age (median)	24 years	25 years
EC use (median)	2.07	2.33
EC use (first time)	5	5
EC use (greater than twice)	3	5

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used it before and this kind of medical advice on hand helps.

(Interview 1E, WiC user)

I would prefer to come somewhere like here (the WiC) or my doctor who knows just a little bit more about it all. Just like today for my own well being they had to look into it for me. You know, you wouldn't get that at a pharmacy.

(Interview 2A, WiC user)

To a certain extent, WiC users' preconceptions about accessing EC from a pharmacy were echoed in pharmacy users' experiences. Several pharmacy users commented on the knowledge and training of the pharmacists, although most also remarked about the difficulties of being overheard in the queue. One pharmacy user waited in the shop for a period of time until it was a bit quieter to approach the pharmacy counter:

They did whisper – that was very nice for me. It's not something you want everybody to listen to, is it? ... To have to go in and have people behind you as well, you do feel a bit, well embarrassed and conscious of speaking quite loud ... you don't want anybody else to know.

(Interview 4B, pharmacy user)

Another pharmacy user may have agreed with the WiC users who saw the pharmacy as less personal:

I find that pharmacists obviously are just kind of professional and official, there's no kind of caring there.

(Interview 5C, pharmacy user)

However, this particular user goes on to suggest that a more caring or protective role may be one which is also potentially more judgemental:

[If you went to a GP, how would you expect them to be?] I'd expect them to be a bit more like 'What happened?' 'How have you become unprotected?' and a bit more protective of you rather than here's your medication ... this (accessing EC from a pharmacy) is probably the kind of service that I want for me ... I don't need someone to patronize me ... obviously

a mistake's been made so I know that you shouldn't be doing this all the time.

(Interview 5C, pharmacy user)

These professional or impersonal associations of pharmacy access were also linked with the perceived positive benefit of anonymity. One 16-year-old pharmacy user could have obtained EC through a PGD at the pharmacy and had it provided free. However she was worried this might entail having to give out personal details (presumably name and address) and stated 'I don't want anyone finding out'. Instead, she opted to pay for her EC where personal details were not disclosed.

Cost

Perceptions surrounding pharmacy availability of EC may also have been linked with the issue of cost. Only one WiC user decided to come to the WiC because she knew it was free; she knew would have to pay for it from a pharmacy. The other WiC users were unaware of pharmacy availability or were aware of pharmacy availability but unaware of the cost or felt that the availability of EC free from the WiC was not the crucial factor in their selection of venue. In this latter group, women reported that it was the nature of the service at the WiC (eg, the provision of advice), which made them choose a WiC.

Not surprisingly, as the pharmacy users had just had to pay for their EC, the cost of £24 for EC was not perceived as a deterrent to accessing EC. The cost was a price worth paying and, as stated by one respondent, 'cheaper than a child.' This reflects their high level of motivation not to be pregnant and the relative wealth of this group of users. Five pharmacy respondents felt £24 was quite expensive, with several mentioning they would have gone elsewhere (for free) had it not been the weekend and they needed to take it as soon as possible. Two respondents clearly saw that there was a trade-off between cost and convenience:

I don't think it's right that you should have to pay for it but then I'm not going to wait two or three hours in a surgery ... [I: so you think it's worth paying the £24 to actually get it?] To not have to wait for one or two hours.

(Interview 5D, pharmacy user)

Yea, it's worth it really (paying £24), just to be able to just turn up and get it and not have to go to my GP ... I knew I could get it here and I could walk in and get it without getting more hassle.

(Interview 7B, pharmacy user)

In this sense, notions around accessing EC from a pharmacy were less around the potentially high cost of EC per sé but rather that there you *could* purchase it from a pharmacy. It was an item of commerce; a business transaction:

I was coming in as a consumer to buy something I wanted.

(Interview 4a, pharmacy user)

EC attracted a cost when accessed from a pharmacy (except where available on a PGD) and was available over-the-counter. Both of these facts reinforced the notion that the pharmacy was a business environment, making it a less personal space for private consultation and having less scope for medical advice and interaction.

