



***How Women Access and Use Plan B in the United States:
Findings of an Online Consumer Survey***

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We also acknowledge the many organizations that hosted links to our survey on their websites and spread the word about it to various social networking sites and listservs. Some, but by no means all, of these sites are mentioned in the report. Without their help, we would never have reached as many women as we did. Finally, and most importantly, we thank the survey respondents, whose willingness to share their experiences with Plan B will ultimately improve policy and practice.

The Academy for Educational Development (AED), an independent, nonprofit organization, works globally to improve education, health, civil society, and economic development. AED's mission is to make a positive difference in people's lives by working in partnership to create and implement innovative solutions to critical social and economic problems. The authors have no financial interest in the commercial success or failure of Plan B.

Introduction

Plan B is the only dedicated emergency contraception (EC) product currently sold in the U.S. According to the package label, Plan B (a levonorgestrel-only regimen of EC) can be used up to 72 hours after unprotected sex or contraceptive failure to prevent pregnancy. Recent research has found that levonorgestrel regimens of EC can be effective if used up to 120 hours after sexual intercourse.¹ Research studies have also determined that the sooner Plan B is taken the more effective it is.² For this reason, medical and health professionals, and women's reproductive rights and health advocates have sought ways to reduce barriers to access.

These barriers have included lack of information or misinformation among consumers, health care providers, and pharmacists; religious objections to EC; cost; corporate refusal to stock EC; individual pharmacist refusals to dispense; negative or judgmental attitudes about sexual and reproductive matters; and the absence (or lack of enforcement) of policies requiring hospital emergency department policies to provide victims of sexual assault with information or an EC product.³ Since the

appearance of EC products on the market, much has been done at the policy and practice levels to improve awareness and access. Research has provided critical data to inform and assess this work.

In August 2006, the U.S. FDA approved Plan B for sale over-the-counter (OTC) in pharmacies, thereby potentially increasing access for consumers ages 18 years and older. As a condition of the approval, Duramed Pharmaceuticals agreed to the CARE® program, a post-approval program designed to ensure that Plan B is used responsibly. One area of the CARE program addressed consumer feedback on Plan B use.

Duramed engaged AED, a nonprofit, social change organization, to conduct an internet survey of women eligible to purchase Plan B over the counter. AED researchers had been conducting research on EC awareness and access since 1999.

Prior studies of EC use conducted in the U.S. addressed knowledge and attitudes in the general population – nonusers and users. These studies have small samples of users because the percentage of women who have used Plan B in the population is small. Studies with clinic population samples had been conducted as well, but little was known about consumers' access to and use of EC in the general population subsequent to EC availability OTC.

The current study was designed to explore consumers' experiences the year following Plan B OTC availability in a large, nationwide sample. More specifically, the research addressed how women learned about Plan B, whether

¹ Trussell J and Raymond EG (2008). *Emergency Contraception: A last chance to prevent unintended pregnancy*; <http://ec.princeton.edu/questions/ec-review.pdf>; accessed 7/3/08.

² Task Force on Postovulatory Methods of Fertility Regulation. Randomized controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet*, 1998; 352: 428-433.

³ The Guttmacher Institute (2002). "Emergency Contraception: Steps Being

Taken to Improve Access." *The Guttmacher Report on Public Policy*, 5(5).

they encountered barriers to access, interactions with pharmacists and health care providers, number of times and reasons the product was used, attitudes about Plan B after taking it, contraceptive use, and subsequent contacts with health care providers and pharmacists.

Methods

The study sought to address the following aspects of access, use of Plan B, use of other birth control, knowledge, and attitudes.

Access

- Availability of Plan B in pharmacies and health clinics
- Changes in availability over time
- The time between unprotected sex and use of Plan B
- Barriers encountered

Use of Plan B

- Repeat use
- Information and/or medical care sought after use of Plan B

Use of Condoms and Birth Control

- Use of condoms and birth control before and after using Plan B

Knowledge

- How consumers learn about Plan B
- Extent to which women are informed about Plan B

Attitudes

- Satisfaction with the product
- Attitudes about making Plan B available OTC to women younger than 18 years
- Attitudes about other women's use of Plan B

The research also sought to determine whether there were differences in knowledge, attitudes, and practices regarding Plan B among groups by age, education, and/or geographic area.

Online Survey Methodology

This report is based on data collected from an online survey hosted by AED from December 2007 to March 2008.

Online surveys have advantages and limitations. For our purposes, the main advantage was being able to reach a large number of women, nationwide, who had used Plan B. The online survey afforded respondents confidentiality and time to reflect on their experience because recruitment, with only minor exceptions, did not occur at the "point of sale." In addition, the fact that the online survey allowed a quick response was a big advantage, given that the research was conducted in a short timeframe. Another advantage of the online survey was its low cost. Because there is no separate data entry, costs were reduced and we avoided data entry errors. The online format also allowed us to exclude respondents who did not meet the study criteria described below.⁴

A serious limitation of online surveys is that they exclude people who do not have ready access to computers or who may not be comfortable using them. Although our survey was targeted to women ages 18 to 44 years, we were aware that those in the upper age groups might be less comfortable with the technology than younger women. Also, while studies have shown that low-income populations are

⁴ Lois Ritter, Co-author, *Conducting Online Surveys*. Personal communication.

increasingly using computers,⁵ women with low incomes or low educational attainment may have limited private access to computers.⁶

Eligibility

To be eligible for the survey women needed to fit the following three criteria:

- Be between the ages of 18 and 44 (19 to 44 for Alabama and Nebraska residents)⁷
- Took Plan B after January 1, 2007
- Live in the United States

Recruitment

The study recruited women electronically through postings on multiple websites. Staff sought the cooperation of the major trusted providers of information about EC, including www.not-2-late.com, www.go2planb.com, www.ec-help.org, and www.go2ec.org. Organizations that partnered by placing the button on their websites or sending an announcement to membership included Planned Parenthood chapters, Advocates for Youth, the American Public Health Association's Population and Family Health Section, Our Bodies Ourselves, the National Sexual Violence Resource Center, and the National Latina Institute for Reproductive Health. An article on www.salon.com announced the survey's launch.

Special efforts were made to recruit women from low-income communities through electronic means. The link also was placed on social networking sites (Facebook and MySpace). An html "button" was designed for websites to post on their sidebars or directly in their content. Women clicking on the button were linked directly to the survey. We provided those interested in posting the button on their webpage with a simple code that could be cut and pasted into their layout. The button is displayed below.



To interest women in following the link to the survey, the button and survey description mentioned a random drawing for a \$150 Target gift card.

