

**INTRODUCING  
EMERGENCY CONTRACEPTIVE PILL  
SERVICES AT FAMILY PLANNING CLINICS  
IN PHILADELPHIA:  
THE ORGANIZATIONAL AND SOCIAL CONTEXT**

**The Pacific Institute for Women's Health**

**REPORT**

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## EXECUTIVE SUMMARY

In 1998 the Pacific Institute for Women's Health conducted a study to examine the responses of the directors, staff and clinicians at eight Philadelphia family planning clinics to two strategic approaches that were designed to increase women's access to emergency contraception pills: 1) the Reproductive Health Technology Project's emergency contraception public media campaign; and 2) the Family Planning Council's (FPC) new policy to offer emergency contraceptive pills (ECPs) in advance to all family planning clients.

*Study Goals* were:

- C to examine changes, if any, in dispensing ECPs during the period in which the public media campaign was occurring;
- C to determine how the media campaign was perceived by staff at the organizations that initiated emergency contraceptive pill (ECP) services;
- C to describe management and program factors involved in effectively integrating this new service into different health care settings;
- C to identify potential challenges and offer recommendations regarding the integration of ECPs into existing family planning services.

*Methods:* Multiple methods were used to collect data about the delivery of ECPs at the clinics. Surveys of staff and face-to-face interviews were conducted with managers, clinicians and other staff prior to the campaign's initiation and 10 months later. Data on the number of ECPs distributed "prophylactically" as well as the number of clients who made emergency visits to the clinics for ECPs were also reviewed. The study clinics included two Planned Parenthood (PPs) affiliates (located in suburban areas); three community health clinics (one in a small city); and three hospital-based centers, two of which were adolescent clinics. The PPs served mostly White clients. Other clinics predominantly served African Americans, with some Latino and Asian clients.

*Major Findings:* The dynamic interaction between the new reproductive health technology (ECPs), key program elements and the broader social context in which ECPs are introduced must be addressed in order to effectively increase access to ECPs by all women. Although clients served by the study clinics were from different racial, ethnic, cultural and class backgrounds, the majority were low income African American women. Thus, a recurrent theme is the effect of racial history/racism on the response of some low income African American women to the introduction of ECPs and media efforts to promote them. Some interviewees suggested that a "collective consciousness," so to speak, of experiences with racism may have resulted in limited requests for the pills by women of color as "emergent" clients and confusion and skepticism among them about the "prophylactic dispensing" of ECPs.

Clearly, the introduction of a new family planning method requires considerable planning with providers and clients as well as prior educational activities with the broader community of health care professionals and the public. Overall, it appears that the FPC's policy to implement the advance provision of ECPs to all family planning clients has made them accessible to more women who want to use them. Data seem to indicate an increase over the study period in requests for ECPs and in pills provided. Surveys and interview data suggest that, during the campaign, women's attention was drawn to the hotline. Nonetheless, even after the FPC policy was in effect and the media campaign had taken place, no clinic experienced an overwhelming demand for this new method.

*Media campaign:* Media advertisements including the hotline were seen or heard by most staff, although few interviewees reported that their clients said they saw or heard the campaign. Similarly, the majority of survey respondents reported that none or few of their emergent clients saw or heard about EC in the media campaign. Clients' source of information about ECPs and requests for it were reported by staff to be "through friends" and "word of mouth."

Most apparent is the need to broaden the media campaign and tailor the messages to reach out to specific populations. Several African American clinic managers reported that their African American clients either refused or did not respond to the ECP campaign. They attributed this lack of interest to the mistrust of the medical profession among some African Americans that is based on a history of abuse and racism (e.g., the Tuskegee experiments and the past promotion of Norplant implants as a requirement for welfare). These responses highlight the fact that a truly effective educational/awareness campaign and new product delivery must respond to the centrality of racism and its meaning in the lives of women of color that influence reproductive health decisions.

Some strong criticism was voiced about possible misinterpretations by clients of the media campaign--such as the condom advertisement incorrectly communicating the idea that ECPs protect against HIV because some clients' associate "unprotected sex" with HIV/AIDS.

Adolescents, women with disabilities, and men were found to have special issues that needed to be more effectively addressed by the campaign and by services offered.

Finally, there were major points of disagreement between some managers and staff at different clinics as to whether the ads should state that ECPs were important for women who had been raped. Most of the study clinics reported clients who had experienced forced sex--one reported as many as one-third of their clients had experienced this violence. Some staff believed that the lack of attention to rape in the campaign excluded victims from learning about this opportunity to prevent unwanted pregnancy. Others thought that the association of ECPs with rape in advertisements would stigmatize the pills among other sectors of the population. Survey respondents also reported that they would benefit from training on issues related to involuntary sex.

*Organizational Issues:* Organizational problems raised in the course of interviews included differing

levels of knowledge about ECPs among staff and the resulting training needs; critical management issues such as time management, scheduling and 24-hour, weekend and holiday access; client education and the need for informational materials; and the lack of a dedicated ECP product. Some organizational issues ultimately were less a problem for some clinics than they expected (e.g., scheduling), and others were minimized over time--while several had not been predicted.

Since "emergent" clients are fit into regular schedules, some providers remained concerned about insufficient time to properly counsel them about STD/HIV tests, to communicate the importance of an annual pap smear, and to instruct them in the use of contraceptives. Staff were also unable to follow-up with "emergent" clients, as a result of time constraints.

*Staff Training:* Insufficient training prior to the introduction of ECP appears to have been responsible for much staff resistance. Some believed that the directive to dispense ECPs "prophylactically" to all clients was sending them a negative behavioral message -- that clients were not trustworthy to protect themselves from unwanted pregnancy.

*Attitudes and Beliefs of Clinic Staff:* Clinic response to the introduction of ECPs was partly shaped by the beliefs and attitudes of the clinic director/managers and clinicians. These included whether it was safe to use a history rather than lab tests and physical exams to assess contraindications to ECPs; concerns about safety; clinician liability; repeat use; anti-abortion beliefs by staff and clinicians, etc. The FPC's policy was highly controversial for some clinic directors, clinicians and staff at all clinics. Community clinics experiencing the greatest difficulty in implementing the service included those with high staff turn-over that forced them to rely on clinicians, some of whom had little or no knowledge of ECPs or who were not pro-choice and, therefore, would not prescribe ECPs. Most clinics found that medical students and residents who rotated through had not been taught about emergency contraception in their medical programs.

Over time, experience dispensing ECPs and using only a medical history questionnaire to assess eligibility alleviated many clinician and staff concerns. At every site, however, some clinicians continued to order lab tests and perform physical exams for some clients, at their discretion. Moreover, almost all clinics eventually relaxed their procedures to provide ECPs prophylactically to all patients, particularly, to those who were good contraceptive users, teens, and women who simply did not want them.

Numerous recommendations on ways to ease the introduction of ECPs emerge from the experience of these clinics in Philadelphia. They include:

#### *Media*

- # tailor media to specific populations (e.g. use situations and examples that are appropriate to specific populations)
- # understand and be sensitive to particular population's history and experiences with public agencies and their use and trust of the medical system
- # identify who best provides information in a community and how they do so
- # make sure the message is understood by the targeted population (e.g. issue of unprotected sex...does it refer to unplanned pregnancy, HIV/STD or both)

#### *Organizational*

- # anticipate organizational issues and make suggestions for resolution prior to implementing the service
- # provide staff with relevant written materials such as service protocols, informed consent forms, etc.
- # address the need for clinician coverage for weekends and 3 day holidays prior to service implementation
- # be prepared to deal with negative staff attitudes towards ECPs (concerns about safety and "abusive use", viewing ECPs as abortifacients)
- # recognize the potential problems associated with repackaged ECP's (i.e., staff time

required, extensive client instructions, the need for understandable package inserts, etc.)

- # ensure full and continual supplies of pills earmarked for ECP repackages
- # schedule sufficient time for staff to spend with clients for counseling, instruction, and follow up
- # provide appropriate informational materials - in different languages and appropriate literacy levels for all clients
- # establish a mechanism for record keeping and reporting as part of existing system

#### *Training*

- # provide specific training for all categories of staff prior to implementing an ECP service, including front line staff who are often the first to communicate with clients about ECPs
- # provide ACOG regulations and literature from medical journals in advance of training
- # acknowledge and discuss clinicians' and other staff's professional concerns in these trainings
- # have physicians conduct the training of the medical staff
- # address the following topics: issues of rape; how to instruct new contraceptive users; how to restart a client on pills; what information to give women using long acting methods such as Depo-Provera, Norplant, IUDs; how often ECPs can be used (repeat usage); and the appropriateness of ECPs for women who are breast-feeding or who have had different types of cancer
- # train staff to recognize and sensitively respond to the emotional content and urgent nature of a request for emergency contraception
- # train staff to encourage "emergent" clients to return for on-going, comprehensive reproductive health care
- # mobilize the community by offering comprehensive training to medical students, residents in local hospitals, pharmacists, and health care providers at emergency rooms

#### *Research*

- # is needed to elicit the perceptions of diverse groups of women about the media campaign as well as to become well-informed about their experiences, opinions and use of ECPs. Such

information could help inform the development of effective and appropriate advertisements as well as sensitize providers about how to best communicate to clients about new products.

- # on the role of racism in women's assessments of health care services and new products.
- # the use or misuse of language in promoting new reproductive health care technological advances.

## I. BACKGROUND

In 1997, the Reproductive Health Technologies Project (RHTP) conducted a national public media campaign on emergency contraception (EC) in five cities across the country.<sup>1</sup> The campaign included a variety of public service print, radio and television spots informing the public of the existence of emergency contraception and referring them to the *Emergency Contraception Hotline*.<sup>2</sup> This public media campaign has been hailed by both the advertising and the reproductive health communities as the first large-scale private/public sector partnership to promote a single method of contraception. The RHTP has been keeping track of the number of calls made to the *Hotline* before, during, and after the media campaign, and has been able to show significant increases in the volume of calls coinciding with the airing of the various media messages. This suggests that the campaign has been effective in publicizing the availability of emergency contraception.

