

Young women's accounts of factors influencing their use and non-use of emergency contraception: in-depth interview study

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Abstract

Objectives To explore young women's accounts of their use and non-use of emergency contraception.

Design Qualitative study using in-depth interviews.

Participants 30 women aged 16-25; participants from socially deprived inner city areas were specifically included.

Setting Community, service, and educational settings in the London area.

Results Young women's accounts of their non-use of emergency contraception principally concerned evaluations of the risk conferred by different contraceptive behaviours, their evaluations of themselves in needing emergency contraception, and personal difficulties in asking for emergency contraception.

Conclusions The attitudes and concerns of young women, especially those from disadvantaged backgrounds, may make them less able or willing than others to take advantage of recent increases in access to emergency contraception. Interventions that aim to increase the use of emergency contraception need to address the factors that influence young women's non-use of emergency contraception.

Introduction

Increasing the use of emergency contraception is one means of reducing unwanted and teenage pregnancies.¹ Emergency contraception costs £24.00 (\$38.10, €37.81) and can now be obtained over the counter by those aged 16 and over. Among teenagers in inner city areas, however, there has been low use of free emergency contraception provided by local pharmacies.² We used qualitative methods to allow women to define the issues relevant to their own use or non-use of emergency contraception. We are unaware of any such published work outside university settings.³

Methods

CF interviewed women aged 16-25, recruited from general practices, hostels for homeless people, youth groups, schools, and family planning clinics in the London area. We purposefully sampled young women

and specifically included those living in deprived inner city areas with high pregnancy rates among teenagers.

Each interview lasted about an hour, or until no new themes emerged. We tape recorded and fully transcribed the interviews, then conducted a thematic analysis of the transcripts.

Results

CF interviewed 41 women. We report here the findings from the 30 women who were sexually active. The table gives their personal details. We present the key themes identified by our analysis.

Eight of the women were either pregnant or had children; of these, seven had become pregnant while a teenager. All but three of the women had experienced a problem with contraception at a time when they did not want to be pregnant. Seventeen of the women had used emergency contraception at least once; nine of

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Personal characteristics of women interviewed

Characteristic	No of women (n=30)
Age	
16 or 17	10
18 or 19	6
20 or 21	4
22-25	10
Ethnic group	
Afro-Caribbean	5
White British	20
Black British	2
Other white	3
Place of residence	
Deprived inner city*	11
Mixed inner city†	10
Homeless	3
Suburban‡	6
Educational level	
At school	7
Left school:	
<16 years	3
16 years	3
17 or 18 years	7
College	6
University	4

*Living in wards in top 10% of most deprived wards in England.

†Living in other inner city wards.

‡Living in London area but outside the south circular or north circular roads.

Box 1: Issues of safety and vulnerability**Being extra safe**

I was on the pill as well but we decided to use a condom ... I think it was just an extra just to be extra safe. (Interviewee 3, aged 20, university student, describing her first sexual experience)

And it's better to have two safety barriers than none at all and get pregnant and have a child. (Interviewee 10, aged 17, planned to go on to university, describing her only relationship, started within the past 6 months)

Relaxing contraception use over time

You know I was I'm surprised how sensible I was cos really it scared me, it scared me the thought of having sex and not being protected but as I say after I'd been on the pill for a while (I thought) I'm not going to get pregnant. (Interviewee 15, aged 24)

Personal invulnerability

And I thought oh no I'll never I won't get pregnant I just thought oh nothing will happen to me I really I just didn't think at all that I'd get pregnant. (Interviewee 16, aged 25, talking about her experiences as a teenager)

You are aware that they can happen but they can't happen to you. (Interviewee 28, aged 23, talking about her experiences as a teenager)

Vulnerability to pregnancy

We didn't use a condom and then the next morning woke up in an absolute panic. (Interviewee 11, aged 20)

Interviewer: Was there any time when you haven't used contraception?

Interviewee: Yes yeah (laughs) there has ... We did that once and then the next day I was paranoid and went down with my friend and they gave me emergency contraception. (Interviewee 17, aged 19)

these also reported episodes when they had not used emergency contraception after problems with other forms of contraception.

Safety and vulnerability

Those women who described the strongest desire to avoid pregnancy used contraception and, if necessary, emergency contraception. Such women tended to have strong aspirations for education, careers, travel, or life-style rather than motherhood. Typically they reported that a pregnancy would be a "complete disaster" and contraception use that was anything less than "obsessional" left them feeling highly vulnerable to pregnancy (box 1).

Many women reported a lower sense of vulnerability to pregnancy. Those with the lowest sense of vulnerability thought that the risk of pregnancy was small when they missed or did not use contraception. Some experienced users of contraception said that over time they had come to believe that they were less at risk of pregnancy and consequently their use of contraception had relaxed.

Several women reported a sense of personal invulnerability—pregnancy happened to other people and not to them—either currently or in the past. This was different to not believing that the behaviour was risky. Women who reported that their behaviour wasn't particularly risky or had a sense of personal invulnerability did not use emergency contraception.

