"Not that sort of practice": the views and behaviour of primary care practitioners in a study of advance provision of emergency contraception

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Background. Advance supplies of emergency contraception (EC) were made available to women aged 16–29 through general practice and family planning services in Lothian, Scotland. Although this intervention was not associated with an overall reduction in abortion rates in Lothian, it was hypothesized that some general practices may have been more successful than others in promoting and delivering the intervention.

Objective. To investigate, using comparative case studies, whether, and why, some general practices were more successful in promoting and delivering advance supplies of EC than others.

Methods. Eleven purposively sampled general practices from the 97 participating in the intervention were studied. The number of packs of advance supplies distributed was recorded and distribution rates per 100 eligible women per practice calculated. 44 semi-structured interviews with staff were used to describe the mechanisms through which advance supplies were distributed and health professionals’ views of the intervention.

Results. Distribution rates varied from 0.9 to 32.0 per 100 eligible women. Respondents described three mechanisms through which advance supplies were distributed: passive, reactive and proactive. Views about EC, and the suitability of their patient population for advance supplies, varied and configured specific practice contexts that facilitated or hindered the delivery of advance supplies. Favourable views and proactive mechanisms were associated with higher distribution rates, less favourable or ambivalent views and passive delivery mechanisms with lower distribution rates.

Conclusion. If primary care professionals are to actively engage with a sexual health promotion agenda they need to develop appropriate interpersonal skills and address their values, attitudes and cultural competences.

Keywords. Emergency contraception, advance provision, primary care, case studies, professionals’ views and behaviour.

Introduction

Rising abortion rates throughout the world have made unintended pregnancy an important public health problem and a reduction in these rates is a key aim of the UK government’s sexual health strategy. Emergency contraception (EC) is seen as an important plank in strategies to prevent unintended pregnancy, yet it is not very widely used. Limited availability of GP appointments, restricted opening times of specialist clinics, and women’s fear of judgmental attitudes from health professionals when requesting it are all reported to curtail women’s use of EC and have prompted recent relaxation of restrictions on its provision in the UK. EC can now be purchased in UK community pharmacies at the cost of approximately £24. However both professionals and users remain ambivalent about making EC available in this way, fearing that its provision without attendant advice about safe sex and longer term contraception will lead to its misuse, overuse or abuse. Making EC available through routine primary care services in advance of need at no cost offers the prospect of circumventing many of the access issues which have
previously impeded its use whilst maintaining the advantages of providing it within the context of wider health care provision.

The Lothian Emergency Contraception Project—an initiative that aimed to increase access to EC with a view to reducing abortion rates—made multiple courses of hormonal EC available to women aged 16–29 years in advance of need through existing primary care services in Lothian, Scotland. The project, described in greater detail elsewhere, ran from September 1999 to December 2001. Eligible women were invited to ask for project packs of 5 courses of EC from their general practices and other participating centres (family planning clinics, hospital gynaecological and genito-urinary medicine departments and Brook Scotland, a non-statutory sexual health service for young people) and health professionals working at participating centres were encouraged to offer advance supplies to eligible women.

The project was not associated with a reduction in overall abortion rates in Lothian. However, the outcome of any health intervention depends not only upon the effectiveness of the intervention (in this case advance provision of EC) but also upon the effectiveness of its implementation. In an earlier paper we suggested that health professionals in primary care were generally ineffective in promoting and delivering the intervention to the women most in need of it, and that inadequate distribution of project packs of EC may have been partly responsible for the overall failure of the Lothian Emergency Contraception Project to be associated with a reduction in abortion rates. However there was wide variation in the number of packets distributed by each general practice suggesting some practices were more effective than others in implementing the intervention. This paper aims to investigate whether, and why, some general practices were more successful in promoting and delivering advance supplies of EC than others. Specifically, we investigated two main hypotheses based on the existing literature on professionals’ views of EC, and on our knowledge of the local provision of contraceptive services in Lothian. These were:

As GPs are generally wary of EC as a means of contraception in the longer term, and treat EC as an anomaly in the repertoire of approaches to family planning, health professionals’ views of EC and advance provision would form important facilitating or hindering contexts for whatever mechanisms were used to deliver the project; and Because of different levels of enthusiasm for the project, and existing differences in the way in which contraceptive services were delivered, practices were likely to adopt different strategies to deliver the advance supplies of EC to eligible women, and these would contribute to variation in distribution rates of advance supplies between practices.