We held two gift-card drawings. Women were assured that entry into the drawing was voluntary. Those in the drawing were asked for their contact information; however, the survey instructions clearly indicated that respondents' names would not be linked to their answers. Contact information for those entering the random drawing was kept in a separate, secure database. Fifty-five percent of the 1,721 survey respondents entered the random drawing.

The survey contained 30 questions, all but one in fixed-response format. The survey took about 10 minutes to complete. Useable data were collected from 1,618 women of the 1,721 women who responded to the survey during the four months it was on line.

⁵ Fox S. (2005) Data Memo. Generations Online. Pew Internet and Personal Life Project; http://www.pewinternet.org/pdfs/PIP_Generations_Memo.pdf; accessed 7/10/08.

⁶ Lois Ritter. See note 4.

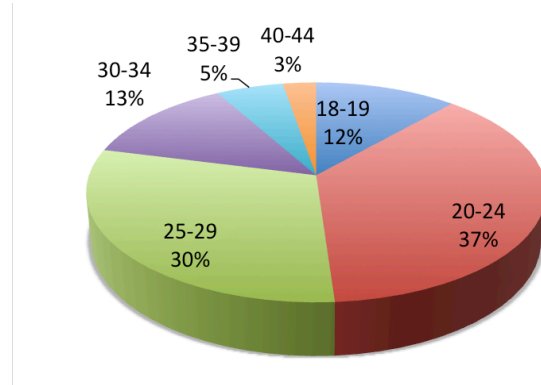
⁷ The age of majority in Alabama and Nebraska is 19 years for unmarried persons.

While the respondents are not representative of all women 18 to 44 in the U.S. population, this study provides important information about a large number of women from all 50 states who have used the product. Duramed Research, Inc funded the study.

Description of Respondents

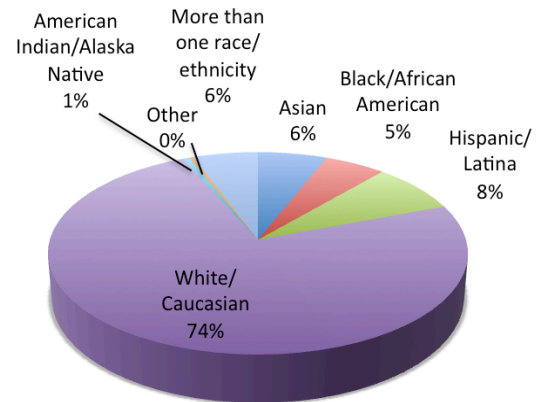
Respondents ranged in age from 18 to 44; 79% were under 30.

As noted above, the survey was open to women ages 18 to 44; the mean age of survey respondents was 26. Of the 1,618 women in the final sample, 12% were 18 to 19, 37% were 20 to 24, 30% were 25 to 29, 13% were 30 to 34, 6% were 35 to 39, and 3% were 40 to 44.



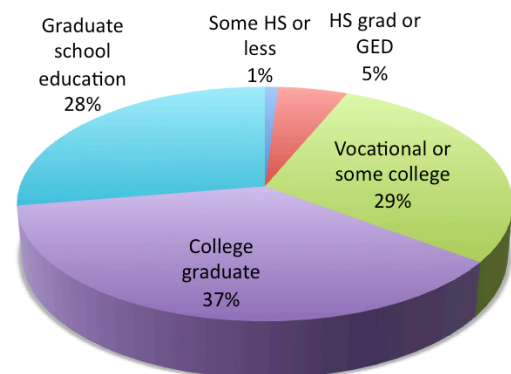
A large majority (75%) of survey respondents were White/Caucasian.

Seventy-five percent of respondents identified themselves as White/Caucasian, 8% as Hispanic/Latina, 6% as Asian/South East Asian/Pacific Islander, 5% as Black/African American, and 6% identified as more than one of these or another race/ethnicity. A total of 203 of the 1,618 respondents left this question blank (147) or responded that they didn't know or preferred not to answer (56).



Women who took the survey were highly educated.

As shown in the exhibit below, 29% of respondents had some college or post-high school vocational education, 37% were college graduates, and 28% had some level of graduate education. Six percent had not gone beyond high school.



Most respondents (68%) reported that they were in a committed or monogamous relationship with their sexual partners when they last took Plan B.

Just over two-thirds of the women (68%) characterized their relationship with their sexual partner as committed or monogamous when they last took Plan B; 29% described their relationship as casual; and 2% percent had been forced to have sex. One percent checked "Other."

There was a fairly even geographic distribution of respondents.

The largest percentage of respondents (30%) lived in the West (as classified by census region). Respondents from the Northeast and South each represented 25% of the sample, while 21% of respondents were from Midwestern states. Overall, 19% of the sample was living in one of the nine “pharmacy access states” where participating pharmacists can provide Plan B directly to consumers of all ages through collaborative practice agreements between pharmacies and prescribers.⁸

Plan B had been purchased in every state in the U.S. by at least one respondent.

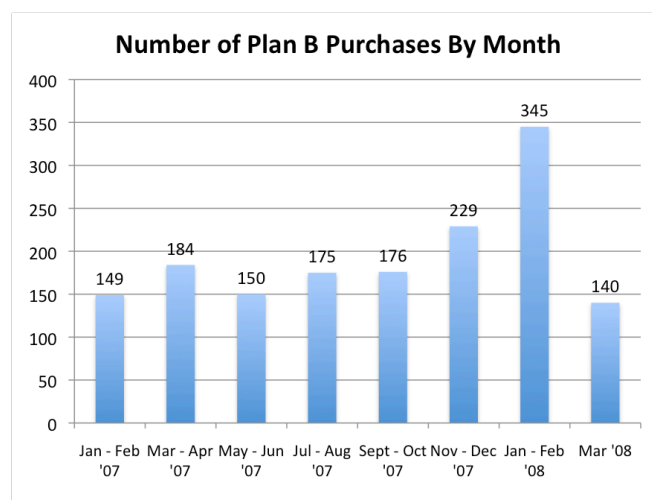
Respondents were asked: “In what state did you (or someone else) buy the Plan B you took the last time?” The highest percentage of purchases were made in California, contributing to 14% of the sample; New York – 11%; Illinois – 5%; Texas – 5%; and Florida, Massachusetts, Pennsylvania, and Washington each representing 4% of the sample. The other states represented less than 4% of the sample population.

The last time women reported using Plan B ranged from January 2007 to March 2008; 46% of respondents reported recent use of Plan B.

To be eligible to take the survey, women had to have used Plan B at least once after January 2007. Most survey questions asked respondents about the last time they used it. A question on the survey

asked women to report the month and year they used Plan B the last time. Our purpose was to compare experiences soon after Plan B became an OTC product with experiences some months later.