The link between advice and the WiC was also demonstrated with regard to the issue of contraceptive advice. One of the concerns of doctors in previous research has been that women would miss out on additional advice regarding the use of contraception when accessing EC, particularly from a pharmacy. Generally, most women who accessed EC from a WiC reported receiving, and did not mind receiving (even when they perceived they didn't need it), contraceptive advice:

We had a chat about contraception but I did say that I do realize about contraception and it is nice that they make you aware of it but I am not in any relationship.

(Interview 2E, WiC user)

In contrast, most women who obtained their EC from a pharmacy did not want contraceptive advice – and did not appear to receive it in their interaction with the pharmacist:

I mean I know all about contraception. I find it a bit condescending to tell you the truth when people do that ... I would ask if there was anything I wanted to know.

(Interview 4C, pharmacy user)

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[Would it have been helpful to have had advice on contraception?] No, I'm up with it on contraception ... I'm between boyfriends, between periods of the pill so that's the only reason I'm here, I understand what's needed.

(Interview 5E, pharmacy user, age 16)

Convenience was the main factor driving these women's choice of venue, with some affected by the cost of different options. Within these constraints, it may be that women select pharmacies because they do not want advice – contraceptive or otherwise – seeing it as a way of obtaining EC on their terms in a quick and professional (or impersonal) manner. Having it available *to purchase* reinforces this notion of obtaining it on their terms in a business-like encounter. Women may select WiCs because they want advice and desire what they perceive as more personal and caring attention.

Influence on women's behaviour

The final issue investigated was whether the increase in availability of EC through pharmacies and WiCs, might affect women's sexual or contraceptive behaviour. Would women have more sexual encounters or engage in more risky sexual practices? With increasing availability, might women use EC instead of regular contraception? Most respondents felt that increased availability of EC was unlikely to affect women's sexual behaviour:

I don't see more people having sex with more people just because there is more availability of this ... it just sounds like a silly concept.

(Interview 1D, WiC user)

You would be a lot better off going and buying a packet of condoms and sleeping with 3 or 4 people than taking the morning after pill. It seems a lot less hassle to go and buy condoms than to go and get the morning after pill.

(Interview 2C, WiC user)

Some women felt that increased availability was unlikely to affect the sexual or contraceptive behaviour of women of any age. However, for the remainder, the view was expressed that increased availability could affect women's contraceptive behaviour, particularly younger women's. There

was a sense that some of these women might 'take advantage' or might 'need to be watched'. One respondent felt that EC was 'losing a bit of its stigma because so many places can offer it now to people'. This view was echoed by the following respondents:

I've heard of some younger girls in my school and my previous school, that they are taking it ... very frequently [I: More than once a month?] Yes but it just shouldn't be. I don't know, it's just not proper, is it?
(Interview 6A, pharmacy user)

[younger, less mature people] They are the sort of people who need advice and telling off a bit to shock them into things and to realize what they are doing, because you get a lot of people who aren't responsible at all.
(Interview 8A, pharmacy user)

This concern was expressed particularly in relation to availability from a pharmacy, where EC was perceived as being more freely available than EC from other sources:

Younger people will try and get away with it and I don't think there's proper control over it, if it comes from a pharmacy anyway because nobody knows who you are, how many you've taken and anybody can say anything over the counter at the end of the day. So I think if they were younger they should possibly have to go to a GP to have a chat....
(Interview 5D, pharmacy user)

In this sense, the perceived more business-like level of questioning offered by a pharmacy, was considered less appropriate for younger users:

[referring to young people] I do think that it is much better to come and have a chat with someone. And I know that they would do (that) in a pharmacy but knowing that you can just pay 20 quid and have it....
(Interview 2E, WiC user)

It shouldn't be available over the counter because I think you should sit down and talk to somebody about it rather than going into a pharmacy and doing it like that.
(Interview 3A, WiC user)

Nonetheless, all the respondents thought increased availability of EC was generally positive – because, for those who were sensible and responsible (like themselves), it was a convenient option. Concerns about increased availability centred on 'other women' and particularly 'other younger women' with the definition of what constituted a younger woman rising with the respondent's own age. For those that were concerned about the possible negative side to increased availability of EC, pharmacy availability could be particularly worrying if it were accessed by younger women. These misgivings about pharmacy availability may, in part, relate to its associations as a place of business: an impersonal and commercial environment, where an EC transaction will be handled in an efficient, business-like manner with little additional advice, regardless of the customer's age.