Methods

Methodological approach
The data on which this paper draws were gathered through an evaluation of the Lothian Emergency Contraception Project using a comparative case study design within a framework of ‘realistic evaluation’. This framework suggests that the outcomes of interventions can be explained by the action of particular mechanisms within particular contexts and that the crucial task is to investigate, through hypothesis making and testing, the extent to which the context enables or disables the mechanisms for delivering the intervention.

Sample selection
At the outset 11 case study general practices were selected from the 97 practices in Lothian participating in the Lothian Emergency Contraception Project. Sampling was purposive to include practices serving populations with a range of socio-economic backgrounds, in varying geographic locations and with a range of enthusiasm for the project. Practices were categorised as ‘very enthusiastic’ if they responded to the first invitation to participate in the project, ‘moderately enthusiastic’ if they responded to the second invitation and ‘unenthusiastic’ if they agreed to participate only following a personal approach from the investigator. Later in the evaluation further theoretical sampling took place so that we could pursue analytically important distinctions between practice contexts. For example, an explanatory proposition emerged in the early case studies that the intervention might be most relevant, and distribution rates higher, in very deprived populations, which were not represented in our initial sampling, and in student populations. In order to test these predictions a student health service, and a practice in the most deprived area of the city were also studied. Two of the initial sample of 11 practices dropped out from the case study evaluation: one in an urban location with a deprived population, and one in an inner city location with a socio-economically mixed population.

Data collection

Outcomes. The outcome used in this paper is practice distribution rates of advance supplies of EC per 100 eligible women. Each practice provided data on the number of women aged 16–29 years registered with them. The number of project packets distributed by each practice was recorded centrally.

Mechanisms and contexts. In semi-structured interviews that covered approaches to the delivery of advance supplies, views about EC, the project and experience of participating in it, health professionals described the mechanisms that were used to deliver packets of advance supplies of EC to women in their practice. They described both their own and, as far as they could,
colleagues’ approaches. Their views of EC in general, and of the project in particular, were analysed as contextual factors that hindered or enabled approaches to distribution. Forty-four interviews in the 11 case study general practices were undertaken by PS between November 2000 and June 2001. At least one doctor and one nurse were interviewed in each practice.

**Analysis**

Interviews were audio-tape recorded and transcribed verbatim. In order to develop and test an analytical framework, all authors read a sample of transcripts. PS and KF examined all the transcripts, and identified broad themes within the data. These reflected the original hypotheses to be tested in the evaluation and included views about EC, views about and experience of contraceptive provision more generally, views about the intervention, ways in which the intervention was delivered, and the experience of offering EC to keep at home. The sections of interviews relating to each of the themes were then examined in detail to identify emergent categories within the data. The perceived suitability of the practice population for home supplies of EC was an emergent category. Views about the safety of EC, and of its status as contraception emerged in the theme ‘views of EC’. The transcripts were loaded into the qualitative data analysis computer package QSR Nvivo and the coding framework was applied to all transcripts. Further analysis involved comparing all the transcripts of interviews at each case study site to identify the prevailing contexts within each practice, and their approaches to distribution of project packs of EC. Deviant cases were explicitly sought and explored within the data as it was considered that these would help explain differences in outcomes.

**Results**

**Outcomes**

Distribution rates for project packets among eligible women varied between practices (see Table 1), with a range from 0.9 per 100 eligible women to 32.0 per 100. For the purpose of this analysis distribution rates of 20.0 per 100 or more were categorised as ‘high’, 5.0 per 100 to 19.9 per 100 as ‘moderate’, and less that 5.0 per 100 as ‘low’.