The data show that use of Plan B was fairly evenly distributed across the months before the launch of the survey, spiking from November 2007 to March 2008. Forty-six percent of respondents reported having used Plan B during the months the survey was posted. It should be noted that the last bar in this chart represents only one month of data, not two.



Time Period	Number of Purchases	Percentage of Respondents
Jan - Feb '07	149	10%
Mar - Apr '07	184	12%
May - Jun '07	150	10%
Jul - Aug '07	175	11%
Sept - Oct '07	176	11%
Nov - Dec '07	229	15%
Jan - Feb '08	345	22%
Mar '08	140	9%
Total	1548	100%

⁸ Pharmacy access states include Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Vermont, and Washington; 19% of the US population lives in these states.

Access

Easy access to Plan B is critical, given research findings that the sooner Plan B is taken after unprotected intercourse, the greater its effectiveness.⁹ Common barriers to access cited in the literature include lack of information among consumers and health care providers, cost, and institutional barriers.¹⁰ Among the women who used Plan B, the majority took it when most effective. However, it is important to note that the survey findings do not include those women who were ultimately unable to access Plan B.

Fully 98% of respondents reported starting Plan B within 72 hours of unprotected sex.

Most women in this study were able to access Plan B quickly. More than half (56%) were able to take Plan B within 24 hours of unprotected sex; 29 respondents (2%) took it later, including four who reported taking it after 120 hours, the outer limit of effectiveness.

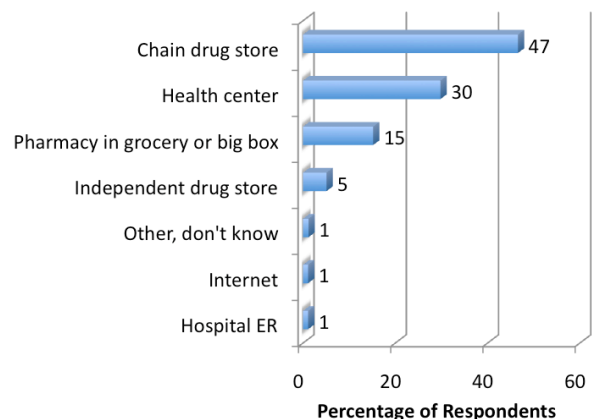
Almost all respondents (90%) obtained Plan B themselves.

Ninety percent of the respondents got Plan B themselves, while 10% reported “someone got it for me.” Most women (62%) purchased Plan B at a chain drug store or at a pharmacy in a grocery or “big box” store. Thirty percent obtained Plan B at a health center (e.g. Planned Parenthood or an Indian Health Service center).

⁹ Task Force on Postovulatory Methods of Fertility Regulation (see footnote 2).

¹⁰ Trussell J and Raymond EG (2008). Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy; <http://ec.princeton.edu/questions/ec-review.pdf>; accessed July 1, 2008.

Place of Purchase



A large majority (77%) of women paid the full cost of Plan B.

A total of 77% of women reported that they, or the person who bought it for them, paid the full amount; 13% said they or someone else got it for low or no cost from a clinic. Insurance covered some of the costs for 6% of the women, and Medicaid or another government health insurance plan covered costs for 2% of the women. Three percent answered “don’t know” or “other.”

Seventy-nine percent of women found Plan B at the first pharmacy they went to or called.

A large majority (79%) of women who purchased Plan B at a pharmacy found it easily and 21% had more difficulty. That is, 16% of women found Plan B at the second pharmacy they tried and 5% tried three or more pharmacies.

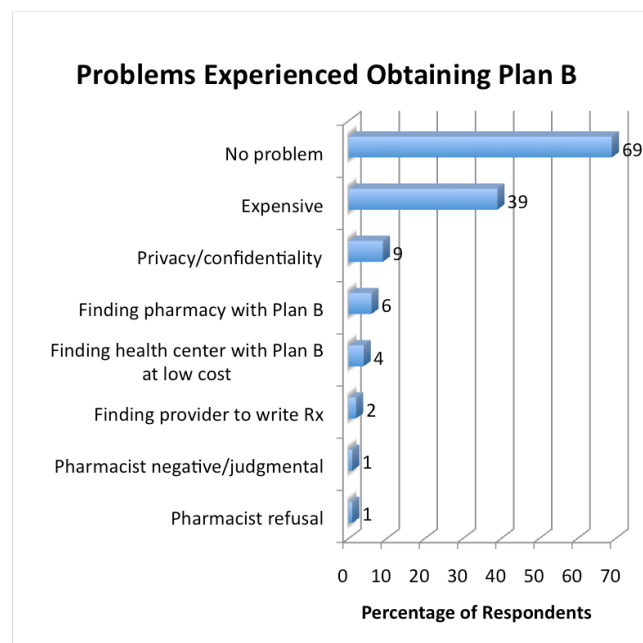
There were no significant relationships between the number of pharmacies woman went to before finding Plan B and the number of times Plan B was used, residence (metropolitan or non-metropolitan), whether the state was a pharmacy access state, or the type of pharmacy where Plan B was purchased (chain, independent, or grocery/big box).

Most women (93%) described the distance they traveled to get Plan B as convenient.

Ninety-three percent of women reported as convenient the distance they had to travel to the place they found Plan B (including health center and pharmacy); 7% experienced the distance as inconvenient.

Most women (69%) reported not encountering any problems in obtaining Plan B.

By a large margin, the most frequently reported problem was cost. Other problems were lack of privacy or confidentiality, and trouble finding a pharmacy or health center that carried Plan B.¹¹



Older women were less likely to report that expense was a problem ($r = -.125$, $p <$

¹¹ The question was worded as follow: "Some people find it easy to get Plan B, other people run into problems. What was your experience the time you got Plan B? (Check all that apply.)"

.001) and also less likely to report having difficulty finding a health care provider to write a prescription($r = -.100$, $p < .001$).

Some respondents described their experiences accessing Plan B in a text box provided for responses to the fixed-choice category, "Other, please specify." These quotes illustrate the situations women confronted and how they overcame them.

