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Original article

## “I’ll See What I Can Do”: What Adolescents Experience When Requesting Emergency Contraception

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### ABSTRACT

**Purpose:** To understand the experiences of adolescent females when they try to obtain emergency contraception (EC) from pharmacies.

**Methods:** Female callers, posing as 17-year-old adolescents, used standardized scripts to telephone 943 pharmacies in five United States cities. Two investigators independently coded qualitative data from these calls. Codes were discussed and a thematic analysis was conducted. Investigator, expert, and informant triangulation were used to ensure data credibility.

**Results:** Four major themes emerged. First, ethical terms (personal or religious) were used to explain institutional pharmacy policies on EC availability. Second, there was confusion about the dispensing regulations regarding EC, given recent changes in United States policies. Third, pharmacy staff often introduced false barriers to EC access. In some cases, pharmacy staff used these barriers as justification for refusing to dispense EC; however, in other cases, pharmacy staff helped the adolescents overcome these false barriers. Finally, the degree of confidentiality in providing EC was unpredictable, with some pharmacies guaranteeing strict confidentiality and others explicitly telling adolescents, incorrectly, that their parents had to be informed.

**Conclusions:** Adolescents requesting EC from pharmacies are often explained pharmacy policies in ethics-laden terms, and confidentiality is not always guaranteed. They are told of false barriers to EC access, and there is confusion concerning the evolving policies regarding EC dispensing. It is important for clinicians, pharmacy staff and others to be aware of these experiences as they work to help improve adolescents’ access to EC.

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### IMPLICATIONS AND CONTRIBUTION

Emergency contraception (EC) is a safe and effective method to prevent pregnancy after unprotected intercourse; recent regulatory changes have aimed to increase access. Adolescents requesting information about EC encounter a range of responses from pharmacy staff. Understanding these experiences can help augment the types of accurate information adolescents receive regarding EC.

The United States (US) has the highest teen birth rate in the industrialized world, at 70 per 1,000 adolescents aged 15–19 years [1,2]. Approximately 80% of teen pregnancies are unintended, and

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result from either a lack of use of contraceptives or contraceptive failure [3]. A form of EC, also called Plan B or the morning after pill, is the only contraceptive method available over the counter designed to prevent pregnancy after intercourse [4]. Emergency contraception, specifically levonorgestrel, can reduce the risk of pregnancy by up to 74% when taken after unprotected intercourse [5]. Its efficacy decreases with time and is most effective when used in the first 24 hours after coitus; however, it has been shown to be effective up to 120 hours after unprotected intercourse [6–8].

Previous research, including our own, has demonstrated a myriad of barriers to EC access. Physician and pharmacist knowledge regarding EC, the type of community where a pharmacy is located, and adolescents' knowledge and understanding of EC each have been shown to affect access [9–17]. Although the Obama administration and the Department of Health and Human Services appear to favor an age threshold to access EC without a prescription, federal judges—following the lead of most medical professional societies [4,18–20]—have found such thresholds arbitrary and without medical or legal basis [21–23]. In June 2013, the Justice Department dropped its appeal and allowed the Food and Drug Administration (FDA) to move forward with making the name-brand form of EC available over-the-counter without age restrictions or identification requirements. These latest regulatory and legal actions have led to multiple changes to rules regarding EC dispensing, and although there are multiple EC brands currently on the market that contain the same hormone, they each have different dispensing regulations.

In the context of the potential confusion generated by these rapidly changing regulations, it is important to understand what adolescents experience when they interact with pharmacy staff to try to obtain EC. Understanding such experiences will allow clinicians and other reproductive health advocates to empower adolescents and ultimately improve EC access.

Using mystery callers posing as female adolescents, we conducted scripted, semi-structured phone calls to obtain information about EC. We systematically collected qualitative data on how pharmacy staff addressed the adolescents' concerns and responded to their questions about EC access without a prescription. We paid particular attention to patterns of truths and untruths regarding access, missed or seized opportunities for pharmacy staff to assist the adolescents, and the terms that pharmacy staff used to convey institutional policies on dispensing the medication.

## Methods

### Design

From September to December 2010, two female research assistants posing as 17-year-old adolescents phoned every commercial pharmacy in five major US cities. Callers were randomly assigned to pharmacies, and they followed standardized, semi-structured scripts (Figure 1) to elicit specific information on EC availability and access. These scripts were designed to collect both quantitative and qualitative data; quantitative results have been published elsewhere [16,17]. The Boston University Medical Center Institutional Review Board deemed this study to be non-human subject research.

### Sample

Our sampling frame was composed of every commercial pharmacy geographically located in the counties of Nashville, Tennessee; Philadelphia, Pennsylvania; Cleveland, Ohio; Austin, Texas; and Portland, Oregon. States without individual state pharmacy access laws that supersede federal regulation were selected. Lists of pharmacies were obtained from state boards of pharmacy; noncommercial pharmacies were excluded from the sample.

### Callers

Female research assistants posed as 17-year-olds who had recently had unprotected intercourse. The callers' age was chosen to be 17 to reflect the FDA dispensing regulations for over-the-counter access to EC at the time the calls were made in 2010. This dispensing rule was the result of a federal court case in 2009 that lowered the age for behind-the-counter access from 18 to 17 years. However, identification was still required to document consumers' age at the time of purchase. Cellular telephones programmed with local area codes were used. All calls were made on weekdays between 9 A.M. and 5 P.M. local time, when pharmacies were most likely to be fully staffed.

### Data collection and call scripts

Semi-structured interview scripts were piloted through an iterative process with pharmacies in states not included in the sample. Each call was divided into four successive steps. Probe questions introduced each step with the intent to initiate realistic dialog (Figure 1). In Step 1, callers inquired about same-day availability of EC. When EC was available, callers queried whether they specifically could obtain it given their age (Step 2). If the caller was told she could obtain EC, she asked about the age threshold for access without a prescription (Step 3). The final question (Step 4) inquired about parental notification and privacy.

Callers were trained to probe with more specific queries as needed until each question was answered or until the call ended. Callers recorded all data in standardized abstraction forms, and any utterance that did not fit into a quantitative field was transcribed verbatim as qualitative data. Callers were trained to ask pharmacy staff to repeat themselves if they were not sure about the exact phrasing of each response.

### Data analysis

The semi-structured call scripts allowed investigators to explore underlying themes regarding access to EC. To analyze the narrative data, investigators independently reviewed each transcript and created a list of tentative codes to characterize the content of each phone call. Throughout this process, the primary coders (T.W. and G.V.) met on a weekly basis to discuss their findings, consolidate their codes, and split codes that described heterogeneous phenomena. Disagreements were resolved through discussion with a third investigator (M.S.). The transcripts were then re-reviewed, and the final codes were applied independently to the transcripts. Finally, the transcripts were sorted by codes using Dedoose software [24], connections across codes were identified, and salient themes were extracted.

### Data credibility

To ensure data credibility, we used the following techniques: (1) investigator triangulation, in which the data were independently analyzed by two investigators and consensus was obtained at each step in the analysis; (2) expert triangulation, in which investigators convened multiple meetings in which the

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