

February 2011

Decreasing Unwanted Pregnancies by Increasing Use of Emergency Contraceptive Pills (ECPs): A Leadership Approach

Kara McGinnis

Follow this and additional works at: <https://digitalcommons.unf.edu/fphr>

 Part of the [Public Health Commons](#), and the [Social and Behavioral Sciences Commons](#)

Recommended Citation

McGinnis, Kara (2011) "Decreasing Unwanted Pregnancies by Increasing Use of Emergency Contraceptive Pills (ECPs): A Leadership Approach," *Florida Public Health Review*: Vol. 8 , Article 5.
Available at: <https://digitalcommons.unf.edu/fphr/vol8/iss1/5>

This Article is brought to you for free and open access by the Brooks College of Health at UNF Digital Commons. It has been accepted for inclusion in Florida Public Health Review by an authorized administrator of UNF Digital Commons. For more information, please contact [Digital Projects](#).

© February 2011 All Rights Reserved

Decreasing Unwanted Pregnancies by Increasing Use of Emergency Contraceptive Pills (ECPs): A Leadership Approach

Kara McGinnis, BA

ABSTRACT

Unwanted pregnancies burden the U.S. healthcare system, as well as create challenges for women, families, and children. Emergency contraceptive pills (ECPs) can prevent a large percentage of unwanted pregnancies if used appropriately. Factors contributing to non-use of ECPs include the negative social environment created by views on sexual health, misunderstanding concerning the mechanism of action, women's misperceptions of their risks of getting pregnant and how ECPs work, barriers to obtaining ECPs, and lack of counseling about ECPs from healthcare providers. Leadership is needed to address these factors contributing to the problem. Health educators are in a unique position to lead the field in preventing unintended pregnancies through increasing the use of ECPs, because of their expertise in education, health literacy, and sexual health. Following the five leadership practices of Kouzes and Posner can guide health educators to improve the situation of unwanted pregnancies at the local level.

Florida Public Health Review, 2011; 8, 25-30.

Background

Unplanned pregnancies are a major issue in the United States, with two-thirds mistimed and one in three pregnancies classified as unwanted (The National Campaign to Prevent Teen and Unplanned Pregnancy [The National Campaign], 2007). These pregnancies result in over 1.3 million abortions a year and over half a million children born unwanted, or to parents who were not intending to *ever* have (more) children (The National Campaign, 2007). These pregnancies place burdens on the health care systems, women, families, and the children who are sometimes born into adverse situations. Unlike assumptions that place the blame of unintended pregnancies on young people, women of all ages are facing unintended pregnancies, with rates of unintended pregnancies increasing between 1994 and 2001 (The National Campaign, 2010). Emergency contraceptive pills (ECPs) could prevent 75% of unplanned pregnancies if used effectively (Trussell, Stewart, Guest, & Hatcher, 1992). However, since their debut in the United States, ECPs have faced controversies over their mechanism of action, age discrimination, user confusion on when and how to use them, and a lack of provider initiative to learn about and counsel women to use them. Compounding these issues, women who are having unintended pregnancies are lacking basic knowledge of what puts them at risk for a pregnancy. Health educators have an opportunity to step up as knowledgeable leaders to initiate action towards stopping unintended pregnancies with the aid of ECPs. Using the framework of leadership as described by Kouzes and Posner (1995), health educators can lead the field in the prevention of

unwanted pregnancies, beginning at the local level. This paper explains the significance of unwanted pregnancies, factors contributing to the problem, and leadership implications for health educators.

Significance of the Problem

Unplanned pregnancies are a major burden on individuals and the healthcare system. Almost half of all pregnancies in the United States are unplanned (Jaccard, 2009) and disproportionately affect women who are young, unmarried, poor, less educated, and members of minority groups (Kuroki, Allsworth, Redding, Blume & Peipert, 2008). Unplanned pregnancies include those that are unintended *ever*, ones that are aborted, those that are miscarried but not planned, and ones mistimed. Pregnancies that are unplanned, especially those that are unwanted, defined as those born to women who are never intending to have a child again, often end in abortion or can have serious repercussions for the child.

Unplanned pregnancy rates are still high despite growing numbers of contraceptive methods and campaigns to reduce unwanted pregnancies. Whereas teenagers are often assumed to be the largest proportion of unplanned pregnancies, in reality, it is those between the ages of 20 and 24 (The National Campaign, 2010). Additionally, whereas 38% of all unplanned pregnancies are to unmarried women ages 20-29, 30% of unintended pregnancies occur with *married* women (National Campaign, 2010). The issue of unplanned pregnancies is one that is affecting women of all reproductive ages, and not isolated to younger, immature women as commonly misperceived.