No problem

- *I am very lucky – it is sold OTC at the OSU student clinic!*
- *It was easy but only because I knew to go to Planned Parenthood.*
- *I was able to keep some for emergencies so quick access was not an issue.*
- *I got it from a friend who got it easily.*
- *The nurse offered me Plan B when I was in for another issue.*

Expensive

- *My insurance wouldn't cover it – it was \$50.*
- *I called three places to find the cheapest place selling it. Prices ranged from \$49-\$88.*
- *Had to expedite shipping on-line, which was costly.*
- *Sooooooooooooooooo expensive – \$50 – because I didn't have a prescription.*

Privacy/confidentiality

- *He didn't know if they had it or what it was. I had to explain it to him and after he made a call he actually yelled to me "What is it called?"*
- *All of the employees in the pharmacy were quiet and staring at me as I purchased it.*

Finding a pharmacy with Plan B

- *Everywhere in my vicinity was out!*

- *The first drug store was sold out – it was a Sunday morning.*
- *Had trouble finding a pharmacy that gave it without a prescription.*
- *I know the local pharmacies don't supply it at all; Planned Parenthood was great though.*

Finding a health center with Plan B at low cost

- *Planned Parenthood is unable to offer me affordable rates on Plan B due to significant cuts in their funding. However, it was still more affordable than any other alternative.*

Finding a provider to write Rx¹²

- *The doctor did not want to give me Plan B even though I had been sexually assaulted.*
- *The doctor I saw about getting Plan B was ill-informed as to what pregnancy tests I had to take in order to get the prescription. He was also rude and negative towards me. The ER staff were rude towards my husband.*
- *I had to argue with the nurse at my doctor's office to get her to prescribe it without having to go to the office.*
- *I needed it before any doctor could schedule the appointment.*
- *My primary care physician is at a hospital that is religiously affiliated and would not prescribe it for me. I had to find a different physician.*

- *Military hospitals REFUSE to carry Plan B.*

Pharmacist negative/judgmental

- *The pharmacist was great but the lady that rang me up was really rude and seemed judgmental.*
- *The pharmacist used his religion as an excuse to not issue and pass judgment.*

Pharmacist refusal

- *The first time I used it, pharmacist refused to dispense. Had to return when the next shift came on.*
- *Several pharmacies gave me the "run around" or said they were out. The place I finally got it was VERY nice and helpful.*
- *The pharmacy would not give it to me without a prescription. The doctor would not give me a prescription without a visit. (I was out of state at the time.)*
- *Pharmacist refused to sell it to my partner when he tried to purchase it for me while I was at work so I had to wait an extra day to purchase it myself, which added hassle and reduced the effectiveness of the pill.*

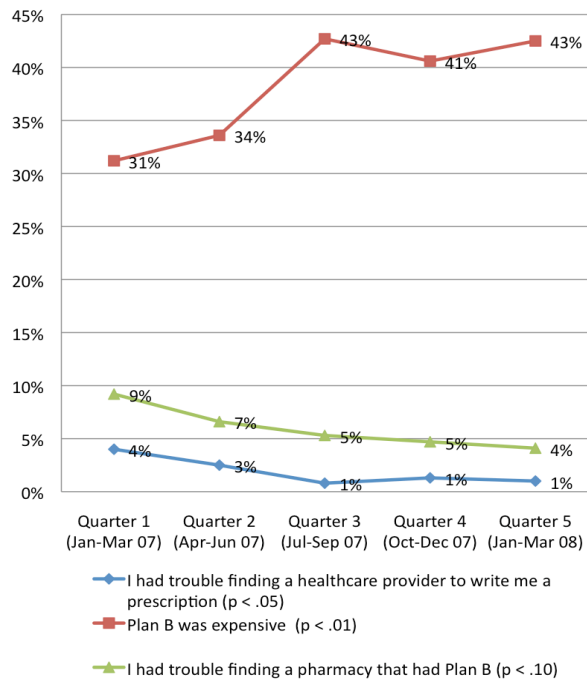
Other

- *I was unaware that the law had changed to make it available over the counter.*
- *I had to find someone to buy it for me.*
- *I was shy; I made my boyfriend go.*

An analysis of changes in access since the beginning of 2007, revealed that problems finding a health care provider to prescribe Plan B or finding a pharmacy with Plan B in stock have decreased, while concerns about cost have increased over time, as shown in the table below.

¹² Some adult women obtain prescriptions for Plan B even though it can be purchased OTC. Among the reasons they may choose prescriptions are bypassing the ID requirement or securing Medicaid coverage for the product.

Problem(s) experienced as a function of time of purchase



Correlational Findings about Access

Older women were more likely to obtain Plan B with a prescription ($r = .088$, $p < .001$) and also used Plan B fewer times in the past year ($r = -.099$, $p < .001$).

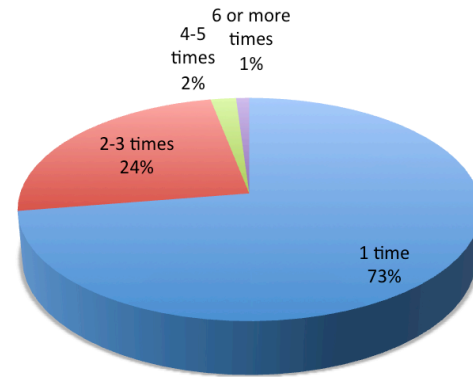
As would be expected, women who lived in a pharmacy access state were more likely to obtain information regarding Plan B from a pharmacist than from other types of health care providers ($r = .067$, $p = .007$).

Use of Plan B

The large majority of women (73%) who used Plan B, took it only once in the previous 12 months.

Most of the women surveyed (73%) reported taking Plan B one time in the

past 12 months. Almost one-quarter of respondents (24%) took it two or three times. Very few women (3%) used Plan B more than four times.

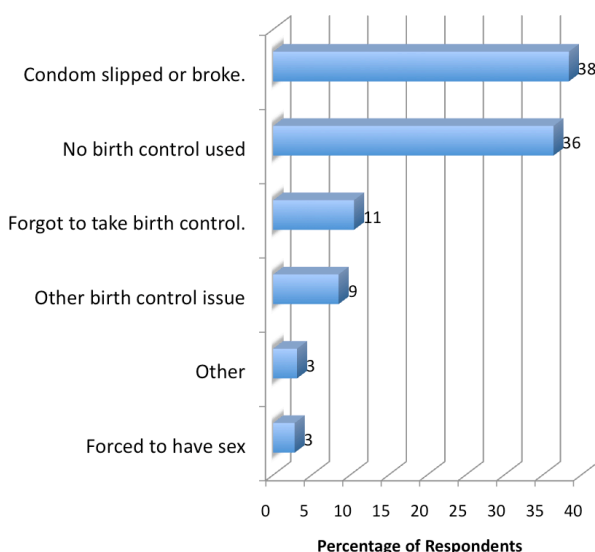


Among our respondents, younger women were more likely than older women to report using Plan B more than once ($r = -.095$, $p < .001$).