**Mechanisms—the approaches to the delivery of advance supplies of EC in the sites studied**

Practices employed three mechanisms—passive, reactive and proactive—for the delivery of advance supplies of EC. Passive mechanisms involved giving out project

<table>
<thead>
<tr>
<th>Practice</th>
<th>Mechanism</th>
<th>Context 1: professionals’ views of EC</th>
<th>Context 2: professionals’ perception of practice population</th>
<th>Outcome: distribution rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Pro-active</td>
<td>Facilitative</td>
<td>Organised and responsible</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Could be in need of EC</td>
<td>32.0/100</td>
</tr>
<tr>
<td>5</td>
<td>Pro-active</td>
<td>Ambivalent</td>
<td>Organised</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not in need</td>
<td>26.1/100</td>
</tr>
<tr>
<td>7</td>
<td>Pro-active</td>
<td>Facilitative</td>
<td>Organised</td>
<td>High</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>In need</td>
<td>22.7/100</td>
</tr>
<tr>
<td>6</td>
<td>Pro-active</td>
<td>Facilitative</td>
<td>In need</td>
<td>High</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Young</td>
<td>20.9/100</td>
</tr>
<tr>
<td>9</td>
<td>Reactive</td>
<td>Ambivalent</td>
<td>In need</td>
<td>Moderate</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Young and chaotic</td>
<td>14.1/100</td>
</tr>
<tr>
<td>4</td>
<td>Reactive</td>
<td>Ambivalent</td>
<td>Not in need</td>
<td>Moderate</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Organised</td>
<td>13.7/100</td>
</tr>
<tr>
<td>13</td>
<td>Reactive</td>
<td>Ambivalent</td>
<td>In need</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non chaotic</td>
<td>11.0/100</td>
</tr>
<tr>
<td>14</td>
<td>Reactive</td>
<td>Ambivalent</td>
<td>In need</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>But not priority</td>
<td>11.0/100</td>
</tr>
<tr>
<td>2</td>
<td>Reactive</td>
<td>Ambivalent</td>
<td>Not in need</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Organised</td>
<td>2.1/100</td>
</tr>
<tr>
<td>11</td>
<td>Passive</td>
<td>Non-facilitative</td>
<td>Not in need</td>
<td>Low</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Organised</td>
<td>1.3/100</td>
</tr>
<tr>
<td>3</td>
<td>Passive</td>
<td>Non-facilitative</td>
<td>Need unassessed</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Chaotic</td>
<td>0.9/100</td>
</tr>
</tbody>
</table>
packs only in response to a direct request from women. For example:

“We’ve had very little of that (request for advance supplies), I think that’s why we’ve found it very difficult to participate in the project is that very few people have actually said they’ve seen some publicity and would like it.” GP1 practice 11

Reactive mechanisms involved offering advance supplies when women presented with an immediate need for EC or presented ostensibly to discuss contraception. Although this strategy involved an element of pro-activity in that the health professional advocated the project within the consultation, it was prompted by the patient’s agenda in the consultation.

“Most times I’ve given it out it has been something to do with contraception or that sort of side of things you know, it hasn’t been a 16 year old coming through the door with a sore ankle or a headache and I’ve said ‘think about this as well’, probably because of time restraints. You’ve got so many other things to do as well so maybe its not the most appropriate place to deliver that kind of thing as well, you know where there’s so many other things happening during a consultation.” GP1 practice 9

Pro-active mechanisms involved the offer of packs to women regardless of the nature of the consultation. This approach involved health professionals predicting or acknowledging a woman’s potential future need for EC.

“There are various reasons they come to their GP, not all of which would necessarily be easy to bring emergency contraception into the story, but I know that one of the partners has made a, not made a habit, has decided to do that on quite a few, with quite a few people who are in for other reasons, so he’s been particularly positive in that way, whereas I think the others of us have tended to wait for the actual triggers in the consultation.” GP1 practice 8

At an individual level this approach was conditional upon finding an appropriate space and sufficient time within a consultation to offer project packs. The circumstances in which the consultation was most likely to afford such space included discussion of a topic to which the issue of EC could be linked. To this end, opportunities such as routine cervical smears were most often cited, but some health professionals felt able to make an offer in relation to discussions as diverse as holiday and travel advice or general discussions of life events that might include talk of relationships, or at new patient registration appointments. Professionals often reported that the time constraints of routine ten minute consultations prevented them from adopting more pro-active strategies within consultations.