Florida Public Health Review, 2011; 8:25-30.
<http://health.usf.edu/publichealth/fphr/index.htm>

25

In 2001, there were over 3 million unplanned pregnancies out of a total of 6.4 million pregnancies (The National Campaign, 2010). Of these, over 2 million, or *1 in 3* pregnancies are classified as unwanted (The National Campaign, 2007). The National Campaign (2010) found that the rate of unwanted pregnancies increased between 1994 and 2001 for all age groups except for teenagers. These unwanted pregnancies resulted in 1.3 million abortions (42% of all pregnancies) and about 567,000 births to women who did not ever intend to have another child (The National Campaign, 2007).

Mothers

Unwanted pregnancies can be unexpected challenges for women facing financial, familial, and/or social challenges. There may be a correlation between unplanned pregnancies and depression, anxiety, and a decline in psychosocial well-being (Gipson, Koenig, & Hindin, 2008). Of the women who choose to follow through with the pregnancy they are less likely to obtain timely prenatal care and research is unclear as to whether those mothers successfully discontinue negative behaviors (e.g., smoking or drinking) and whether they successfully begin healthy habits like taking vitamins (Logan, Holcombe, Manlove, & Ryan, 2007). Additionally, women who have a child due to an unwanted pregnancy report more relationship changes within five years of the birth than women with intended pregnancies and are more likely to encounter physical abuse (The National Campaign, 2008).

Children

Children born as a result of an unintended pregnancy have poorer physical and mental health, poorer relationship with their mother, poorer educational attainment, lower cognitive test scores, and higher rates of adolescent delinquency (Holcombe, et al., 2007; The National Campaign, 2008). Many of these issues are compounded by the fact that many unintended pregnancies occur to unmarried women, and children of single-parent households are more likely to drop out of school, become teen mothers, have higher rates of divorce, and be poor (The National Campaign, 2008).

Factors Contributing to the Problem

Whereas using contraceptives ahead of time is the ultimate goal for reducing unplanned pregnancies, the use of ECPs could help provide women with an alternative means of preventing unintended pregnancy after risky behavior or barrier malfunction. The use of ECPs could prevent 75% of unintended pregnancies (Trussell, et al., 1992). Unfortunately, the numbers of unintended pregnancies have not to date correlated with increased access to ECPs. Many issues exist that create challenges for women to access and successfully use ECPs, including US culture,

Florida Public Health Review, 2011; 8:25-30.
<http://health.usf.edu/publichealth/fphr/index.htm>

confusion over the mechanism of action, women not knowing they are at risk for a pregnancy, difficulties getting it, and lack of provider counseling.

U.S. Culture

An American culture surrounding female rights, sex, sexuality, and promiscuity has defined the backdrop of the use of ECP. As Wynn, Erdman, Foster, and Trussell (2007) note, unintended pregnancies, unprotected sex, and even things like ECP are framed as a public health problem needing "harm reduction." This is in contrast to other industrialized countries that frame these issues as "women's rights" and where ultimately, we see a supportive environment with less unintended pregnancies and risky behaviors (Wynn, et al., 2007). By creating a structural "problem" of sexual health as being unhealthy in almost any circumstance, Americans have designed a world where those seeking to plan their lives or have nontraditional sexual encounters are in most cases looked upon as deviant. This status creates social stigmas, limited educational opportunities and outright discrimination towards some groups trying to access education, services, and products.

Mechanism of Action

Stemming directly from inherent cultural barriers in the U.S., the fear of abortion and the labeling of a fetus as a living child inhibit many women from learning about or using ECP. Although conception is defined medically when a fertilized egg is *implanted* in the uterus, religious, moral and societal groups have equated conception with fertilization (Allen & Goldberg, 2007). Additionally, there is confusion in the scientific world as to how ECP actually works. The strongest evidence points to the primary mechanism as prevention of ovulation and the secondary mechanism as limiting the movement of the sperm through the cervix (Allen & Goldberg, 2007). Neither of these mechanisms would prohibit an already fertilized egg from possibly implanting or a pregnancy from continuing safely. Current data are unable to disprove conclusively that a fertilized egg might be hindered during implantation, but most studies do not believe that the ECP will prevent a fertilized egg from implanting (Pitts & Emans, 2008; Allen & Goldberg, 2007). Still, confusion in the scientific world over the mechanism of action and political and moral controversies in the social world over rights of the fetus have been factors in women's usage of ECP.