Women reported that the most common reasons for using Plan B were that “the condom slipped or broke” or that they had not used birth control.

In response to the question “What were the reasons you took Plan B the last time?” 39% reported “the condom slipped or broke,” and 36% said “no birth control used.” Eleven percent of the women forgot to take their birth control pills and 9% had “some other birth control problem.” Three percent reported being forced to have sex, and 3% said there were “other” reasons. (Multiple answers were allowed.)

Reasons for taking Plan B the last time



The explanations of “other” reasons demonstrate the importance of Plan B as a second chance to prevent pregnancy. For example, 11 respondents mentioned the effect of antibiotics on birth control pills:

Was unaware of the effects of antibiotics on birth control pills; was advised to take EC.

A number of women used Plan B as an extra precaution.

Was not sure if condom was used or stayed on properly; was not using other type of birth control; wanted to be on safe side.

Used condoms but felt nervous anyways.

Six women specifically mentioned failure of the withdrawal method.

My partner wasn't sure he pulled out soon enough, and we decided it was better to be safe than pregnant.

Other women described problems involving other birth control methods.

I was on the patch, and after having sex I noticed that it had fallen off me.

Forgot to reinsert the NuvaRing within necessary timeframe.

Was a little late with my birth control pills, and I wanted to be extra safe.

Sixty-six percent of respondents had recommended Plan B.

Two thirds (66%) of respondents answered “yes” to the question: “Did you ever recommend Plan B to a friend or family member”; 28% had not; and 6% were unsure. Younger women were more likely than older women to recommend Plan B to another woman ($r = -.081$, $p = .002$).

Use of Birth Control and Condoms before and after Plan B

Women were asked to report condom use before and after they took Plan B the last time as well as their birth control use (other than condoms), as shown below.

Before you took Plan B the last time, how often did you use a birth control method (other than condoms)?

And

How often do you and your partner(s) currently use a birth control method (other than condoms) to try and prevent pregnancy?

Response options were:

- (1) Never
- (2) Only sometimes
- (3) Most of the time
- (4) All of the time
- (5) Don't know

Before you took Plan B the last time, how often did you use and your partner use condoms?

And

How often do you and your partner(s) currently use condom?

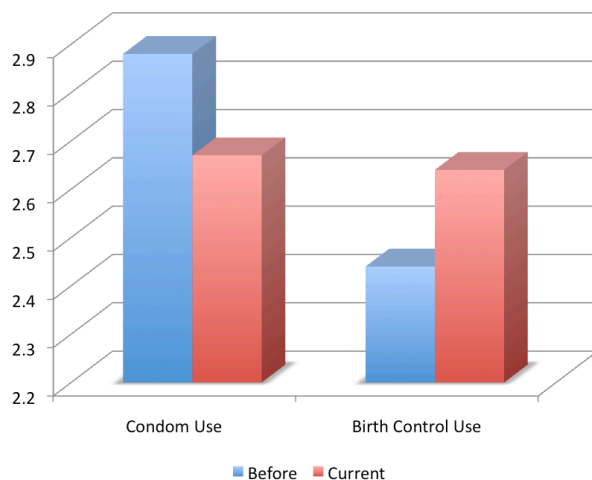
Response options were:

- (1) Never
- (2) Only sometimes
- (3) Most of the time
- (4) All of the time
- (5) Don't know
- (6) Doesn't apply to me

Based on women who responded with options 1 to 4 for condom usage ($n = 1,261$) and those who responded with options 1 to 4 for birth control usage ($n = 1,330$), we were able to compare mean use before and after for condoms and birth control, with the results show in the table and chart below.:

	Mean Response	Standard Deviation	Significance
"Before" condom use	2.88	1.15	$p < .001$
"Current" condom use	2.67	1.23	
"Before" birth control use	2.44	1.29	$p < .001$
"Current" birth control use	2.64	1.38	

Mean Response for Condom/Birth Control Use Before Plan B and Currently



As the table and chart above both show, overall condom use decreased somewhat while birth control use increased. Statistically, these means are significantly different from one another. From a public health perspective, a decrease in condom use after any intervention would be considered problematic. We conducted

further analyses to explore what was likely to be a complex relationship.

We found that "current" condom use was significantly correlated to "before" condom use ($r = .716, p < .001$) and that "current" birth control use was significantly correlated to "before" birth control use ($r = .580, p < .001$) – meaning that women who used condoms or birth control before using EC were likely to use it after as well. We found an inverse relationship between changes in condom use and birth control ($r = -.285, p < .001$).

The next sections provide a further look at the relationship between condom and birth control use, based on pre- and post-information provided by survey participants.

A Comparison of Means

We calculated a change score for each participant who answered 1-4 for both questions. Scores could range from -3 to $+3$ by subtracting "before usage" from "current usage." Therefore, if a woman reported no current use of condoms but that she had used condoms all the time before taking Plan B, her change score would equal -3 . If a woman responded that she now uses condoms all the time but she never used them before, her change score would equal $+3$. We assigned a score of zero to those who did not change.

Using these change scores, we calculated an average change score to further investigate the pre- and post-Plan B relationships. The mean change score for condom use was $-.2167$ ($SD = .9073$). The mean change score for birth control use was $.1799$ ($SD = 1.2087$). These means are significantly different from one another, $t(1, 1194) = -8.039, p < .001$. This relationship held using each individual's change scores.

	Frequency	Percent
<i>Condom Change</i>		
No change	902	55.7
Increase	118	7.3
Decrease	241	14.9
<i>Birth Control Change</i>		
No Change	850	52.5
Increase	290	17.9
Decrease	190	11.7

It is important to note that a majority of women *did not* change their behavior. In terms of condom use change, 902 (55.7%) women had a score change of zero. For birth control use, 850 (52.5%) women did not change. However, for those women who *did* experience a change in their condom or birth control use, the change was dramatic, as the previous data show.

Correlational Analyses

We conducted further analyses to explore possible explanations for the decrease in condom use. Comparing the changes in condom use before and after using Plan B, we found the following relationships:

Condom Use Before and After Plan B

- Those women who showed an increase in condom use were more likely to report that their reason for using Plan B last time was that no birth control was used ($r = .123, p < .001$).
- Those who showed a decrease in condom use were more likely to report having visited a health care provider for follow up after using Plan B the last time ($r = -.152, p < .001$).
- Women who reported a decrease in condom use were also more likely to report more reliable birth control use at last sex ($r = -.315, p < .001$).