Pro-active organisational strategies at a practice level were used by only 2 practices. One practice flagged the notes of eligible women to trigger the offer in routine consultations and another practice wrote to all eligible women encouraging them to make an appointment to collect their advance supplies of EC.

**Contexts—facilitating factors or barriers to distribution of supplies**

The specific practice contexts within which the Lothian Emergency Contraception Project operated seemed to be figured by health professionals’ views. Firstly, and as we hypothesized, their views about the nature of EC and its place within the family planning repertoire and, secondly, and unanticipated by us at the outset of the evaluation, about the suitability of their patient population for home supplies.

Facilitative views of EC—where it was seen as both safe and a proper contraceptive solution—were uncommon, as were overtly non facilitative views of EC as both risky to physical health and morally jeopardising. Most commonly professionals held ambivalent views of EC, regarding it as a generally safe method, but seeing its promotion as potentially contradictory of safe sex messages and responsible, planned contraception.

“This idea of having a lot of packets to use for emergencies just in case I think, is still a little alien, I think we’d still be preferring to help people to think more pro-actively and prevent.” GP1 practice 11

Therefore, as in previous research, EC generally maintained an anomalous position within a wider repertoire that favours planned and pre-emptive strategies in contraception.

The suitability of a practice population for advance supplies of EC was influenced by their perceived need for EC and the extent to which they were considered organized or chaotic in their use of contraception. Professionals reported a high level of need in their populations when they perceived high termination of pregnancy rates. Populations which were perceived as young and/or deprived were routinely characterised as most in need.

“I think our teenage girls are daughters of working class people at this stage, . . . The girls I’ll see in my view who’d benefit from this kind of programme very much are working class, probably you know starting to have sex quite young as well and therefore a good captive audience if you can get through to them, you know.” GP 1 practice 9

Yet more socio-economically advantaged populations were seen as more likely to be sufficiently organized to use advance supplies appropriately.

“I think the women who is educated, maybe middle class, I think these women are maybe more likely to take advantage of this initiative than some of the types of people that we see in this practice, who perhaps aren’t as aware, that this initiative is actually taking place for whatever reason, or, em,
don’t feel that they can take that control over their... eh they need somebody else to say to them, this is what you should do, so I think a lot depends on the women themselves.” PN practice 2

Table 1 illustrates how practice contexts and delivery mechanisms interacted to determine distribution rates. Facilitative contexts and adoption of pro-active mechanisms were associated with higher distribution rates. Practices with lower uptake rates were characterized by non facilitative or hindering contexts and passive delivery mechanisms. Boxes 1–3 summarise the interplay between practice contexts, delivery mechanisms and distribution rates for 3 of the cases.

Discussion

There was a 35-fold difference in distribution rates between the most effective and least effective practices in our evaluation. In their interviews health professionals reported that women rarely asked for advance supplies of EC despite extensive advertising of its availability. Distribution rates were therefore dependent upon the actions of health professionals in giving out advance supplies to eligible women. Our hypotheses that their views of EC would form important contexts for the delivery of advance supplies, and that different approaches to delivering the intervention would contribute to variation in uptake, measured by distribution rates, were upheld by the analysis presented here. Professionals’ views about EC were generally consistent with those reported elsewhere in that most felt ambivalent about its use. However we have shown that where professionals’ views were discrepant with those previously reported, that is they held overtly positive or negative views about EC, they configured specific practice contexts and mechanisms for delivery of advance supplies that were associated with either
high or low distribution rates. We also found, unexpectedly, that professionals’ views of the suitability of their practice population for advance supplies may have influenced their approach to delivery. For example even where unintended pregnancy rates were perceived to be high, and the need for EC great, distribution was stifled by perceptions of the practice population as too chaotic to use advance supplies appropriately.

Distribution strategies in which there was a degree of pro-activity from professionals were most effective. However pro-active approaches were rare. Only when professionals held positive views about EC, and saw advance provision of EC as both necessary and desirable in the provision of relevant care for women registered with their practice would the mechanisms for pro-active distribution become more clearly developed.