Discussion

This aim of this study was to report on women's experiences of new providers of EC, notably from WiCs and pharmacies. Convenience and accessibility drove women's selection of provider, with a minority influenced by cost. All women liked the quick access (eg, lack of waiting) for both these services and all reported that they had received a non-judgemental service, whether from a WiC or pharmacy, and that they valued this type of approach. WIC users liked the personal nature of the interaction with the nurse, with some selecting a WiC because they wanted additional advice and this type of personal interaction. Pharmacy users did not view the cost of EC as a major deterrent to access. Pharmacy users tended not to want additional advice and considered it an inappropriate time to receive contraceptive advice, feeling they were well aware of contraceptive issues. Findings from this study confirm the findings of our earlier work prior to deregulation (Folkes *et al.*, 2001) and that of other authors regarding users' views on receiving contraceptive advice from a pharmacy (Bissell and Anderson, 2003) and the effect increased availability of EC may have on increasing risky contraceptive and sexual behaviour by younger users (Karasz *et al.*, 2004; Fairhurst *et al.*, 2005; Ziebland *et al.*, 2005).

Limitations of the study relate to the possible selection bias in the sampling. Including users of
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WiCs and pharmacies but not users of GPs, Family Planning Clinics or the Brooke may have resulted in less positive comments about these venues as this was a group of women who had deliberately decided not to go to these providers. Favourable views of these providers would have been more likely if we had sampled from these providers as well. Similarly, as our sample was recruited from pharmacies and WiCs, positive views of these providers were unsurprising. Further, including users who paid for EC, unsurprisingly, resulted in comments that indicated they were willing to pay. Not captured were any women that may have chosen to go elsewhere because they did not want to pay or could not afford to pay for EC. Income has been found to be an important predictor of over-the-counter EC use (Marston *et al.*, 2005) which may be reflected in our findings with women who had relatively little difficulty in paying for EC.

The pharmacies in our study were both part of a large chain. A smaller independent pharmacy could not be recruited to the study and it may be that users of this type of provider and/or pharmacies prescribing lower numbers of EC packs had different experiences. Previous research suggests pharmacies are chosen for different purposes: smaller, independent pharmacies are chosen as they are more personal and used as a source of health care advice in comparison to larger chains that are seen as official and treated as a supplier of medicine (Abu-omar *et al.*, 2000). The impersonal nature of the latter type of pharmacy makes it the preferred pharmaceutical supplier of EC. The public's desire for brief encounters when receiving advice in a community pharmacy, have also been noted (Morris *et al.*, 1997). If we had been able to recruit a smaller pharmacy in a small community, it may be that the users' experiences may have more reflected the experiences described by those accessing EC from WiCs. Given the large number of pharmacies in the UK, it may be that women's choice of provider may vary with type of provider (eg, WiC, pharmacy, Brooke) and within types of providers, with different ones perceived as having different attributes particularly in relation to private consultation areas.

The women in our sample tended to be older and, due to the limitations of our ethical approval, we were unable to recruit women under 16. The users of WiCs and pharmacies in this study were resolute not to be pregnant. One of the WiCs in our study is sited in a poor residential area. Few

packets of EC were provided compared to the city centre WiC. Free's study in a socially deprived inner city area found that these women saw themselves as having a low vulnerability to pregnancy and as such believed that they did not need EC (Free *et al.*, 2003). This provides a dramatic contrast to the group in this study who reported taking almost no risks. Our data are unlikely to include the views of this particular group, partly because we recruited fewer women from the WiC in the socially deprived area and partly because these women may have considered themselves unlikely to need EC.