Very little information, however, is available about how the health care providers and agencies responded to the calls and/or provided the emergency contraceptive pill (ECPs) services. Nor is much known about the social and institutional context of offering, advertising, and providing ECPs to diverse groups of women, in various organizational settings or in response to increased demand. In February 1998, the RHTP expanded this campaign to include one more city, Philadelphia, Pennsylvania. The expansion of the campaign to include Philadelphia provided an opportunity to prospectively examine (a) clinic responses to efforts to improve access to emergency contraceptive pills and (b) anticipated increases in demand for ECPs within the context of the public media campaign.

The Pacific Institute for Women's Health, therefore, undertook, in March of 1998<sup>3</sup>, a study to examine the introduction of emergency contraception services in eight Title X family planning clinics in and around Philadelphia. Specific goals of this study were:

- C. to examine changes, if any, in the provision of emergency contraceptive pills during the period in which the public media campaign was occurring;
- C. to determine how the media campaign was perceived by staff at the clinics that initiated ECP services;
- C. to describe management and program involved in effectively integrating this new service into different health care settings;
- C. to identify potential challenges and offer recommendations regarding the integration of ECPs into existing family planning services.

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<sup>1</sup>The RHTP's media campaign was carried out in Chicago, Los Angeles, Miami, San Diego and Seattle.

<sup>2</sup>The *Hotline*, nationally accessible and free of charge from any telephone, provides a directory of emergency contraception providers in the local area as well as information about emergency contraception.

<sup>3</sup> The study was conducted from February, 1998 through December, 1998.

## II. RATIONALE

The introduction of new contraceptive technology is profoundly influenced by the organizational setting and socio-cultural context in which it takes place. The same is true for emergency contraception services. For many years most women have not had access to post-coital hormonal therapy, which can substantially reduce the need for abortion by preventing an unintended pregnancy. Availability alone, however, will not ensure that emergency contraceptive pills will reach the women who need them. The introduction of a new contraceptive technology must be accomplished in a way that does not compromise the quality of care or the informed choice of clients. Sufficient time and training of clinicians and staff is required to enable providers to sensitively counsel clients about the potential benefits of the new technology and be responsive to their questions and concerns in ways that motivate them to try the product.

Attitudes and norms about contraception are shaped by culture, ethnicity, class, religion, racism and the realities of women's lives, including sexual behavior. It is within this social context that reproductive health policies and programs function.<sup>4</sup> An understanding is, therefore, needed about the relationship between the technology, program capabilities and the broader social context in which they exist, if clinicians and managers are to develop sensitive and population-appropriate reproductive health services that meet client needs.

When new contraceptive methods such as Norplant and Depo Provera were introduced, little attention was paid to the organizational challenges that providers would encounter in integrating these new methods into existing services. Health care providers were not prepared to respond in a timely way to these challenges, resulting in misinformation and patient dissatisfaction with the new methods. To help avoid some of these same problems, the Pacific Institute for Women's Health undertook this study of the introduction of emergency contraception in Philadelphia to document the challenges family planning providers faced in incorporating ECPs into their services. This, in turn, could assist others in making emergency contraception accessible and acceptable, thereby also improving the capacity of health care organizations to provide comprehensive reproductive health care.

### *Family Planning Context*

In February 1998, the Reproductive Health Technologies Project expanded its public media campaign on emergency contraception to include Philadelphia. Between March and August 1998, RHTP placed posters at bus stands throughout this city, ran advertisements in magazines, collaborated with journalists to write articles describing the media campaign and emergency contraceptive pills, aired advertisements on television and radio, and provided printed materials to family planning clinics and clients, such as postcards and flyers. RHTP's Emergency Contraceptive Hotline number was included in all advertisements.

During the summer of 1997, prior to the media campaign, the Family Planning Council<sup>5</sup>, a non-profit organization that serves a network of twenty-four Title X family planning provider agencies in the

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<sup>4</sup> Simmons, R., et al. 1997. "The Strategic Approach to Contraceptive Introduction," in *Studies in Family Planning*. Vol. 28, No. 2. June, pp 79-92.

<sup>5</sup>The Family Planning Council (FPC) has management responsibilities for 24 family planning clinics in Philadelphia. Its primary function is to obtain public monies (e.g., Title X funding) and to act as an intermediary management corporation between the public funding sources and provider agencies. The FPC also develops policies and systems to ensure efficient operation, continuation and expansion of high quality programs and services; develops resources; designs and implements training for programs, staff and organizations; and conducts research.

five-county Philadelphia area, began to require that its agencies dispense emergency contraceptive pills in advance to all clients. (Clinics and FPC staff referred to this policy as “prophylactically dispensing ECPs”). Barring medical contraindications assessed by a medical history, clinic staff were required to counsel all family planning clients about ECPs and to provide them with the pills. While some clinics were slow to implement this policy (with one taking almost a year to offer the services), most began to provide ECPs.

### *Socio-political Context*

The political climate in Philadelphia is pro-choice, although constant vigilance and intervention by advocates is required to maintain that position. For the surrounding suburban, peri-urban and rural communities, this is not the case, with direct bearing on the results of this study. Here, religious fundamentalism and politically conservative forces are stronger, and present obstacles to increasing availability and accessibility of ECPs and other reproductive health care to women.

The economic and social environment plays a role as well. As in urban centers throughout the U.S., Philadelphia’s neighborhoods are stratified according to class, race and ethnicity. Access to resources reflects these differences and accompanying economic disparities. In particular, a history of racial discrimination and abuse has been documented to affect the way in which some African Americans perceive new medical services and outreach attempts by unknown agencies or those thought to be sponsored by governmental institutions.<sup>6</sup>

In the early 1990s, following the introduction of Norplant, rumors circulated throughout the inner-city communities that African-American women, in particular, were being forced to use this contraceptive method.<sup>7</sup> Some believed that this was part of a conspiracy by “the powers that be” to perpetuate black genocide. The beliefs about Norplant were based on newspaper articles and statements of some policy makers at the time about the possibility of requiring the implantation of Norplant as a condition for continuation of mothers’ welfare benefits. This idea was reinforced by an editorial that appeared in the *Philadelphia Inquirer* December 12, 1990, suggesting that mothers on welfare should be offered a monetary incentive to use Norplant.<sup>8</sup> At the time of this study, a newspaper article appeared in the *Philadelphia New Observer*, and a demonstration took place against the University of Pennsylvania to protest the harmful effects of “medical experiments” conducted on inmates of correctional facilities in Philadelphia in the 1950’s-1970’s. Serious health consequences for women were cited, such as hysterectomies and reproductive tract disorders.<sup>9</sup>

Such complex factors are part and parcel of the social context in which ECP services and the media campaign were introduced in Philadelphia during the study period. Philadelphia’s diverse population and the range of reproductive health care provider agencies involved (university health clinics, teen clinics, several Planned Parenthood clinics, community health centers, etc.) made it possible to explore the delivery of ECP services in a range of organizational settings and with various client populations.

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<sup>6</sup> Herek, G.M. and Capitanio, J.P. 1994. Conspiracies, contagion and compassion: trust and public reactions to AIDS. *AIDS Educ. Prev.* Aug; 6 (4): 365-75.

<sup>7</sup> Turner, P. 1994. *I Heard it Through the Grapevine*. Berkeley, University of California Press.

<sup>8</sup> *Philadelphia Inquirer*, December 12, 1990, “Poverty and Norplant,” A18.

<sup>9</sup> *Philadelphia New Observer*, November 11, 1998, 21. “Ex-Prisoners Take Actions Against U of P,” by Henry De Bernardo.

### **III. METHODS**

Qualitative and quantitative methods were used to collect data about the delivery of ECPs at eight health care clinics in Philadelphia. The clinics were chosen because 1) managers and key staff expressed willingness to participate in the study; 2) they were located in different geographical areas and serve a diverse population; 3) they provided variation with respect to clinic type; and 4) they were at different stages of implementing ECP services—ranging from the planning stage to full implementation of ECP provision “prophylactically” and emergency services. By selecting a broad range of types of clinics, the intention was to document the variety of challenges that providers might expect to encounter as they integrate ECPs into their service offerings.

#### **A. Characteristics of Provider Agencies**

The eight family planning clinics in this study are Title X clinics. Each has a contract with the Family Planning Council. Three of the clinics are community health centers, two are Planned Parenthood affiliates (PP), and three are hospital-based ambulatory care clinics, of which two serve teens exclusively.

The Planned Parenthood affiliates are located in the suburbs of Philadelphia. All others are located in or near low income, inner city, minority neighborhoods in Philadelphia—with the exception of one community-based clinic, which is in a smaller city outside of Philadelphia that has suffered substantial economic deterioration over the past 15 years.

All three community health centers offer a full range of health care services to community adults and children, including reproductive health care. The PP affiliates offer reproductive health care, but not on-site abortion services. Among the hospital-based clinics, reproductive health care services are offered to adults at one clinic and to teens under the age of 19 years at the other two.

The two Planned Parenthood affiliates and one of the teen clinics had, prior to the FPC policy, already been providing ECPs upon request to clients for 10 to 15 years. The PP affiliates followed the guidelines and protocols for dispensing ECPs that are provided by the Planned Parenthood Federation of America, similar to the FPC requirements and protocol. One of the hospital-based clinics had dispensed ECPs upon request for several years. Prior to the FPC’s requirement, one hospital-based teen clinic and the community health clinics rarely dispensed ECPs.