Birth Control Use after Plan B

We also conducted further exploration of correlates with the birth control change scores. The following significant correlations were found:

- Most significant was the finding that women whose birth control use *increased*, decreased their use of condoms ($r = -.285, p < .001$).
- As age *increased*, change in birth control use *decreased* ($r = -.59, p < .05$).
- Those with an increase in birth control use were less likely to find Plan B expensive ($r = -.066, p < .05$).
- Increased score change for condom use was inversely related to use of birth control implant ($r = -.057, p < .05$), vaginal ring ($r = -.098, p < .001$), IUD ($r = -.169, p < .001$), and the pill or another oral contraceptive ($r = -.197, p < .001$). In other words, where condom use scores decreased, use of a regular/consistent birth control method increased.
- Current birth control use (including sponge and diaphragm) was also inversely related to change in condom use ($r = -.256, p < .001$), and this relationship was more pronounced with use of an even more consistent or regular form of birth control (such as the pill), ($r = -.315, p < .001$).
- Visiting a health care provider after Plan B the last time was negatively associated with condom change ($r = -.152, p < .001$) but positively associated with birth-control change ($r = .181, p < .001$).

Partner Willingness and Support

- Having a partner more willing to use a condom after Plan B use was

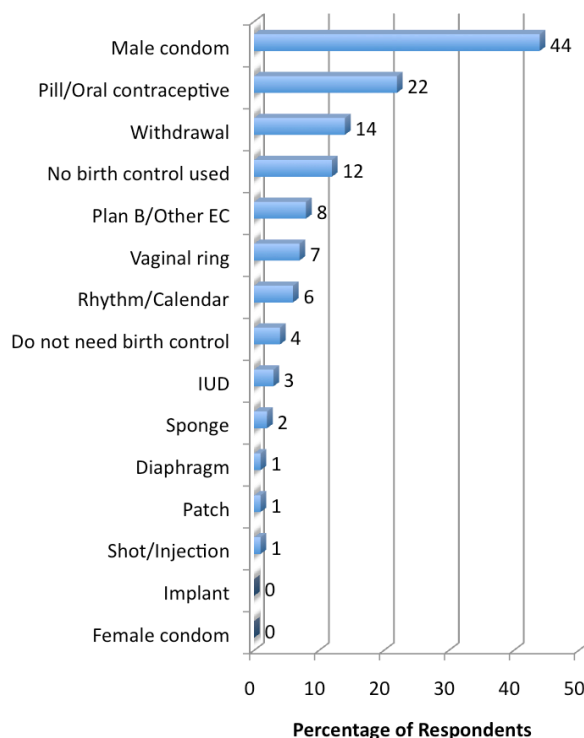
predictably associated with an increased condom change score ($r = .078$, $p = .019$).

- Partner willingness to use a condom was inversely related to the woman's age ($r = -.096$, $p = .003$). Partner support of a birth control method other than condoms was also inversely related to age ($r = -.154$, $p < .001$).

Male condoms and the pill were the current methods of choice for survey respondents.

Eighty-eight percent of respondents reported using some form of birth control at last intercourse (which was not necessarily the last time they used Plan B). Respondents most frequently reported that the last method(s) used were the male condom and oral contraceptive (see chart in next column).

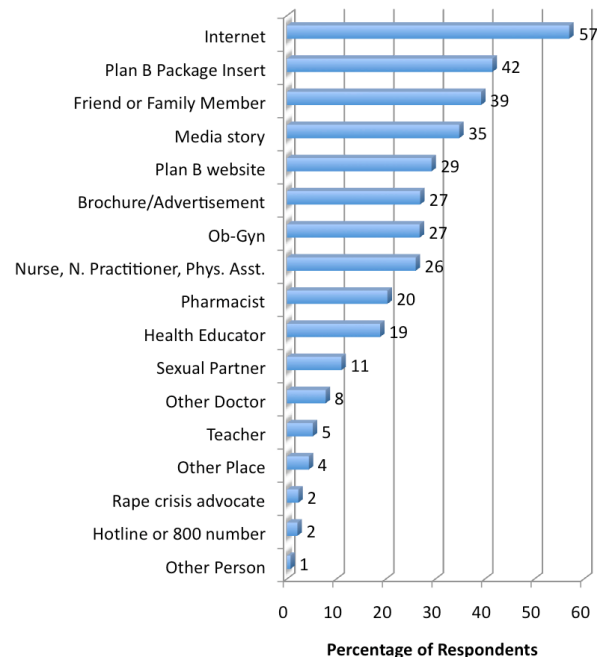
Current Birth Control



Knowledge

Women described the internet and the package insert as the places they were most likely to learn about Plan B, while 39% of consumers learned about Plan B from friends and family.

Where /From whom did you get information about Plan B?



For the questions regarding *where* or *from whom* they received information about Plan B, participants could respond in an open-ended ("other") field. Of the 1,618 respondents, 383 (24%) opted to do so. Nearly half ($n=189$, 49%) of the responses specifically named Planned Parenthood, or another reproductive rights organization, as a source of information about Plan B. This was the most predominant written-in response. Other responses included the internet – blogs, in particular – ($n=27$, 7%), and school or university health clinics ($n=28$, 7%).

The older the women, the less likely they were to obtain information from a teacher

($r = -.130$, $p < .001$), health educator or counselor ($r = -.125$, $p < .001$), sexual partner ($r = -.177$, $p < .001$), or friend or family member ($r = -.170$, $p < .001$).

However, older women were more likely to obtain information from a story in the media ($r = .080$, $p = .001$).

More highly educated women were more likely to receive information from the internet ($r = .103$, $p < .001$), a media story ($r = .167$, $p < .001$), and from the Plan B package insert ($r = .052$, $p = .037$).

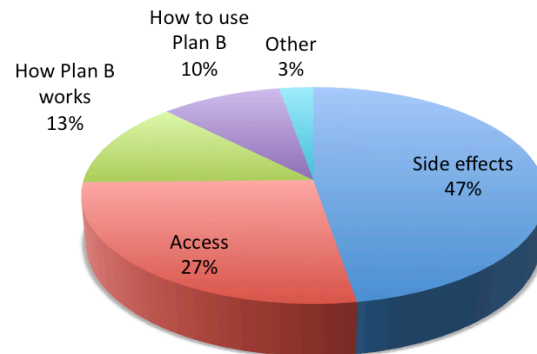
Women who used a hotline number were also more likely to contact a health care provider ($r = .127$, $p < .001$), but they were not significantly more likely to visit one ($r = -.022$, $p = .387$) after using Plan B.

Many women (22%) who used Plan B still had questions after taking it.