The co-existence of a personal, caring advice-giving environment sits uncomfortably with the realities of some pharmacies, particularly large pharmacies selling a range of other non-medicine items. It is particularly problematic in sensitive areas such as those involving sexual health. Current developments in pharmacy have advocated a wider role for pharmacists in the areas of medicine use review, advice giving for recently deregulated medicines and the provision of health promotion advice. While these developments may be good for the profession of pharmacy, and potentially patient care, it may not change people's perception of pharmacy as a place of business. Other authors have suggested that, if EC were provided free (under a PGD) from a pharmacy, pharmacists would not be negatively associated with commerce (Bissell and Anderson, 2003). Private consulting rooms (away from the pharmacy counter) may also help dissociate the advice-giving functions of a pharmacy from its business functions. None of our pharmacies had a truly private consulting area nor did we interview women who had received EC from a pharmacy free. This would be an interesting area for future investigation: to see if the conceptions surrounding a business environment, with fairly brief impersonal interactions, predominate or if pharmacists are seen to be providing a more caring, medical role.

Previous research has noted the concern of health care professionals that increasing access to EC would decrease the provision of advice regarding future contraception. A report from 'Which?' suggested that pharmacists were not providing information relating to general contraception or health promotion and the prevention of sexually transmitted diseases (Anonymous, 2004). What was interesting in this study was that pharmacies provided the type of service that the women who

accessed it wanted. This underlines the tension between health care providers deciding what they think is the best for patients and the imperative to design services around the needs and wishes of patients (Department of Health, 2000; Coulter, 2002).

Contraception consultations are problematic as they can be viewed as medicalising an area of normal social/sexual behaviour. Previous authors have described such consultations as repeated conflict situations with power resting with the provider rather than the user (Candlin and Lucas, 1986). There is the potential for greater conflict with EC as it is used *after* sexual intercourse (Ziebland, 1999). Requests for EC necessitate a response to a specific and recent sexual encounter at odds with the ordered ethos of family planning services (Hawkes, 1995). The concerns of some of our respondents regarding younger users may reflect their desire to subject younger women to a form of EC access in which they would have to receive a higher level of 'advice' in a manner where they would have inherently less power. In this sense, pharmacy access is suggestive of a more egalitarian encounter between woman and pharmacist. If power rests with the professional who gives out advice regarding contraception and appropriate sexual behaviour, pharmacists are not equivalent to other providers. Most women pharmacy users did not want additional advice from them, nor did they appear to receive it. Reinforcing the work of Hassell *et al.* (2000), women as purchasers and consumers, in contrast to women as patients, would reinforce this conception of women having greater power and autonomy in the pharmacy compared with other venues of EC access. It may be that the thought of younger users having such power was, for some respondents, an alarming prospect. Equality may foster more communicative interaction in some encounters but the environment of the pharmacy, as a commercial space, may mitigate against it.

Allowing EC to be sold over-the-counter has not resulted in an increase in use, nor has the characteristics of those using it changed (Marston *et al.*, 2005). Since deregulation, more women have bought EC over-the-counter in preference to other venues such as GPs or Family Planning Clinics. Concerns about EC by health professionals, echoed by our women users, regarding abuse of EC by younger women, have been shown to be

Practice points

- Policy initiatives to emphasize the role of the pharmacist in medicines advice may sit uncomfortably with people's perceptions of a pharmacy as a place of business
- For sensitive areas such as sexual health, women may seek out the anonymous, business-like environment of a pharmacy to access EC
- Women may value pharmacy access because, in a business setting, they have more control over the consultation
- Women perceived WiCs as a more personal, intimate environment particularly appropriate if they need advice

unfounded. Over-the-counter EC has not led to a decline in the use of more reliable methods of contraception (Marston *et al.*, 2005). Women want more choice and, to date, have exercised that choice with many accessing it through pharmacies. Pharmacy provision of EC clearly meets the needs of some women. Whether changing the nature of that provision to a more personal and less business-like consultation will be what women users want remains to be seen.

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