Women's Knowledge and Beliefs

The literature on who is using ECP and why, as well as who is not using ECP and why is very minimal. This is especially problematic as ECP became available over the counter for women 18 and over in 2006, with limited research on the implications. Research does indicate that as a woman's knowledge of ECP increases, so does her

usage (Whittaker, Berger, Armstrong, Felice, & Adams, 2007), and that women who used ECP were most likely to do so because their usual method had failed, followed by they were not using protection (Kavanaugh & Bilma Schwarz, 2008; Phipps, Matteson, Fernandez, Chiaverini, & Weitzen, 2008; Rocca, et al., 2007; Hoades, 2005). However, what has important implications for public health education is that of the few studies who have looked at why women were not using contraception before having an unintended pregnancy, women's most common answer was that they did not believe they were at risk of getting pregnant (Allen & Goldberg, 2007; Polis, et al., 2007; Raymond, Trussell, & Polis, 2007; Rocca, et al., 2007; Nelson 2006), citing reasons such as withdrawal, health problems, menstruating, and other misconceptions (Nelson, 2006). This alarming finding has received little attention and indicates a major gap in education.

Difficulties Obtaining ECP

There are many barriers for a woman receiving ECP in the United States including age, cost, stigma, and pharmacist refusal. In 2006 ECP went over-the-counter, but in reality they remain "behind-the-counter" as women (or men) need to show proof that they are over 17 to purchase ECP. While ECP is safe for all users, this was a policy regulation that was unfounded in facts (Harper, Weiss, Speidel, & Raine-Bennett, 2008). Although many teens have friends or family who could purchase ECP for them, the need for a prescription might limit a teenager from trying to access this contraceptive. Additionally, ECP can be costly depending on where a woman goes, and cost as a barrier has been under-examined. Research supporting this assumption occurred in California where ECP usage rose 88% when insurance companies covered the full cost of ECP (Postlethwaite, Trussell, Zoolakis, Shabear, & Petitti 2007). Stigma, shame or embarrassment can also prevent women from visiting a pharmacy or clinic to receive ECP (Mollen et al., 2008; Raymond, et al., 2007). This may reflect larger cultural barriers in the US or the additional barrier of pharmacist refusal. In many states in the US, individual pharmacists can refuse to fill a prescription for ECP if it is against their beliefs. However, the issue is more complicated. As Richman (2008) found, pharmacists were uncomfortable not only for personal belief reasons, but because they were unsure of the mechanism of action, if a woman was repeatedly using ECP, the age requirement, perceptions of individual women, and potential side effects. These difficulties to obtaining ECP represent factors as to why it is not being used sufficiently to help prevent unintended pregnancies; they also highlight important areas that health educators can contribute their knowledge and expertise.

Lack of Provider Counseling

A final factor influencing why women may not be turning to ECP to help prevent unwanted pregnancies is the lack of provider counseling. Limited counseling for child-bearing women has been noted for providers in urgent care settings (Bilma Schwarz, Gerbert, & Gonzalez, 2007), emergency rooms (Kavanaugh, Saladino & Gold, 2007), pediatric residents (Updahya, Trent, & Ellen, 2009), staff at Title X funded clinics (Whittaker, et al., 2008), physicians (Xu, Vahratian, Patel, McRee, & Ransom, 2008), and obstetricians/gynecologists (Kavanaugh & Bilma Schwarz, 2007; Xu et al., 2008). This is unfortunate because women who are counseled by a provider or healthcare staff member are more likely to obtain correct information and increase their use of ECP (Kavanaugh & Bilma Schwarz, 2008; Whittaker, et al., 2008; Fagan, Boussios, Moore, & Galvin 2006). Additionally, 89% of women in one study preferred to learn about ECP from a healthcare provider (Fagan et al., 2006). Unfortunately, a further study found that 50.6% of physicians reported never having discussed ECP with their sexually active female patients, and claimed the reason for that was that patients did not ask them about it (Xu et al., 2008). This lack of initiative by providers and healthcare workers may be playing a large role in perpetuating the stigma that surrounds ECP as well as contributing to the misunderstanding and lack of use by women and couples. These missed opportunities by providers may translate into an area where health educators can fill in the needed information.

Implications for Leadership

Leadership is needed in public health to overcome these barriers and help women decrease risky intercourse, recognize risky sexual behaviors and understand their options for pregnancy prevention after the fact. ECPs could provide millions of women with an alternative solution to an unwanted pregnancy, but only limited interventions and marketing have been done to reach women. As many of the barriers can be minimized with better education, awareness and counseling, health educators are in a unique position to address this issue through their expertise in education, health literacy, and sexual health. Whereas this guideline is intended to be used at the local level, it could easily be broadened to the state, regional, or national level.