Reticence to pro-actively distribute supplies appeared to stem partly, as we hypothesized, from professionals’ ambivalent views about EC and partly from perceptions that their practice populations were either not in need of advance supplies or unlikely to use them appropriately. Overtly negative views of EC were associated with passive approaches to distribution of advance supplies which effectively disabled the intervention.

The study does have limitations. The comparative case study included only 11 general practices. Purposive sampling ensured as far as possible that practices with varying characteristics were included in the evaluation, and when specific characteristics were revealed to be missing from the original sample of practices, two other practices were sampled and included in the evaluation. However, whilst all professionals in the case study practices were invited to be interviewed, not all were. It is possible that the respondents did not fully represent the views within their practice and that we have therefore suggested a homogeneity in practice response to this intervention where there was none. Nevertheless this study is unique in that it demonstrates how professionals’ views about EC, and the women in their practice, may have influenced the delivery of advance provision of EC and may have resulted in women at most risk of unintended pregnancy not receiving advance supplies.

What are the implications of these analyses for primary care based advance provision of EC? All of the practices agreed to take part in the Lothian Emergency Contraception Project which required practices to agree to give out advance supplies to women who requested them. Beyond this it was left to each practice to decide who else to offer project packs of EC to and how to do this. Even the most enthusiastic practices encountered barriers to distributing the packs, while professionals who were lukewarm about advance supplies of EC simply did not actively distribute them. It is not surprising that doctors’ and nurses’ behaviour is influenced by their interests and enthusiasms. However unwanted pregnancy is an important public health problem for which EC is seen as a potential solution and if primary care practitioners are not able to productively engage with this agenda alternative strategies may be sought which bypass primary care altogether. This has consequences for delivering the sort of consistent and

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**Box 3** Practice 2: ‘low’ distribution rate

<table>
<thead>
<tr>
<th>Setting</th>
<th>Contexts: professionals’ views</th>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 partner inner-city practice</td>
<td>EC not ‘proper’ contraception.</td>
<td>Passive. Offered supplies only in response to direct request for advance supplies.</td>
<td>0.9/100</td>
</tr>
<tr>
<td>1 practice nurse</td>
<td>“It’s a stop gap, fill in and they should really think about more permanent measures.” PN</td>
<td>“We haven’t had very much uptake at all and we haven’t actively promoted it, so we haven’t been going out and offering it and I can honestly say only about 6 people have asked for it.” GP1</td>
<td></td>
</tr>
<tr>
<td>1 health visitor</td>
<td>Physically risky: “Well it’s a pretty high dose pill, it’s not exactly brilliant for the cardiovascular system to keep on taking it.” GP1 Morally jeopardising: “I think if somebody’s relying on packs of the morning after pill, I think they’re possibly a bit more chaotic in their outlook.” GP2 Practice population unsuitable for advance supplies: “Some of the types of people we see in this practice don’t feel they can take control over their (lives). They need somebody to say to them this is what you should do.” PN</td>
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</table>
integrated sexual health services seemingly preferred by some women and professionals. It seems unlikely that primary care health professionals who have been ineffective in delivering this intervention would be able to adopt more pro-active approaches to advance provision of EC in the future unless there is a commensurate shift in their values and attitudes that form such an important part of the context within which they are working.

The research presented here highlights the difficulties of implementing an intervention at practice level without attending beforehand to the complex contextual factors that mediate its delivery to the target population. Furthermore it suggests that, at present, existing values and competences in many general practices may act as a context that is generally non-facilitative of radical sexual health initiatives. If primary care professionals are to actively engage with a sexual health promotion agenda they need to develop appropriate interpersonal and communication skills and address their own values, attitudes and cultural competences. In particular the use of small amounts of time—the most valuable of all resources in general practice—in addressing sexual health promotion must be seen as valuable and relevant and without significant opportunity costs. This might require both re-conciliation between an ethos of personal care and a public health driven agenda, and an improvement in sexual health training in undergraduate medical and nursing curricula and postgraduate training which allows practitioners to feel comfortable broaching sexual health issues in routine consultations.

Declaration

Funding: Wellcome Trust.
Ethical approval: Lothian Local Research Ethics Committee.
Conflicts of interest: none.

References