Negative evaluations of emergency contraception use and users

The use of contraception and the ability to use services were predominantly reported as illustrations both of the responsible way the women were behaving and of their maturity. In contrast, needing emergency contraception was linked to negative evaluations for many of the women (box 2). It was seen as a personal failing, and the women felt ashamed. A few women dissociated themselves from emergency contraception entirely, reporting that they were not the kind of person who would ever need it.

In contrast some women reported use of emergency contraception in the absence of negative evaluations of either themselves or other users. Such women were older or had gone on to university.

Getting emergency contraception is an overwhelming task

Some women put the risk of pregnancy to the back of their mind. It was easier for these women not to think about the risk of pregnancy, which might not occur,

Box 2: Negative evaluations of emergency contraception use and users**Feeling guilty or ashamed**

I thought it was a really bad thing to say I need a morning after pill. (Interviewee 5, aged 16)

The thing is you do something bad and you come you come here and you discuss and you think to yourself well he or she might think "well why didn't she use it why didn't she use it instead of coming here" or something and it just feels embarrassed ... so I think that's one reason why you don't want to bother coming ... (Interviewee 19, aged 18)

Concerns about what others may think

Interviewee: And to say to the doctor can I have the morning after pill it's embarrassing.

Interviewer: What's embarrassing about it?

Interviewee: Cos I'm still young erm and they might think you're a little slag or something so but but they are all right the doctors ... you feel you're still young you shouldn't be having sex and coming for the morning after cos you might be pregnant. Twenty that's all right cos it doesn't matter everyone knows if you're twenty you must be having sex not when you're fifteen. (Interviewee 25, aged 16)

Dissociating oneself from negative evaluations

I wanted to tell them I've been going out with him for along time and it wasn't just a flippant thing and I did use contraception and they don't really want to know about that well I feel I need to justify it to them. (Interviewee 2, aged 23)

Getting emergency contraception is an overwhelming task

It's sometimes that err you don't really want to know you don't really want to know you just want to block it off. If you come in (to the clinic) it's going to be even more worrying cos you are going to be thinking even more by the time you get off the bus get to the clinic but if you just pretend that it didn't happen then you don't worry that much. (Interviewee 19, aged 18)

It's like when you do a mistake and you know you are doing the wrong thing and I was thinking oh I'll just sort it out later on when it does happen to me but I doubt it will ever happen to me so I'm not going to think about it now. (Interviewee 17, aged 18)

than to endure the stigmatisation over the need for emergency contraception and unplanned pregnancy (see box 2). Women describing this strategy for dealing with risk were teenagers either living in the most deprived areas or homeless.

Knowledge, service barriers, side effects, and moral concerns

Limited knowledge and service barriers were each reported to have contributed to non-use of emergency contraception by two women. Side effects of emergency contraception were reported by more than half of the women. Concerns about the harmful effects of emergency contraception had contributed to a decision not to use emergency contraception in three women. One woman who had used emergency contraception was concerned that it was similar to having an abortion (box 3).

Experiences with healthcare professionals and services

The women reported both positive and negative experiences of interactions with healthcare professionals (box 4). For some of the women a good relationship with a healthcare professional made it easier to get emergency contraception.

Consultations that focused largely on the risks that had been taken made the women feel told off and reluctant to reattend (box 4). Such women resorted to a different service or chose not to use emergency contraception. A few encounters were described in the most negative terms.

Discussion

Young women's accounts of their non-use of emergency contraception mainly concerned evaluations of the risk conferred by different contraceptive

Box 4: Experiences of healthcare professionals and services

Positive experiences

I've been coming here so the receptionists sort of they all know me, they know my family and everything so when I walked in I said I really really really need to see Dr X and er she (name) sort of looked at me and said OK she just gave me the card and let me sit down and ... they're really good out there. (Interviewee 15, aged 24)

And then when I went there I was still nervous but when they actually spoke to me they made me feel relaxed so I was OK ... and as I've got older there is nothing to be embarrassed about. (Interviewee 14, aged 21)

Negative experiences

I did feel like she was really telling me off ... and I think and I think that's what made me in some ways not wanna go back but ... I mean she was making sense but she was ... it was a bit of a sort of erm. It was a bit of a telling off way but it was also sort of concerned way like do you know the risks that you are taking and you know this isn't a form of contraception I just remember that so well this isn't a form of contraception you know. (Interviewee 16, aged 25)

The first time I got it was an absolutely horrendous experience, I think I was about erm twenty and erm I'd just started having sex with my first boyfriend ... it's two days after my twentieth birthday, that when and erm erm I went to this clinic by myself and erm the lady who gave it to me was horrendous, I think, and made me feel like a, you know, a slapper basically. And erm it was just a really awful experience and I had a panic attack after taking the second lot of pills.

Interviewer: Did you, right.