In response to a survey question asking respondents if they contacted a health care provider or pharmacist to ask more questions about Plan B after taking it the last time, 7% said “yes.” The next survey question, which was open-ended, asked all women “What, if anything, would you still like to know about Plan B?” In response, 22% of women ($n=359$) still had questions and because some had more than one, there were a total of 393 questions posed by respondents. For the analysis, responses were grouped into categories: Access, How to Use Plan B, Side Effects, How EC works and Other.

With regard to side effects, the most frequently posed questions concerned the effects of repeat use, short-term effects – including the effect on the next menses – and long-term side effects, particularly with more than one use of Plan B.

Topic Areas for Further Questions about Plan B



The access category included financial access and negative experiences with a health care provider, pharmacist, or institution. This category also included questions about OTC availability for women under 18 and lack of information about Plan B and its availability OTC. Eleven percent of the questions, in one way or another, asked why Plan B was so expensive. An additional 11 questions (3%) concerned the lack of insurance coverage for Plan B.

Questions about mechanism of action were asked in several ways. Most of these questions concerned Plan B’s effectiveness, especially for those women who had just taken it and were anxious to know if it would work. Several women had questions about the mechanism of action at different stages of the menstrual cycle.

Conflicting information about whether to take both doses at once or if doses should be taken 12 hours apart, and how many hours after sexual intercourse Plan B could be taken were categorized as “How to use EC.” In addition, we included in this category six questions concerning the use of Plan B with other methods of hormonal contraception.

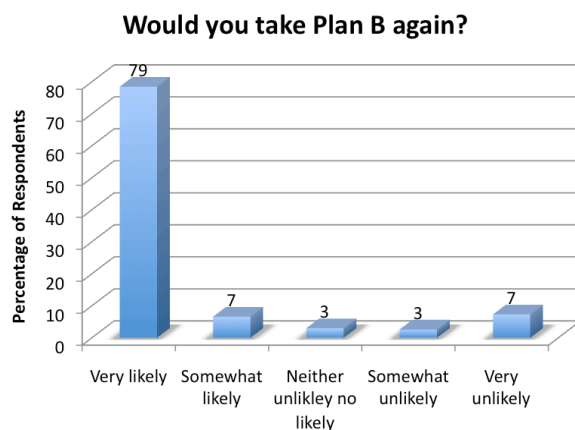
Almost all respondents (99.5%) knew that Plan B does not protect against HIV and other sexually transmitted infections.

Of the 1,486 women responding to the question, “Does Plan B protect against HIV and other sexually transmitted infections?” 1,481 (99.5%) answered “no”: six (.4%) respondents were “unsure,” and only one (.1%) answered “yes.”

Attitudes

Most women (87%) reported they would be “very likely” or “somewhat likely” to take Plan B again if they were in a situation where they had unprotected sex and wanted to prevent a pregnancy.

Eighty-seven percent of women reported that they would “very likely” or “somewhat likely” to use Plan B again; 3% reported they would be “neither unlikely nor likely;” and 10% reported they would be “somewhat unlikely” or “very unlikely” to use Plan B again.



Three-quarters of respondents (75%) supported OTC Plan B availability for women under 18 years of age.

In response to the question, “Do you think that Plan B should be available without a prescription for women under age 18?”

75% of respondents said “yes,” 11% were “unsure,” and 14% said “no.”

Most women thought that using Plan B would either not have an effect on other women’s use of condoms and/or birth control or improve it.

Prior research has suggested that women were more confident about their own responsible use of EC than that of other women. Our findings, however, showed substantial confidence in others. More than half of our respondents (56%) reported that using Plan B would not change how most other women used condoms and/or other types of birth control, and 37% thought that using Plan B would improve their use of contraception. Seven percent thought other women would use birth control and condoms “less often.”

Summary

U.S. FDA approval of Plan B as an OTC product for women (and men) 18 years and older in August 2006 marked a major milestone in the expansion of access to a means of preventing pregnancy after unprotected sexual intercourse. Plan B, with the new dual label, was shipped to pharmacies in November 2006. Other domestic initiatives to increase awareness and mainstream access were already underway when Plan B went OTC. For example, widespread availability of Plan B in family planning centers had been instrumental in increasing access. According to a report about mainstreaming EC “. . . sales of EC pills at Planned Parenthood affiliates increased by an average of 25% a year from 2001 to 2006, going from fewer than 500,000 units in 2001 to nearly 1.5 million in

2006, the latest year for which figures are available.” (p.15).¹³

Two other significant initiatives included the adoption of pharmacy access models in nine states and legislation requiring hospital emergency departments to inform women about EC and offer it to women who wanted it (15 states).¹⁴ Medicaid coverage of the OTC product (in eight states) and coverage of the prescription product also expanded access to low-income women. Professional associations and advocacy organizations undertook initiatives to increase EC awareness among health care providers and pharmacists.

While these efforts have been extremely successful, there is still more to be done. Among the barriers commonly acknowledged in the field are cost, the dual status of Plan B – which bars women under the age of 18 from purchasing Plan B OTC – and pharmacists’ reluctance to stock a product with limited demand. Health clinic staff have reported being aware of a small number of pharmacists who refuse to dispense Plan B because of personal beliefs and some instances have received much attention in the press.

This four-month study was undertaken to learn about access to Plan B from the women who used the product after it went OTC. Further, the study sought to learn about women’s experience using the product and its effect on their use of condoms and birth control.

¹³ Blomberg R (2008). *Mainstreaming Emergency Contraception: A Report on the Compton Foundation’s Emergency Contraception Initiative, 2002-2007*.

¹⁴ Legislation in one additional state requires only that information be provided.

Women between the ages of 18 and 44, who used Plan B between January 2007 and March 2008 and were living in the U.S., were recruited to respond to an online survey hosted by AED from December 1, 2007 to March 31, 2008. The 1,618 women in the final sample were mostly White, college-educated, and urban. Respondents came from every state, although women from California and New York comprised 26% of the sample. On the whole, these were likely to be women with the skills to “navigate the system” and the money to purchase Plan B.

It is unfortunate that the sample was not more diverse and that the study design did not explore language and cultural barriers nor allow us to learn about women unable to access Plan B. It is likely that the magnitude of problems experienced by the survey group would be considerably greater among women with lower incomes and less education, as well as among rural woman.

Despite these limitations, the women who responded to the survey provided an important first picture of the experiences of a large number of women at a particularly significant point in the history of EC in the U.S.

Discussion and Conclusions

This section presents the major conclusions from the study about EC access, availability, and use, as well as the ongoing challenges in these areas.

Availability

In this study, it was encouraging that 56% of women were able to use Plan B within the first 24 hours after unprotected sex, the time period when it is most effective. Most women reported being able to find Plan B in pharmacies and health centers located at a convenient distance.