#### **B. Characteristics of Clients**

All clinics serve clients between 12 and 48 years of age. The two Planned Parenthood affiliates serve suburban and rural women, mostly White and middle class, although they also had some low income women as clients. Clients attending all three community health clinics resided in low income and physically deteriorated neighborhoods and are predominantly African Americans (55%, 80% and 90% respectively). Between 10-25% of their clients are Latinos. One community health clinic additionally reported a small population of Vietnamese clients. Another clinic located in a peri-urban area outside of Philadelphia has some Asian and White clients. The client population at the three hospital-based clinics were similar to the community health clinics in being predominantly low income African-American, with

one hospital-based clinic including Asian, African and Latino immigrants from East Asia, West Africa, Somalia, and Mexico.

### **C. Data on Dispensing ECPs**

The Family Planning Council routinely collects data on dispensing of contraceptives. They had agreed to provided data, at several points in time, on the number of ECPs distributed “prophylactically” as well as the number of clients who made emergency visits to the clinics for ECPs (referred to as “emergent” clients by the clinics and FPC). These data would allow for an examination of changes, if any, in demand for ECPs.

### **D. Surveys**

Two surveys of clinic staff were conducted. The population of interest for the surveys was clinic staff involved with the provision of ECPs including, but not limited to, the managers of key staff. These staff were identified by the clinic administrators. For both surveys, self-administered questionnaires were distributed to the clinic administrators who gave them to the appropriate staff. To facilitate confidentiality, self-addressed envelopes were attached so that questionnaires could be returned directly to the research team. Both surveys were anonymous.

The first survey was conducted in February 1998 at which time 50 questionnaires were distributed. The questionnaire items assessed staff familiarity with ECPs, sources for learning about ECPs, ease of and support for introducing ECPs at their clinic, clinical protocols, response from other professionals and the community regarding their providing ECPs, training needs, attitudes and knowledge about ECPs and barriers to providing ECPs in southeastern Pennsylvania. Forty-eight staff members responded, yielding a response rate of 96%. The majority of respondents were women (95%). Half (50%) were White, 35% were African American/Black, 8% were Asian/Pacific Islander, and 8% were Hispanic/Latino. Fifty-two percent were in a nursing occupation, 23% were social workers or counselors, 10% were physicians, and the remainder held other positions.

The second survey was conducted 10 months later to understand staff awareness and perceptions of the media campaign. Forty-eight questionnaires were distributed. The questionnaire items assessed staff perceptions of the campaign’s effectiveness in increasing awareness of emergency contraception and the RHTP Hotline; whether staff had seen or heard the media advertisements; the extent to which clients reported having seen, heard, or learned about emergency contraception from various media; the extent to which clients reported having been referred by the RHTP Hotline; staff perceptions of the media campaign; and related topics. Thirty-four staff responded, yielding a response rate of 71%. Most respondents were women (94%). Over half (57%) were White, 27% were African American/Black, and 7% were Hispanic/Latino; the remainder were Asian/Pacific Islander or of mixed race/ethnicity. Many respondents (44%) were in nursing occupations, 25% were social workers/counselors, 16% were medical assistants, 6% were physicians, and the remainder held other positions.

Survey data were analyzed using SPSS. Frequency distributions and/or means for all variables were generated. Not all respondents answered all questionnaire items. Only those respondents who answered the items were included in calculations of percentages and means. The number of respondents who answered individual items are indicated in the tables.

### **E. Interviews**

In-depth semi-structured, open-ended, face-to-face interviews were conducted with clinic administrators and key staff responsible for ECP services. Interviews took place in February, at the outset of the study, which was just prior to the inauguration of the RHTP media campaign and, again, in late November, 10 months later.

Interviewees included clinician and non-clinician managers or clinic directors, nurse practitioners and counselors. Sixteen and twenty people were interviewed in the initial and second round, respectively.

The initial interviews were directed towards collecting information about the range of reproductive services provided, existing requirements for the provision of ECPs, staff training, clinical protocols, client education materials, recent changes in request for and provision of emergency contraception, staffing patterns, management and operational issues relating to the initiation of the new service, provider and staff attitudes about (and acceptance of) ECPs, as well as anticipated concerns and outcomes related to the media campaign.

The second set of interviews was conducted shortly after the media campaign ended. Questions were asked about changes in services and requests for ECPs, perceptions of the media campaign, changes in staff attitudes and service provision, number of clients referred by the RHTP Hotline, recommendations for improvement of the campaign and ways to assist other provider agencies in initiating ECP services.

## **F. Limitations of the Study**

The media campaign was conducted during the same period as the FPC policy was being implemented at clinics throughout the Philadelphia area. Because these two initiatives were intertwined, it was not possible to assess the effects of each separately. In addition, the FPC also included information about ECPs on its established hotline called CHOICE. This CHOICE hotline is *not* the same as the 1-888-Not-2-Late hotline operated by the RHTP. This means that beginning in March of 1998, when the RHTP launched its media campaign in Philadelphia, referring people to its hotline, the community had access to two ECP hotline, thus making difficult to know where women were getting their information. Finally, the media discussion about *Preven*, a new dedicated ECP product, began in the period between the initial and follow up interviews. Some providers mentioned that they or their relatives had seen the media coverage, thus possibly influencing providers' perceptions of ECPs and the media campaign.

The reliance on data collected exclusively from the providers, managers and other staff of clinics is a major limitation of the study. No data were collected from women about their experiences, perceptions, or use of ECPs. Funding constraints and limits on time prevented interviewing women in general, or women clients who obtained ECP services from the eight study clinics, specifically. Given what are often differences in class, race and ethnicity between providers and clients, it is likely that their perspectives will diverge. Future studies that include clients' perceptions and experiences will contribute to a more complete understanding of the issues involved in the promotion, delivery, and use of ECPs.

## **IV. FINDINGS**

### **A. Media Campaign and Hotline**

#### ***1. Dispensing of ECP's***

Change in client requests for ECP services as a result of the media campaign was to have been examined using the service statistics reported to the Family Planning Council by the individual clinics. Tracking of ECP dispensing, however, proved difficult. The Planned Parenthood affiliates had their own data collection system; and the other clinics had another. Many clinics had problems recording the number of ECPs dispensed. As a result, most of the clinic managers and staff who were interviewed questioned the accuracy of the data reported to the FPC. Almost all believed that the number of clients to whom ECPs were dispensed is greater than that indicated by the FPC data.

Staff could not determine the number of clients who had been referred from the RHTP’s Hotline. This was, in part, because the clients were not asked who had referred them, and also because two hotlines were in operation during the period of the study. The FPC had added information about ECPs to its established hotline, CHOICE, prior to the beginning of this study which meant that two hotlines were accessible to women during the period of study. Two of the eight managers who were interviewed stated that most of their referrals came from the CHOICE Hotline. For these reasons, the information about the number of ECPs dispensed reported below must be viewed with caution.

Table 1. Dispensing of ECPs (data provided by FPC)				
	Planned Parenthood Affiliates (n=2)	Hospital-Based Clinics (n=3)	Community Health Clinics (n=3)	Total (n=8)
December 1997 “Emergent” Requests	19	5	2	26
“Prophylactic”	27	158	69	254
August 1998 “Emergent” Requests	67	20	10	97
“Prophylactic”	61	183	57	301

It is noteworthy that interviewees, with the exception of the Planned Parenthood affiliates, initially did *not* anticipate large numbers of “emergent” clients calling to request ECPs as a result of the media campaign. Nevertheless, the data show that in December 1997 the 8 clinics in total dispensed ECPs 26 times to women who requested it and did so 97 times in August 1998. This coincides with the media campaign and the more complete integration of the service into routine care.

The data in Table 1 also show that fewer ECPs were “prophylactically” dispensed at the community clinics in August of 1998 than in December of 1997. One community clinic manager offered the following explanation about the decline in dispensing ECPs at community clinics: according to her there are a finite number of regular clients who attend some community clinics and by August of 1998 most of them probably had been provided with ECPs “prophylactically.” Therefore, fewer ECPs would be dispensed over time.

One of the community health clinics had introduced ECPs into its reproductive health care services in the summer of 1998. The clinic manager, when re-interviewed in November 1998, stated that they had been receiving two to three calls per week from women requesting ECPs, which was not reflected in FPC statistics (above). Staff at another community health clinic reported success in the advance provision of ECPs during the study period, which they thought may not have been recorded properly.

## 2. Staff Exposure and Response to the Media Campaign

It is important to assess staff response in light of the fact that initially, almost all clinics, in response to the FPC policy, were actively, and in some cases grudgingly, already dispensing ECPs “prophylactically” to all family planning clients -- and could be expected to have a heightened consciousness to ECPs in the media. Furthermore, clinic staff and providers in this study were mostly White and middle class, while their clients were of diverse cultural, racial/ethnic and class backgrounds. These factors make it difficult

to extrapolate from the response of staff to that of their clients and need to be considered in the interpretation of study findings.

Survey questions assessed staff exposure to the media campaign. Most clinic staff had seen or heard the public service announcements (PSAs) and/or advertisements about emergency contraception and the RHTP hotline, during the prior nine months: 70% had seen PSAs or ads in a magazine, 63% read a newspaper article about emergency contraception, 62% had seen PSAs or ads on television, 55% heard PSAs or ads on the radio, and 47% had seen PSAs or ads on a poster at a bus stand. The majority (73%) remembered seeing or hearing PSAs or ads with the Hotline number. Whereas most survey respondents reported having seen PSAs or ads with the picture of a broken condom (63%) and with the picture of the dangling telephone (54%), only a third (33%) reported having heard the “Oh-Oh” PSA and only 13% had seen the PSA that featured the Tsunami wave.