Interviewee: And you know very ashamed right at the beginning the first time you know. And erm this lady made me feel like you know I she just made me feel dirty which was horrible thing for her to do. (Interviewee 2, aged 23)

behaviours, their evaluations of users of emergency contraception and of themselves in needing it, and personal difficulties in asking for emergency contraception. Limited knowledge, problems in gaining access to emergency contraception, and concerns

Box 3: Knowledge, side effects, service barriers, and moral concerns

Knowledge

I didn't know where I was supposed to go and if I was allowed to go to the doctors to get it, because I was young I was like 14. (Interviewee 9, aged 17)

Side effects

But it did make me feel really sick and headaches I was vomiting as well ... weren't nice and I vowed never to take it again but I ended up taking it another two times after that I think it was. (Interviewee 30, aged 23)

Service barriers

Interviewee: Yeah I was here about three hours ... waiting its bad waiting in here ... After that I didn't come down here to get nothing I just left it ... cos I couldn't be bothered to wait and erm it made me feel ill as well so I didn't wanna come back and get that. (Interviewee 25, aged 16)

Moral concerns

I know it's sort of equivalent to having an early abortion really. If you actually had an egg it would. And I never thought about it then but thinking about it now I wouldn't take the morning after pill again I feel it's a bit ... you know it's my responsibility to take precautions and my partner's responsibility to take precautions and it's not the baby's fault. So I think that's just wrong. (Interviewee 16, aged 25)

What is already known on this topic

Limited knowledge of, or poor access to, emergency contraception, and concerns about side effects and moral issues may reduce the use of emergency contraception in women at risk

Young people can be embarrassed about using contraception services

Interventions to increase knowledge of and access to emergency contraception have had limited success among teenagers

What this study adds

Perceptions of low vulnerability to pregnancy, negative self evaluations about the need for such contraception, and concerns about what others think deter young women from using emergency contraception

These women find it difficult to ask for emergency contraception

The attitudes and concerns of young women, especially those from deprived inner city areas, may render them least willing and able to obtain emergency contraception

about side effects also contributed to non-use of emergency contraception.

The importance of perceived vulnerability is pivotal to the adoption of behaviour that is protective to health.⁴ A similar process may be occurring with risks of pregnancy. Some of the women believed that they were invulnerable to pregnancy. Personal invulnerability and the tendency to perceive that others are at greater risk of disease than yourself have been well documented in a range of behaviours.⁵ Many women also felt ashamed about what had happened and about needing emergency contraception.

Personal invulnerability to pregnancy or concerns about what other people think were predominantly reported by the younger women or those reporting their views as teenagers. Younger and more disadvantaged women were also more likely to avoid emergency contraception because of associated anxiety and guilt. These women are less able to afford over the counter emergency contraception. Educational interventions targeted at these vulnerable groups should promote the attitudes and personal skills needed to obtain emergency contraception. In addition, interventions could focus on providing emergency contraception in a way

that avoids young people having to ask for it or that improves their use of other forms of contraception. Consultations with healthcare professionals that focus on the risks of unprotected intercourse can deter women from reattending for emergency contraception.

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β Blockers for glaucoma and excess risk of airways obstruction: population based cohort study

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Topical β blockers are the most commonly prescribed drugs in the United Kingdom for glaucoma.¹ They are known to exacerbate bronchospasm in asthma and chronic obstructive pulmonary disease.² This study examined whether topical β blockers are associated with excess respiratory disease in elderly patients not considered to be at excess risk.

Participants, methods, and results

We used the Mediplus database to identify patients with no previous diagnosis of airways obstruction. We defined exposed patients as patients who had used ophthalmic topical β blockers for the first time in the period 1993-7. Unexposed patients were randomly selected (loosely matched by age and sex to exposed patients). For validation we inspected a random sample of 40 full longitudinal records of exposed and unexposed patients.

We defined patients who had excess respiratory disease in two ways. Definition A patients were patients who in the 12 months after treatment with topical β blockers were given for the first time a drug used for the treatment of reversible airways obstruction (β₂ agonists, inhaled corticosteroids, theophyllines, and inhaled anticholinergics). Definition B patients combined definition A patients with patients who in the 12 months after treatment with topical β blockers had a new Read code for asthma or chronic obstructive pulmonary disease entered on their record.

Exposed patients (n=2645) were slightly older than unexposed patients (n=9094) (68.6 versus 67.5 years). Exposed patients were less likely than unexposed patients to smoke and to use systemic β blockers and were slightly more likely to visit their general practitioner (median six versus five visits). In definition A patients we found an adjusted hazard ratio at 12 months after treatment with topical β blockers of 2.29 (95% confidence interval 1.71 to 3.07)—equivalent to a number needed to harm of 55 patients (table).

Of the 3358 patients (including patients with previous airways obstruction) begun on a topical β blocker during the study period, 148 (4.4%) had used drugs for airways obstruction within the previous year. Airways obstruction had been identified as an active problem (definition B) within the previous year in 316 subjects (9.4%).

Comment

Topical β blockers for glaucoma or ocular hypertension may lead to new airways obstruction requiring treatment in a population not considered to be at excess risk. This finding raises an issue of public health importance because of the large number (approximately 500 000) of elderly patients in the United Kingdom who are treated for glaucoma and ocular hypertension. Topical β blockers have been shown to affect respiratory function in elderly patients with no previous history of airways obstruction, although a