However, the finding that 21% of women who purchased Plan B in a pharmacy could not find it in the first place they tried is a cause for concern.

Where Plan B was Obtained

Approximately two-thirds of women obtained Plan B in pharmacies, predominantly in chain pharmacies or pharmacies located in grocery or big-box stores. Therefore, company policies could be a more strategic focus for advocacy efforts compared to outreach to individual pharmacies. Slightly less than one-third of the women obtained their Plan B in health centers which continue to play a substantial role in regard to EC access.

Cost and Payment Methods

It is unsurprising that the most frequently cited problem women reported with regard to access was cost, which in retail pharmacies ranges from \$35 to \$60 according to the national EC website.¹⁵ Seventy-seven percent of women paid out-of-pocket at the pharmacy. Insurance coverage was minimal. Given their education level, we would have expected our respondents to have insurance coverage, but whether they did or didn't, only 6% of women reported that private insurance paid for any part of the cost of Plan B. Clearly, family planning centers, which can purchase Plan B at a reduced price (\$12.00) and allow women to pay on a sliding-fee scale, play an essential role in ensuring that Plan B is affordable.¹⁶

¹⁵

<http://ec.princeton.edu/questions/eccost.html>; accessed 7/10/08.

¹⁶ Weiss DC, Harper CC, Speidel JJ, Raine TR. (2008). "Is Emergency Contraception Cost-Effective?" Bixby Center for Global

Privacy and Confidentiality

Nine percent of respondents reported that they experienced problems with privacy and confidentiality when they obtained their last packet of Plan B. One creative strategy attempted by the Pharmacy Access Partnership and Pacific Institute for Women's Health is a "client confidentiality card" that women can hand to a pharmacist. The message on the card reads "Dear Pharmacist, I would like to obtain emergency contraception. Please help me learn about this important back-up birth control method in a confidential way. Thank you." ¹⁷

Continued pharmacist awareness-building would also help. Nevertheless, the more critical problem is that space for private interaction between consumer and pharmacist on any issue from diarrhea to HIV is at a premium in most pharmacies where space is equated with sales. Until pharmacists are reimbursed for counseling, privacy and confidentiality is likely to continue to be an issue. In the meanwhile, more creative solutions are needed.

Refusal to Dispense

The fact that one percent of the sample experienced pharmacists' refusals to dispense Plan B the last time they tried to obtain it is troubling. In our sample of women ages 18 to 44, this amounted to 20 women who encountered a situation in which the personal beliefs of a pharmacist overrode the consumer's rights. Several

Reproductive Health, University of California San Francisco;
http://bixbycenter.ucsf.edu/publications/files/sECCostEffective_2008.pdf, accessed 7/8/08.

¹⁷

http://www.pharmacyaccess.org/pdfs/CCC_ConceptPaper.pdf; accessed 7/10/08.

other women in this study mentioned that their health care provider/hospital emergency department refused to provide Plan B.

With Plan B sales in the millions of packets sold each year, the magnitude of the problem from the perspective of sheer numbers of women experiencing refusals must be addressed. Legislation and practice guidelines disseminated by state pharmacy boards are two strategies that seem to work. In New York and other states, incidents involving refusals have been effectively handled informally, on a case-by-case basis, by bringing refusals to the attention of a pharmacy board willing to intervene.

One concern voiced by EC opponents is that women will “abuse” it (i.e. use it multiple times and increase their sexual risk-taking). OTC availability exacerbated that fear. However, in our study, almost three-quarters of the women reported that they had used Plan B only once in the past year.

The issue of extent of use has arisen in states considering whether to use state dollars to cover Plan B OTC for Medicaid clients. Some states that have approved coverage limit the number of doses purchased through Medicaid in a year. A recent study of Medicaid claims for Plan B in New York in 2007, conducted by Family Planning Advocates of New York State, has demonstrated virtually the same proportionate use as found in the current study. The caps seem to be unnecessary given that 97% of women who used Plan B at all, use it one to three times in the past year.

Satisfaction with Plan B

Satisfaction with Plan B was high: 86% of the women in our sample said they would be “very likely” or “somewhat likely” to

use Plan B again if they wanted to prevent a pregnancy after unprotected sex. Two-thirds of the women had recommended it to a friend or family member.

Remaining Questions

It is noteworthy that after taking Plan B, 7% of women contacted a health care provider or pharmacist to ask follow-up questions. In addition, our question “What, if anything, would you still like to know about Plan B” elicited many additional questions about side effects, mechanism of action, and use. Women wanted to know the possible side effects and impact on future fertility with multiple use of Plan B. Women also wanted clarification about the conflicting information about the number of days after sex that Plan B is effective and whether to take both Plan B pills at once. This finding underscores the importance of having more detailed information available to women from multiple sources.

When changes in practice patterns occur, it may be useful for health practitioners and informational materials to advise women of prior practice and explain reasons for the change.

Plan B as Back-Up

Women appear to be using Plan B as a back-up method –38% used it because the condom they were using slipped or broke, 11% forgot to take their birth control pills, and 9% had some other problem with their regular birth control method. Somewhat more than one-third of the women (36%) took Plan B because no birth control was used, and 3% had no control over contraception because they were forced to have sex.

Contraceptive Use before and after Plan B

One of the most important findings of this study concerned contraception. When

reported condom use before taking Plan B was compared with current use, condom use appeared to have decreased.

However, a similar comparison showed that use of other birth control methods increased. This finding is also consistent with women's characterization of their relationship with their partners as committed or monogamous at the time they took Plan B. That is, many studies have reported that condom use tends to be lower between regular partners than with casual partners.

Eighty-eight percent of respondents reported using some form of birth control at last intercourse. Compared to use of contraception by U.S. women, Plan B users in this study were more likely to use condoms (18% vs. 44%) and less likely to use the pill (31% vs. 22%).¹⁸

Protection against HIV

With six exceptions, all the women in the sample knew that Plan B does not protect against HIV and other sexually transmitted infections.

Conclusion

In sum, this study provided a wealth of information about a large group of Plan B users during the 15 months following the availability of Plan B OTC. The online survey and electronic recruitment method worked well for college-educated women. Other study designs must be used to reach less-educated women and women without easy online access. It is also important to know what proportion of women tried, but failed, to get Plan B and gain an understanding about the barriers they faced. Finally, this study was

limited to women who were 18 years and older. It is essential to learn more about Plan B access and use among even younger women.

¹⁸ Guttmacher Institute (2008), *Facts in Brief*, Facts on Contraceptive Use; http://www.guttmacher.org/pubs/fb_contr_use.html, accessed 8/20/08.

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