Interviews with staff also yielded responses that indicated they had seen or heard the ads. At the same time, criticisms of and problems with the media campaign and its appropriateness for their clients emerged during the interviews. A few interviewees commented on the need to see the message several times before realizing that one should write down the Hotline number. They pointedly stated that the ads need to be shown more frequently and have “the message repeated so that it would sink in.” One physician manager who had seen the ads in Philadelphia and Seattle explained,

*“People can’t understand the condom ad... the print is so little you can barely read it.”*  
*“... If you’re not involved in the issue, you wouldn’t know what it was about.”*  
*“... You wouldn’t know the condom was broken unless you looked at it very carefully and the writing is small. The message is confusing; it should show a phone number in relation to HIV and STDs as well.”*

### 3. Staff Reports of Client Exposure to the Media Campaign

Survey respondents and interviewees were asked whether *their clients* reported having seen or heard about emergency contraception through the media campaign. Since no clinic had systematically asked its clients about the referral source, the reporting on the part of the providers was speculative. None of the clinic directors/managers who were interviewed reported that their clients had spoken of the ads. The most frequently given source of information they cited regarding how their clients came to know about ECPs and request it from the clinic was “through friends” and “word of mouth.” Similarly, the majority of survey respondents indicated that during the prior nine months, none or few of the women requesting ECPs (“emergent” clients) reported having seen or heard about emergency contraception in the media.

During prior nine months, number of women requesting ECPs who mentioned having seen, heard, or learned about emergency contraception:	PERCENT				
	None	A few	Some	Most	All
On the radio (n=27)	40.7	29.6	22.2	3.7	3.7
On a poster at a bus stand (n=27)	44.4	14.8	33.3	7.4	0.0
In a magazine (n=28)	39.3	32.1	25.0	3.6	0.0
On television (n=26)	34.6	30.8	26.9	7.7	0.0
In a newspaper article (n=28)	53.6	28.6	14.3	3.6	0.0

Interviewees and survey respondents were asked, “ How many of the new emergency contraception clients that you, personally, have seen or talked to said they were referred to your clinic by the emergency contraception hotline (1-888-NOT-2-LATE)?” Most survey respondents (56%) reported that none or a few of their clients said they were referred by the hotline, 31% reported that some, and 9% reported that most, and 3% reported that all of their clients were referred by the hotline. Although some staff and managers who were interviewed did discuss the importance of the RHTP Hotline as a source of referrals, two managers said that most referrals came from the CHOICE Hotline.

#### **4. Perceived Awareness of the Media Campaign**

The majority (85%) of the survey respondents agreed with the statement that the media campaign increased awareness about the availability of emergency contraception in Philadelphia; 6% disagreed; and 9% did not know if it increased awareness.

Survey respondents were also asked to report changes in client demand for emergency contraception during the period of the media campaign. As shown in Table 3, the majority indicated that, as a result of the media campaign, they had experienced increases in requests for information about and in client demand for emergency contraception. Some interviewees mentioned that the number of “emergent” clients requesting ECPs increased in July and August 1998 immediately following the airing of the advertisements.

	PERCENT			
	No increase	A slight increase	Moderate increase	A large increase
<b>The number of:</b>				
<b>Women who ask for information about emergency contraception (n=33)</b>	6.1	39.4	45.5	9.1
<b>Existing clients who ask for emergency contraception (n=32)</b>	6.3	34.4	46.9	12.5
<b>New emergency contraception clients (n=32)</b>	3.1	37.5	46.9	12.5
<b>Women who ask to be given emergency contraception in advance (n=31)</b>	32.3	29.0	22.6	16.1
<b>Women who say they have had a contraceptive failure (e.g., the condom broke) (n=32)</b>	25.0	25.0	37.5	12.5
<b>Women who say they have been raped or have had involuntary sex (n=31)</b>	77.4	12.9	9.7	0.0
<b>Men who ask about emergency contraception (n=33)</b>	66.7	21.2	6.1	6.1

When asked whether they agreed or disagreed that the media campaign was appropriate for their client population, over three-quarters (79%) of the survey respondents agreed; 15% disagreed; and 6% did not know. Similarly, the majority (79%) agreed that the messages presented by the media campaign were easily understood by their clients; 12% disagreed; and 9% did not know. Twelve percent agreed with the statement that the PSAs or ads were confusing to their clients; 73% disagreed with the statement; and 15% indicated that they did not know.

It is important to remember that these data are perceptions of staff and not necessarily that of the clients. Although public awareness about ECPs may have increased through the media campaign, this does not mean that clients sought and obtained the service based on an awareness of the technology alone. As discussed below, other factors enter into women’s decisions to seek and use new technologies.

Opinions of *both* survey respondents and interviewees included the likelihood that messages would reach more women, if placed in locales and on radio and TV programs that are popular with their clients and that followed a story-telling format. Survey respondents provided the following recommendations for improving the campaign and more effectively informing their client population about emergency contraception:

*“Postcards are a great idea, but the graphics and tiny writing were confusing.*

*New postcards/better-clearer message/distributed widely would be good!”*

*“Make messages a little less subtle, more factual.”*

*“More TV time (e.g., during soaps, sitcoms).”*

*“Present information in a story format. Our clients’ comprehension improves when information is presented in this way.”*

## **5. The Message**

Some criticisms of the media campaign were technical in nature, such as the small size of print and lack of clarity in the picture of the condom. Other interviewees pointed to problems arising from the different associations and meanings that language and symbols take on over time and for different populations. The way that language and symbols are used and understood in the context of a constantly shifting universe of meanings is complex. Several of the staff interviewed mentioned the condom ad as communicating an unclear message, particularly as it relates to HIV/AIDS. According to interviewees, the phrase “unprotected sex” once referred to the resulting pregnancy that might occur in the absence of contraception. Increasingly, clients associate the phrase “unprotected” with HIV or with the possibility of HIV and STDs rather than pregnancy. Similarly, some felt that a condom is now associated with prevention of HIV, rather than pregnancy. The possibility for confusion through mistaken association was expressed in the extreme by one interviewee who felt that the ad could communicate the (wrong) idea that “if you don’t use a condom, you won’t get HIV, because ECPs might prevent HIV.”

In the survey, 42% stated that clients associate the picture of a broken condom with unplanned pregnancy and STD/HIV infection; and 13% reported that clients associated it with STD/HIV infection only. Forty-five percent of the respondents reported that their clients associate the picture of a broken condom with unplanned pregnancy. Again, in the absence of data collected directly from the clients, it is important to keep in mind that staff perception may be very different from that of their clients.

The opinions elicited regarding the clarity and appropriateness of the media messages from survey respondents and interviewees suggest that perceptions and understandings are deeply rooted in complex social and historical experience. To better understand why some data lead one to believe the media messages increased awareness about ECPs, and, at the same time, pointed to some very real problems with these messages, it is helpful to look at the issue of appropriateness more closely.

## **B. Appropriateness of the Media Campaign for Diverse Populations and Implications for Services**

Interviews with staff and managers revealed that life experiences may result in different responses to emergency contraception and methods of promotion.

### **1. Low-Income African-American Women**

While women from many different communities were served by the clinics included in this study, low-income African-American women were the primary consumers (see description of characteristics of

clients in background section.) Widespread reluctance on the part of these clients to accept ECPs “prophylactically” was reported by staff and the manager at one clinic. Another clinic reported that their mostly low-income African-American clients were suspicious of the RHTP Hotline and, indeed, hotlines in general. Clients were skeptical as to who established and operated the Hotline as well as the credibility of the information provided. These two clinics represent different levels of staff and provider support for the FPC’s policy. One clinic was extremely supportive and promoted ECPs as a useful option for their clients, while the other, initially very critical of the policy, felt pressured to implement the service. These cases brought to the fore a number of concerns that centrally affect the accessibility and acceptability of ECPs by some low-income African-American clients. One of these is wariness on the part of some African-Americans about the medical system and medical technology.

As described above (see background section), the timing of the media campaign coincided with a newspaper article regarding medical experimentation in local prisons and a protest demonstration that recently took place in Philadelphia. Mentioned by two African-American administrators, the news article identified army contracts given to major pharmaceutical companies (Dow Chemical, Johnson & Johnson and Dupont) that, together with the University of Pennsylvania, conducted research on inmates. The article and demonstration highlighted the particularly deleterious effects of the medical treatments and experiments on women<sup>10</sup>.

These administrators suggested that some clients view the Tuskegee experiment, the promotion of Norplant implants, and the recently publicized University of Pennsylvania incident as evidence of conspiracy to commit genocide. They believed that these views and the suspicion of the “government” could result in a hesitancy to use the RHTP Hotline and reluctance to accept ECPs. Another clinic manager reported that a number of her clients believe the U.S. government to be responsible for the HIV/AIDS epidemic among low-income African-Americans. Some of her clients are refusing to take combination anti-retro viral treatments, believing that they are toxic and will hasten their death.

Different priorities and values may also influence the perception of and attitudes towards ECPs among diverse populations. A clinic director and her staff offered the following reason that might affect the acceptability of ECPs among their mostly low income African American clients: that pregnancy for some young and/or unmarried girls and women is not always considered a problem. As the director explained, “this is a pro-child culture” where generations of mothers and grandmothers have had children at a young age.

Staff and managers suggested ways to make the campaign more effective among this population. They pointed out that clients are more likely to listen to people they know. “They learn from their friends, their family--sisters, mothers, daughters,” said one staff member. According to staff, clients need to know who is behind the message and that information would be more effectively conveyed with stories that “people can relate to.”

## **2. *Victims of Rape***

Interview data pointed to rape as a particularly important issue for clients attending some reproductive health care clinics. One third of the clients at one community clinic serving mostly low income African American women were estimated to have experienced forced sex. Rape, however, was raised as an issue by some interviewees at clinics serving women from diverse ethnic and racial groups and of different ages. As shown earlier (see Table 3) almost a quarter of the clinic staff who responded to the second survey reported an increase in the number of women who say they have been raped or have had

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<sup>10</sup> *Philadelphia New Observer*, November 11, 1998, 21. “Ex-Prisoners Take Actions Against U of P,” by Henry De Bernardo.

involuntary sex. The director of a clinic serving a White, middle class population reported that she felt as if there was an increase in women mentioning forced sex since the media campaign began. “Some say they had unprotected sex, but when they come in for pills, they say it was forced.” The issue of rape may be an example of how language may obscure rather than communicate. Interviewees reported that many clients do not consider rape to be sex. For women who have experienced forced sexual encounters, the phrase “unprotected sex” (as used in the media campaign) would not be perceived as relevant to their situation.

The question of whether the media campaign should draw attention to this issue met with sharply divergent opinions. Some of the managers and staff interviewed thought that the association of ECPs with rape would stigmatize ECPs among other sectors of the population. What is clear, is that if the language of “unprotected sex” is not perceived or understood by the rape victim to apply to her, then very different language is required to communicate effectively to this segment of the population. And, a media campaign targeted *specifically* towards rape victims would need to be designed differently.

A widespread perceived need for training about sexual violence towards women is borne out by the survey data. Fifty-four percent of the staff who responded to the first survey reported that they would benefit a great deal from training on issues related to involuntary sex; 3% indicated they would gain some benefit and 4% would benefit a little. During the second round of interviews in November some staff and managers still requested such training. Interviewees at the hospital-based clinics, however, reported already having sufficient expertise and training on the subject, stating that they worked closely with the rape crisis centers.

There was concern on the part of some interviewees about encouraging women who are raped to obtain ECPs from family planning clinics. As stated by one administrator, rape victims must have access to trained professionals (most often located in emergency rooms), who can properly collect evidence (trained in the use of rape kits, etc.), can file reports should the woman decide to take legal action, as well as make appropriate referrals to an array victims’ services, including follow-up counseling and safety plans. Other interviewees, however, felt strongly that clients would not go to or be able to obtain ECPs from emergency rooms. As rape is often perpetrated by relatives, friends and acquaintances, there is frequent reluctance to go to an emergency room out of fear of having to officially report the incident. As one interviewee pointed out, if family planning clinics do not advertise ECPs as helpful for victims of rape, it “means an important chance is missed to make a difference in these people’s lives.”

### **3. Teens**

Issues of appropriateness also arose with regard to services for teens. Interviewees initially had considerable concern that teens would be more likely to “abuse” the pills and use them as regular contraceptives. In the first survey, 16% of the respondents indicated that they do not feel comfortable giving out ECPs to teenagers. By the second interview round, researchers were told that staff’s initial fear that teens would abuse ECPs proved to be unwarranted.

One clinic manager reported that their satellite adolescent health center initially refused to implement the FPC’s policy believing their clients would use ECPs indiscriminately or as regular contraception. They may have also feared parental reproach. Respondents at the main clinic said that despite the high teen pregnancy rate, there was a strong cultural belief against talking about sex, particularly with teens, in that part of the state. Initially, the satellite clinic threatened to discontinue family planning services, if they were forced to provide ECPs. They would simply refer their clients to the larger community based health clinic for these services. By the time of the second round of interviews in November, the teen clinic had decided to comply with the policy (although few ECPs were reported as being provided.)

According to the administrators of the teen clinics many clients are not sexually active, or only very sporadically, and the staff did not feel it was appropriate to provide everyone ECPs in advance. Clients who are offered ECPs tend to be older, 18-19 years of age. As the social worker and nurse practitioner at one hospital teen clinic explained, the way in which the subject is broached must take into account the developmental stage of the individual. For this, professionals are needed who specialize in adolescent development. "It requires a flexible and creative approach. They [teens] have a distinct language in which we speak with them," and "we talk with them about a wide range of things, usually not giving them ECPs right away when they come in." Teens who refuse ECPs are usually those who are not sexually active. Sex, as pointed out by an interviewee, tends to be a more sensitive issue among teens. Often they do not want the family to know about their visit and, consequently, do not want to take anything home -- requiring that other arrangements be made: "they take risks ... it's very hard for them to be consistent with a method. Especially for teens who have sex sporadically, like every four months or so, ... ECPs are wonderful." Most interviewees agreed that teens seem to know about ECPs, even if they do not ask for it. Some of the high schools have discussion groups and information is passed quickly by word of mouth.

#### ***4. Women With Disabilities***

Although information was not systematically or specifically collected on dispensing ECPs to women with disabilities, one clinic director told of providing contraceptive services to people with disabilities (described as "physically and/or mentally disabled"). The clients described live in a group home owned and operated by the Catholic Church. Hormonal contraceptives are allowed by the facility's management (who are nuns) for the purpose of "regulating the menstrual cycle." When the clinic began dispensing ECPs, however, the nun administrators objected. Consequently, the clinic no longer prescribed or dispensed ECPs to residents, even if asked. The clinic director was told that it was the home's institutional policy that clients may not "self-medicate." The case suggests that denial of the rights of women with disabilities to equal access to a full range of reproductive health care services is an issue that should be considered and responded to at both program and policy levels.

#### ***5. Men***

All interviewees mentioned the need to educate and pay special attention to men. A third of survey respondents felt that the number of men who ask about emergency contraception had increased as a result of the campaign (see Table 3). Although all clinics reported that men come and call the clinic about ECPs - in one clinic men constitute 20% of clients - the men most often come in with their female partners. At a clinic where ECPs were described as "not wanted by our clients," one young man came to the clinic on three separate occasions accompanied each time by a different young woman seeking ECPs. When asked why, he said that because he knew of the ECP service, he "tried to help out his friends." Some clinics made particular efforts to tell clients of the importance of having partners involved in decisions about contraception. Information and materials specifically designed for men would, therefore, be of value.

### **C. Organizational and Management Challenges in the Introduction of ECP's**

An important goal of this study was to identify the challenges and possible solutions in the integration of ECPs into existing family planning services. Unless organizational challenges and constraints faced by clinics in the introduction of ECP services are addressed by management, women's access to ECPs will be limited. Organizational problems raised in the course of interviews included: the attitudes of the providers to emergency contraceptives; differing levels of knowledge about ECPs among staff and the

resulting training needs; critical infrastructural issues such as time management and scheduling and accessibility; as well as client education and the need for informational materials.

### *1. Provider Attitudes*

Clinic response to the introduction of ECPs was found, in part, to be shaped by the attitudes of the clinic managers and medical directors and clinical staff. The Planned Parenthood affiliates, two of the three hospital-based clinics and one community clinic were highly supportive of the FPC policy and the streamlined medical protocol. Two community-based clinics and a teen clinic were resistant in varying degrees to the initiative and slow to implement the service. Indication of the strong feelings involved emerged in the some of the interviews. Inadequate information about emergency contraception and lack of knowledge about the ACOG guidelines appear to have played an important role in the resistance shown.

The vast majority of respondents to the first survey agreed that all family planning programs should offer information about ECPs to all women, of any age, as part of their general reproductive health care education: 27% agreed and 67% strongly agreed. About a third (36%) agreed or strongly agreed that ECPs should be available over-the-counter, without a prescription. Even so, interviews with managers and staff at several clinics indicated that the FPC policy was highly controversial for some clinics and for some staff at all clinics.

Not only was the policy initially felt to be imposition on the clinics, it was also considered difficult to carry through in situations where clients are not interested. In some cases, clients were using contraceptives regularly, such as Depo Provera, oral hormonal contraceptives, and condoms and, therefore, refused to accept ECPs when offered prophylactically. In others, women confused ECPs with medical abortion (RU486). Although, for the most part, interviewees said that clients did not understand nor want to know the mode of action of ECPs, all clinics mentioned some clients who refused to accept ECPs because they believed that ECPs could induce an abortion.

At all but the teen, clinics, interviewees reported some difficulty in explaining the need for ECPs to clients who were using contraceptives. The majority (84%) of respondents to the first survey indicated that they would benefit from training on how to talk to patients about emergency contraception. Those interviewed at one community health clinic reported that some clients felt they were “pushing” ECPs on them. Not only did it take a good deal of time to counsel and “convince” them to take the pills, staff at several clinics thought that the directive was sending a negative behavioral message -- that clients were not trustworthy to protect themselves from unwanted pregnancy. A manager of a community health clinic suggested that this policy sends a mixed message to patients who are good contraceptors and they, in turn, become suspicious and reject the ECPs when offered in advance.

As noted earlier, in February of 1998 most clinics were providing ECPs to varying degrees. All respondents to the first survey indicated that they provided ECPs or emergency contraceptive prescriptions after patients have had unprotected sex or have experienced a contraceptive method failure. The vast majority also reported that when their clinic decided to offer ECPs, they were personally supportive (39%) or very supportive (52%) of their clinic’s decision; 9% had been unsupportive.

It appears that most clinics, over time, relaxed the “prophylactic” dispensing of ECPs to all family planning clients. Even at the two Planned Parenthood affiliates that were actively supportive of the new protocol for advance provision, neither actually followed it.

Initially, at the most reluctant clinic, the director and nurse practitioner expressed the feeling that they were under pressure from the FPC to adhere to its policies, and that were it not required, they would not provide ECPs “prophylactically” to all of their clients. As mentioned previously, one of its satellite adolescent clinics was steadfast in its refusal to provide ECPs to all clients, agreeing only in the past few months to comply.<sup>11</sup> Perceived as a challenge to the professional autonomy of the clinic and its satellite, the interviewees said that much more time was needed to discuss the new policy with their own medical personnel.

By the second round of interviews, although critical infrastructure problems remained in the implementation of ECPs at clinics (see Section 3 below), professional autonomy of clinicians and problems with the policy were reported to have dispelled over time. Staff and clinicians had become more comfortable with the clinical protocols and adapted to service specific changes. Most clinics reported that initial provider scepticism and opposition was largely giving way as they became more knowledgeable about ECPs, even as individual differences remained at each clinic in the extent of enthusiasm about these services. One clinic manager reported that those who were somewhat reluctant in the beginning have “come around” because she communicated a “sense of urgency” to the staff.

The attitudes of physicians and other staff also played a central role in acceptance of the policy, the greatest resistance initially coming from the medical director and other clinicians. Initial concerns included the perception among some staff that ECPs are an abortifacient; concerns about the safety of ECPs and that ECPs might be used routinely as contraceptives, especially by adolescents thereby posing health risks; and concerns about the need to also provide services for STD prevention.

*Provider attitudes regarding abortion* - Staff and clinician’s religious and cultural attitudes appeared to affect the introduction of ECPs. In a suburban area with conservative attitudes towards abortion and contraception, several high school health clinics rejected an offer by a clinic to provide informational materials to their students about ECPs; and a few local pharmacists refused to fill prescriptions written specifically for ECPs.

Although most (93%) respondents to the first survey did not personally think ECPs cause an abortion, some felt that health care providers’ belief that ECPs act as an abortifacient poses a barrier to the provision of ECPs in southeastern Pennsylvania. More specifically, 14% thought it was a major barrier, 17% thought it was a moderate barrier, 29% thought this was a slight barrier, and 41% thought it poses no barrier.

At two clinics, these negative attitudes seriously interfered more directly in ECP service delivery. In the course of attempting to implement emergency contraceptive services, managers at two clinics discovered that some of their staff and clinicians were anti-choice. Several doctors who were consultant staff at one clinic continued to be reluctant or refuse to dispense ECPs. A new OB/GYN at another clinic was reported not to “embrace” it, saying “he says he is here to deliver babies, not to give this.” (He tries to forward hotline calls to other providers.) These problems caused clinic managers to reconsider their personnel hiring procedures and, over time at one clinic, two anti-choice staff resigned. Unfortunately, as will be discussed below, one of the community health clinics faces formidable obstacles in recruiting clinicians and must hire per diem physicians regardless of their attitudes and opinions about abortion or emergency contraception. Clearly, this has greatly diminished the manager’s ability to effectively implement ECP services.

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<sup>11</sup> Although agencies can request a waiver from the FPC, the clinic ultimately decided instead to try to comply with the policy.

*Staff concerns about safety of ECPs* - Many clinicians, including physicians, nurse practitioners, and nurses, expressed concerns about the safety of ECPs and the need for precautions in the provision of ECPs to clients. Health care providers' concerns about the safety of ECPs were considered to be a barrier to the provision of ECPs in southeastern Pennsylvania by some respondents: 17% thought this was a major barrier, 27% thought this was a moderate barrier, 46% thought it was a slight barrier, and 10% felt it was not a barrier.

Clinicians were particularly worried about "liability" and spoke of "putting their licenses on the line." In the first survey, 15% respondents felt that health care providers' concerns about liability issues were a major barrier to the provision of ECPs; 33% considered them a moderate barrier, 38% considered them a slight barrier, and 15% thought they were not a barrier. Many of the staff and managers who were interviewed asked questions about medical contraindications to use of ECPs and how they could be safely determined in individual women (i.e. what, if any, were the effects on the fetus, on breast-feeding infants, and on women with a history of cancer and if this included all types of cancer); whether there are any long term effects from repeat usage, or if sickle cell anemia was a contraindication to the use of ECPs.

When ECP services were initiated, some clinicians at every site and many of the clinics' medical directors expressed concern about the protocol that replaced physical examinations with a medical history to rule out contraindications. The FPC had introduced a medical history form to screen for contraindications when prescribing ECPs. This form was brief and self administered and was meant to preclude the need for a physical exam. Some managers and clinicians felt that their professional autonomy was being undermined by the imposition of this new protocol. By the time of the second interview, however, staff and managers reported that most of their concerns were allayed.

With experience providing ECPs and using the medical history questionnaire to assess eligibility, the majority of clinicians and other staff became confident that pills could be prescribed safely. Most providers reported that although the medical intake forms required a review by a counselor and usually a nurse practitioner, pills were being provided easily, without a pregnancy exam or prior medical records as a check. Actual practice of individual clinicians at several clinics differed from official procedures. Some physicians and nurse practitioners continued to perform pelvic examinations or laboratory tests to exclude pregnancy, depending on the client's profile, and sometimes within a clinic there were differences of opinion as to whether such tests were necessary in a given case. Although diverging substantially from the official protocol, clinic managers were flexible with regard to "individual clinician discretion." No indication was given that this practice interfered with access.

Several clinic managers commented that initial resistance could have been minimized and the transition for clinical staff eased had they received, prior to implementation (1) the ACOG guidelines and (2) onsite training, conducted by a physician, for medical directors and staff physicians about ECPs and the new protocol.

*Concerns about repeat use* - Initially, providers had fears about the potential "abuse" of pills, i.e. that women would repeatedly take ECPs or use them as regular contraception. In the first survey, 16% of the respondents agreed or strongly agreed that providing ECPs discourages consistent use of other contraceptive methods, 18% agreed or strongly agreed that repeated use of ECPs poses health risks and, as reported earlier, 16% indicated that they do not feel comfortable giving ECPs to teenagers. As it turned out, over the course of the study period, only a few women repeatedly returned for ECPs, which considerably diminished the concerns of the providers.

*Continuity of Care and HIV/STD Prevention* - Lack of attention to other gynecological conditions continued to be cause for concern among some clinic staff. For example, a nurse practitioner at a community health clinic described the care provided to “emergent” clients as “patchwork.” Time available to counsel new clients is limited, because they must be fit into the regular schedule. The opportunity to communicate the importance of having an annual pap smear, use contraceptives, screen for STDs and provide information about HIV testing is, therefore, lost.

In particular, one nurse practitioner expressed concern that first time clients are not tested for chlamydia, the most prevalent STD in the U.S. and the leading cause of preventable infertility and ectopic pregnancy<sup>12</sup>. She also reported that staff have difficulty obtaining clients’ records released from prior doctors in a timely manner, thereby compromising the quality of care provided to first time clients. Constraints upon time may prevent providers from recognizing that a request for ECPs may differ significantly in emotional content from routine contraceptive visits, acknowledging clients’ feelings and providing additional counseling and support--all aspects of good client-centered care.

Less than half (47%) of respondents to the first survey recorded or followed-up with patients to find out if they had used the ECPs that they had dispensed. Interviewees indicated that they rarely, if ever, follow-up with clients to determine the outcomes. ECPs are not 100% effective. If providers do not follow-up with clients after providing ECPs, an opportunity is lost to encourage a client to return for regular care, for a pregnancy test, if the ECPs were not effective, and to offer counseling. The lack of time for proper counseling and provision of comprehensive care to clients is related to organizational problems such as time management and scheduling, discussed in Section 3 below.

## **2. Staff Knowledge Regarding ECPs and Training Needs**

*Level of Knowledge* - Staff knowledge about ECPs varied. The majority of survey respondents were very familiar with ECPs; on a scale from 1 (not at all familiar) to 4 (very familiar), the mean level of familiarity was 3.4. Most learned about ECPs from staff in-service (77%); talking informally with staff or colleagues (63%); and during a workshop, seminar, or training program (58%). Some reported learning about ECPs from a journal or other professional publication (42%) and from a magazine or newspaper article (29%). Almost all respondents to the first survey (98%) knew that ECPs should not be used by women with confirmed pregnancy; and 78% knew that they should not be used by women who, for medical reasons, cannot take birth control pills. A third (33%) indicated that ECPs should not be used by women who are breast-feeding. In the first survey, 87% of respondents knew that two doses of ECPs must be taken within 12 hours of each other. The majority (89%) knew that, if used properly, ECPs work to prevent pregnancy at least 75% of the time.

*Information about side effects* - Clinic managers/directors said that side effects were generally not considered a problem; and that anti-nausea medication is not routinely dispensed or prescribed. Only two clinics reported client complaints about side effects, one of which decided to routinely prescribe Dramamine as a precaution. In contrast to all other clinics who instructed clients to take the pills on a full stomach, the clinic reporting clients with side effects instructed them to take the pills on an empty stomach. This was the only clinic that mentioned prescribing Lo Oval pills when the supply of Nordettes is depleted. All other clinics mentioned that they prescribe Nordettes as emergency contraceptive pills.

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<sup>12</sup> *Contraceptive Technology*. 1994 New York, Irvington Publishers, Inc.

*Training* - A major challenge is the need for staff who are well-educated and informed about ECPs. Staff turnover, especially high in one community health clinic, created a continuous need for staff training and development. Training was offered at the FPC, to which each agency sent at least one or two of their staff members. Subsequent in-service training of other staff members was left to the discretion of the clinics. As a result, some clinics have progressed from having one dedicated counselor to having trained all medical assistants to dispense ECPs. At the same time, there was no consistency in which staff was trained or how training took place.

Finding the time to train staff was mentioned by most managers to be a major problem. Training ranged from some information provided at staff meetings or during lunch breaks to closing the clinic so that the entire staff could take part in the training.<sup>13</sup> Although several interviewees reported no need for further training, the problem of maintaining a knowledgeable and well informed staff continues to be a major difficulty for some clinics. One clinic administrator recommended that training of the entire staff at the clinic should include role playing and assistance with how to communicate with “difficult” clients, i.e. those who do not want to accept ECPs.

Lack of knowledge about ECPs on the part of physicians, residents, and medical students and their lack of training in ECPs were cited as a major problem by interviewees at all the clinics because these providers are often resistant to providing ECPs. Hospital-based clinics rely on residents to provide medical care. Rotating through on a schedule, however, they rarely remain for a sufficient amount of time to learn about ECPs. Medical students who are involved in providing care at one community health clinic are equally uneducated about ECPs.

*Content of Training* - Some staff and managers recommended that the substance of the training be strengthened and expanded. For example, one clinic was explicit about the inadequacy of the training and the lack of attention to certain issues that needed to be addressed, such as rape and incest. Others thought that the training was adequate and little else was required.

In the first survey, respondents were asked to indicate how much they would or would not benefit from training about several emergency contraception topics. As shown in Table 4 below, most respondents thought additional training would be beneficial. In contrast, in the second survey, when asked a general question regarding whether they would like additional training about emergency contraception and/or related topics, only 11% of respondents answered affirmatively.

Emergency Contraception Training Topics	PERCENT			
	Benefit a great deal	Gain some benefit	Benefit a little	Not benefit at all
How it works (n=45)	22.2	42.2	17.8	17.8
Different methods of emergency contraception (n=43)	20.9	48.8	18.6	11.6
Dealing with side effects (n=45)	22.2	51.1	20.0	6.7
How to talk to patients about emergency contraception (n=44)	20.5	43.2	20.5	15.9

<sup>13</sup> The FPC has also provided much appreciated follow-up training by Dr. James Trussell from the Office of Population Research at Princeton University.

**Table 4. Survey Respondents' Report of Expected Benefit from Training on Emergency Contraception, N=48.**

Issues related to involuntary sex (n=46)	54.3	30.4	4.3	10.9
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Yet, interviewees mentioned the need for training of front line staff in how to communicate with clients about ECPs, as these staff members are the first to speak with women who call in requesting ECPs. A standardized guide of questions was requested by a few managers for use by front line staff to screen patients who call for ECPs. This underscores the need to ensure training for *all* staff.

### 3. Critical Management Issues

*Time Management and Scheduling* - Although the additional time necessary to integrate ECP services into the range of existing services was anticipated to be a problem for already over-burdened staff, some clinics were better able to manage the increased client load than others. While it would be necessary to conduct further research to determine the precise factors involved, it appeared to the investigators that those clinics with a strong institutional framework and a very high managerial commitment from the outset were most successful in quickly overcoming these problems.

Flexible scheduling was described as crucial by one clinic manager who successfully resolved time management issues. Clinics with no-show rates of 30-50% and/or those with walk-in policies prior to the integration of the ECP services expected minimal difficulty in absorbing new clients, and easily accommodated them. At one clinic, the manager stressed that they "take absolutely everyone, no matter."

Managers at the first round of interviews described the extra time required to implement the policy as posing serious problems. This included time for (a) explaining the, initially, lengthy consent form, (b) counseling, (c) staff training, (d) repackaging pills, and (e) answering Hotline calls. The biggest challenge, according to one hospital clinic director is "the time to educate clients about ECPs, and to do it efficiently in the time available." It is just such time that becomes particularly crucial when responding to clients who need instructions to be repeated several times before they are understood. Lack of literacy and numeracy skills was raised as a serious issue affecting the ability to understand the media campaign messages and the instructions given for taking the pills.

Some interviewees insisted that an excessive amount of time was spent on counseling of clients who come for their regular Depo Provera injections or other contraceptives and who do not want ECPs. "For clients who are not interested, it lengthens the visit considerably...some just want their shot, and leave." Also mentioned was the lengthy consent form provided by the FPC requiring an extended discussion with each client. In addition to shortening the form (in the case of one clinic to merely three questions), several clinics eventually streamlined their procedures and clients met with medical assistants rather than clinicians to obtain ECPs.

Finally, some of the same clinics that reported successfully managing time, continue to cite lack of time as the reason preventing them from recording information about the numbers of ECP "emergent" visits, repeat visits, about follow-up to determine if women use the ECPs, outcomes of use, etc. Such data are recognized as being critical, if ECP services are to be successfully incorporated into a full range of health care.

*Repackaged Pills and Preven* - Throughout the study period, the lack of a dedicated product made it necessary for clinics to repackage regular birth control pills. Clinics repackaged ECPs in different ways: some cut them up and put the proper dosage in small envelopes or pill bottles containing written instructions; others simply cut off the excess pills from the original oral contraceptive package; and one or two clinics provided several dosages in advance. Clients were particularly confused by repackaged ECPs with the extra pills cut off because the original labels list the days of the week above each pill, causing some women to take the pills only on those days. Additionally, some teens were said to have difficulty with the number of pills that should be taken at each dose.

Initially, all interviewees expressed the need for pre-packaged pills. Some clinics experienced difficulty in obtaining regular supplies of Nordettes, which all clinics use as emergency contraceptive pills. At one clinic, when Nordettes were in short supply, Lo-Ovral pills were substituted for use as ECPs, taken from the regular stock of birth control pills. This created shortages for regular contraceptive clients.

At the end of the study period (in Fall 1998), a dedicated ECP product, *Preven*, became available on the market. The FPC had plans to obtain *Preven* for clinic distribution but had not done so at the time of the study. Several interviewees anticipated problems with this product. Almost every clinic mentioned the cost of *Preven* (anticipated to be approximately \$15 at a clinic and \$20 at a pharmacy) as prohibitive for some or most of their clients. Staff thought that some of their clients might not meet the eligibility criteria to receive *Preven* at no cost, when FPC distributes it. Some also worried that clients might compare the repackaged pills the clinics were providing with *Preven* and conclude that they were receiving a second class product.

*Instructions for Use* - In the course of interviews, staff described client confusion about when and how to use ECPs. A conscientious Depo Provera and condom user was reported to have called a suburban clinic in a state of panic because the condom broke during sex and she did not know if she should take the ECPs given to her. The need for clearly written instructions on when and how to take the ECPs correctly was mentioned by many. Some interviewees reported that many of their clients were unable to read. Others had difficulty with understanding the directions on the packages. One staff member interviewed suggested that the materials and instructions be written at a 5th grade level.

Confusion, incorrect information and lack of understanding may also have been the result of inadequate time spent on counseling. As other interviewees suggested, good education and sufficient time counseling each client would overcome many of these problems. A good relationship between provider and client might also allay suspicion, as one provider mentioned in an interview.

*Accessibility* - A major problem faced by clinics is twenty-four hour, weekend and 3-day holiday coverage by clinicians. Perhaps more than any other issue, this barrier stretched staff's ability to provide emergency contraceptive services to women when they needed it. Most clinics are open only during the week. It is necessary for all the clinics to have someone on 24 hour call. Unfortunately, a physician who is recruited for on-call duty may not know about or refuse to provide ECPs. A concerted effort is being made by FPC to recruit on-call volunteer clinicians who can telephone prescriptions into pharmacists during three-day holidays.

A community health clinic experiencing the greatest difficulty in staff and physician turn-over described an incident with an internist who was on-call and who did not know what to do when a client called from the Hotline. Refusing to prescribe ECPs, he referred her to the emergency room of a local hospital.

However, referrals to local hospital emergency rooms were problematic. Providers reported that their clients were often intimidated from using emergency rooms, afraid that they may have to make a formal report of a forced sexual encounter, or be forced to wait for hours before being seen by a physician who may or may not be inclined to provide ECPs.

The FPC is negotiating with some local hospital emergency rooms to encourage them to provide ECPs. And each clinic has been asked to request that their local hospital emergency rooms be on-call during the weekends to dispense ECPs. Managers from several clinics informed us that this request was met with a definitive negative response. Most emergency rooms appear not to consider the provision of ECPs to be within their purview nor do they consider it to be an emergency.

#### **4. *Outreach to New Clients and Client Recruitment***

The RHTP and CHOICE Hotlines were cited by all clinics as important sources of client referrals for ECPs. Interviewees, in addition, reported that many women learned about ECPs by word-of-mouth and through referrals from high schools that had a clinic staff member out-stationed at the school health programs.

The ability to attract clients for ECP services seems to depend, in part, on outreach efforts at the clinics and the local political environment. For example, some clinics had good relations with local high schools and had staff members who worked at the schools and provided students with information and referrals. This contrasted with the suburban areas where there is strong anti-choice sentiment and lack of receptivity to reproductive health educational services for students. A manager at one clinic cited the abysmal quality of education in the local high school, the lack of literacy among teens and high number of students who drop out of school because of pregnancy. Yet the local, conservative school board rejects the inclusion of sexual health and contraceptive education as part of the health curriculum.

Most interviewees mentioned the desirability of recruiting the first time clients who came for ECPs as regular, on-going clients. The small number of new regular family planning/contraceptive and gynecological clients recruited to the clinics' routine practice was, however, striking. Interviewees said that most women who obtained ECPs from the clinics and who were referred by the Hotline, did not return to their clinics. Many ECPs clients had their own primary care physician who either was not available or did not dispense ECPs. Other women did not want their physicians to know about their use of ECPs. Most of these clients said that they would return to their own primary care physician.

Most clinics had a limited number of available slots for regular clients. More than one hospital-based clinic director pointed out that even if the first time clients wanted to return as regular clients, they would find it extremely difficult to accommodate them. The inability of some clinics to absorb new ECP clients as regular clients reinforces the stand alone and marginal nature of emergency contraceptive services. This suggests that the concern expressed by some clinicians may be warranted, that the full integration of emergency contraceptive services into family planning and gynecological practice is unlikely.

For most clinics in this study, offering emergency contraceptive services was not a way to engage new clients in on-going care. “emergent” clients are more often White, middle class, and have private insurance (and at one clinic, this included Asian women). This population differs from the regular client population of the hospitals and community health clinics. Demographic differences between first time clients coming for ECPs and regular clients exist in spite of the fact that the RHTP Hotline provides a list of clinics located in geographic proximity to the caller. Often, as mentioned above, the ECP clients are students drawn from nearby colleges and universities, looking for an anonymous setting, or women who have private health care providers to whom they return. It is not surprising that the one clinic reporting having absorbed new regular clients from women requesting emergency ECPs is a Planned Parenthood affiliate with a demographically similar client population.

### ***5. Client Education and Informational Materials***

The majority (81%) of respondents to the first survey indicated that all clinic patients are told about or given educational materials (e.g., brochures) about ECPs. Most clinics place brochures and posters in their waiting rooms, in an effort to provide information not only to the “emergent” clients, but to all clients. In some cases, however, the clinic’s location may pose special constraints, such as was the case with one clinic in a children’s hospital that shared a waiting room with another practice that objected to the visibility of emergency contraceptive information and its accessibility to clients they felt were too young to be exposed to the issue.

At the first and second round of interviews, most managers and staff at all clinics made recommendations about the need for new materials on ECPs. Requests included the following: clinical information, consent forms and patient materials including instructional brochures that are attractive, in different languages and at appropriate reading level, specific for men and for teens; an educational video for clients to view while waiting; large, colorful, and bright posters and signs for waiting rooms including one that asks: “*Do You Know What ECP Is?*” with three or four key informational points. Clinics also requested additional funds to place advertisements in local newspapers and flyers in the windows of supportive neighborhood shops. The full range of recommendations can be found below.

## **V. CONCLUSIONS**

The research found that the introduction of emergency contraceptive pills is challenging and requires planning with the providers and clients and prior education with the broader community of health professionals and public. The Family Planning Council’s policy to “prophylactically” provide ECPs to all clients before the need for them has, undoubtedly, made them accessible to more women who want to use them. Data indicated an increase over time in the “prophylactic” dispensing of ECPs and in women requesting the method. Information from surveys and interview data also suggest that, during the campaign, women’s attention was drawn to the hotline. This is reflected in calls to clinics for ECPs. Nonetheless, even after the FPC policy was in effect and the media campaign had taken place, no clinic experienced an overwhelming demand for this new method.

### *Media Campaign*

Survey results indicated that most clinic staff had seen and heard the public media ads, found them to be informative and to have increased public awareness of ECPs. At the same time, clinic staff work with the issue of contraception on a daily basis--and were in the throws of implementing the new ECP

service— probably heightening sensitivity and awareness to the media information. None of those interviewed said that their clients reported seeing or hearing those ads, although survey respondents reported some did. Survey respondents reported receiving increased requests for information and ECPs as a result of the media campaign, but they had difficulty in determining whether clients were referred by the CHOICE Hotline of the Family Planning Council or the RHTP Hotline. Lack of systematic data regarding the source of referrals makes interpreting these data problematic.

Clinic managers, except one, expressed enthusiasm about making ECPs available to their clients. Nevertheless, except for the Planned Parenthood affiliates, they did not anticipate a large increase in demand, if any, as a result of the media campaign. The two Planned Parenthood clinics saw the greatest increase in clients and were also the clinics reporting that first time clients coming in to request ECPs could and did become regular clients. For these clinics, providing ECP services presented an opportunity to increase their general client population, a situation facilitated by the fact that new clients were of the same class, race and ethnic background as their general client population. New clients accessing services at most of the other clinics were of different ethnic/race and class backgrounds than their largely low-income African-American client population. This suggests that the media messages failed to reach sections of the population.<sup>14</sup>

In-depth discussions with clinic managers revealed possible problems with the media messages suggesting deeper issues that influence the acceptance of ECPs among their clients. The problems they raised point to a lack of familiarity with the communities targeted. Staff expressed concern that the message in the ads was unclear and might incorrectly communicate the idea that ECPs could protect against HIV or other STDs. The fact that involuntary and forced sex in the lives of girls and women is a major factor in unplanned pregnancies, that rape is not considered sex, and that pregnancy among unmarried teens is not necessarily unwanted, nor stigmatized, suggests that the messages in these ads may not have been perceived as directed to or communicated as relevant to their clients' needs. In the absence of data collected directly from the clients, these interviews with clinic managers point to the likelihood that such social and cultural factors were key in the way media messages were perceived. Research that directly draws on the opinions of the client population could provide more detailed and valuable information in this regard.

### *Organizational Challenges*

A number of organizational and structural factors influenced the ability to provide ECP services. While some organizational issues turned out to be less a problem than anticipated, others had been unforeseen.

Key factors included: provider concerns about product safety, quality and comprehensiveness of care; scheduling and staffing needs; training, time required for counseling; and the lack of a dedicated product.

The attitudes of the clinic managers, medical directors and clinical staff greatly influenced the clinics' abilities to integrate the delivery of ECPs into their service effectively. Their support or lack of support determined whether or not the services were implemented. Stumbling blocks included: perceptions by some that ECPs are an abortifacient; concerns about the safety of prescribing ECPs without a full exam; apprehension about the possibilities of "abuse" (repeat use); and missing the opportunity to provide STD screening and treatment.

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<sup>14</sup> It should be noted that during the RHTP campaign was designed to reach a very broad audience (women aged 18-34).

Interestingly, over the course of the study, most clinics reported that initial provider scepticism and opposition was largely giving way. As clinicians became more knowledgeable about ECPs and as their fears failed to materialize, most became comfortable with the protocols and adapted to changes in the service delivery. However, overtime almost all clinics relaxed implementation of the policy to “prophylactically” dispense ECPs to all client. Many interviewees mentioned that more orientation and training regarding the provision of ECPs would have eased the integration process. Also identified was the need to train all staff, including receptionists, people answering the phones, and medical students and residents who rotated through the clinics.

Scheduling and staffing also posed a challenge. Flexible scheduling was required to accommodate clients coming in without appointments and all clinics faced the problem of how to offer 24 hour and weekend coverage. Clinics met these challenges over time by streamlining the protocols (including a shortened intake form); taking “walk-ins”; and in many cases, training a range of staff to counsel and dispense ECPs. At the same time, lack of time and lack of trained staff were thought by some clinic managers to affect quality of care and, ultimately, the integration of “emergent” clients fully into their general family planning services. Concern was greatest about “emergent” clients who might not seek medical care for HIV/STD counseling, testing or treatment, and who might be at risk for becoming infected or experiencing unintended pregnancy.

Considerable time was also found to be required for counseling, especially for clients with low levels of literacy. Not anticipated was the amount of explanation required in cases where women were using pills or Depo Provera or were otherwise good contraceptors. Almost all staff requested additional materials on emergency contraception both to help inform themselves and to assist in counseling and informing the clients, and many stressed the need for simple instructions geared at the literacy levels of clients.

Finally, repackaging pills took time away from other staff responsibilities and some clinics experienced problems in maintaining regular supplies of pills. The repackaged pills often required lengthy instructions for use. In addition, concerns were raised about the possible perceptions by some clients that the repackaged pills were a “second class product.”

## **VI. RECOMMENDATIONS**

Numerous recommendations on ways to ease the introduction of ECPs emerge from the experience of the Philadelphia study clinics. One of the most significant findings of this research is the need to understand the differential affects of racism, culture, class and the realities of women’s lives on their reproductive health care decisions and to incorporate that knowledge into creating appropriate educational messages and health services that meet population-specific needs. Clearly, messages must be tailored to specific populations in order to effectively reach them. Regarding the integration of ECPs into the family planning service delivery, the major recommendation would be to fully prepare the staff and anticipate and plan for organizational challenges in advance of introducing the method.

Specific recommendations include:

### *Media*

- # tailor media to specific populations (e.g. use situations and examples that are appropriate to specific populations)

- # understand and be sensitive to particular population's history and experiences with public agencies and their use and trust of the medical system
- # identify who best provides information in a community and how they do so
- # make sure the message is understood by the targeted population (e.g. issue of unprotected sex...does it refer to unplanned pregnancy, HIV/STD or both)

### *Organizational*

- # anticipate organizational issues and make suggestions for resolution prior to implementing the service
- # provide staff with relevant written materials such as service protocols, informed consent forms, etc.
- # address the need for clinician coverage for weekends and 3 day holidays prior to service implementation
- # be prepared to deal with negative staff attitudes towards ECPs (concerns about safety and "abusive use", viewing ECPs as abortifacients)
- # recognize the potential problems associated with repackaged ECP's (i.e., staff time required, extensive client instructions, the need for understandable package inserts, etc.)
- # ensure full and continual supplies of pills earmarked for ECP repackages
- # schedule sufficient time for staff to spend with clients for counseling, instruction, and follow up
- # provide appropriate informational materials - in different languages and appropriate literacy levels for all clients
- # establish a mechanism for record keeping and reporting as part of existing system

### *Training*

- # provide specific training for all categories of staff prior to implementing an ECP service, including front line staff who are often the first to communicate with clients about ECPs
- # provide ACOG regulations and literature from medical journals in advance of training
- # acknowledge and discuss clinicians' and other staff's professional concerns in these trainings
- # have physicians conduct the training of the medical staff
- # address the following topics: issues of rape; how to instruct new contraceptors; how to restart a client on pills; what information to give women using long acting methods such as Depo, Norplant, IUDs; how often ECPs can be used (repeat usage); and the appropriateness of ECPs for women who are breastfeeding or who have had various cancers
- # train staff to recognize and sensitively respond to the emotional content and urgent nature of a request for emergency contraception
- # train staff to encourage "emergent" clients to return for on-going, comprehensive reproductive health care
- # mobilize the community by offering comprehensive training to medical students, residents in local hospitals, pharmacists, and health care providers at emergency rooms

### *Research*

- # is needed to elicit the perceptions of diverse groups of women about the media campaign as well as to become well-informed about their experiences, opinions and use of ECPs. Such information could help inform the development of effective and appropriate advertisements as well as sensitize providers about how to best communicate to clients about new products.

- # on the role of racism in women's assessments of health care services and new products
- # the use or misuse of language in promoting new technological advances.

In sharing with us their experience, the Family Planning Council and the clinics that participated in this study have provided information on the issues providers can expect to encounter when trying to enhance their service capability to provide ECPs. We hope that the knowledge gained from this study will assist others in the introduction of this important new method and that of other new reproductive technologies.