Although leadership may seem intimidating, any professional that is passionate about this topic, willing to follow the guidelines below, and ready to work hard to challenge the status quo is in the right position to emerge as a leader. Any public health professional poised to create change should be encouraged to see him/herself as a leader and strive to embrace that identity. Kouzes and Posner (1995)

offer five leadership practices and ten corresponding leadership commitments that are useful starting points for a public health practitioner to accept a leadership role to head the fight to reduce unplanned pregnancies through increased ECP.

Challenge the Process

Something must be done to prevent these unwanted pregnancies, as the status quo is obviously doing nothing to affect the rate of unwanted pregnancies.

- *Search for Opportunities.* The opportunity to eliminate these unwanted pregnancies is here; ECP is an effective way for women to prevent unwanted pregnancies after a risky sexual behavior, and more women need to understand when they are committing risky behaviors.
- *Experiment and Take Risks.* A public health leader needs to try new methods to encourage ECP use, as nothing currently working seems to be helping. Some ideas include public awareness campaigns of the how ECP actually works, public awareness campaigns of how to know you are at risk for a pregnancy, new health education materials available to all child-bearing women about ECP and risky sexual behaviors, awareness about which insurers will pay for ECP, and increased counseling either through health educators or through training providers to deliver the information. Long-term goals could also include policy changes regarding the age of over-the-counter ECP usage and reducing the need for ECP by increasing the use of preventative contraceptives.

Inspire a Shared Vision.

As a leader, a health educator will have to create an inspiring vision of what the world could look like.

- *Envision the Future.* The leader needs to design a vision that: (1) gives all women access to contraception and power over their sexual health and (2) guarantees that all children are wanted and welcomed.
- *Enlist Others.* No leader can stand alone, and there are some promising avenues of support that could aid a health educator in fulfilling the task of eliminating unwanted pregnancies. First, looking to organizations with similar missions, such as the National Campaign. These groups can help to bolster community awareness and provide formative data. Even if a leader is looking to begin locally, partnering

with national organizations can provide a good backbone and increase credibility. Second, healthcare providers and staff would benefit from participation in an effort to prevent unwanted pregnancies through ECP, as they would be able to help more women prevent and plan pregnancies, educate them about their options, and empower them to make better decisions. Finally, other public health practitioners could be used to help design social marketing campaigns, health education materials, and trainings for providers and staff who regularly see women of childbearing age.

Enabling Others to Act

Leaders inspire change by giving people the reigns and entrusting them to succeed. However, it is not easy for people to take initiatives without support.

- *Foster Collaboration.* Leaders can encourage the people they enlist to help to use each other as resources. Creating a wiki, sending a monthly newsletter with updates and keeping a list of partners accessible to each participant can help people reach whom they need to reach quickly and help to encourage action through the successes of others.
- *Strengthen Others.* Designing and providing educational materials, training programs, and if possible wider public awareness campaigns can help to keep the initiative going. Leaders need to keep their partners up to date with new statistics, ideas, and materials that all work towards a common goal – decreasing unwanted pregnancies by increasing ECP use. Having these materials on hand and a discourse in the public will hopefully encourage more providers and staff to talk to women and more women to ask questions.

Modeling the Way

Kouzes and Posner (1995) emphasize that their five practices are founded on the concept of credibility. Nothing is more credible than others seeing how hard you work and how much you care about the vision.

- *Set the Example.* Regularly participate in larger meetings with all of your partners, frequently update the newsletter or wiki yourself, conduct some of the trainings, and find ways to educate people about the issue in your everyday life.

- *Plan Small Wins.* Considering that two major factors contributing to not using ECP included: women were unaware they were participating in risky sex and women were confused about the mechanism of action, some small wins would be the creation of educational materials in the form of pamphlets, short internet videos, and posters that addressed this lack of knowledge. Also, designing a short training program, either in person or online to help providers and staff know that they can help unwanted pregnancies by spending an extra few minutes talking to women about risky behaviors and ECP. Most importantly, let providers know that the highest predictor for using ECP was counseling by a provider or at a clinic, and that women wanted to hear from them (Kavanaugh & Bilma Schwarz 2008; Whittaker et al. 2007).

Encouraging the Heart

Leaders will fail if they do not continually recognize all of the people that are helping them achieve their vision.

- *Recognize Individual Contribution.* Even if the emphasis is on group or team effort, individuals make things happen.
- *Celebrate Accomplishments When They Occur.* Give certificates to providers and staff who finish trainings, thank colleagues who help design educational materials with small parties, acknowledge everyone and every group who does something great on the newsletter, and most importantly encourage anecdotal stories from providers or educators who have had a patient tell them that they made a difference.

Challenging the status quo, inspiring vision, enabling others to act, modeling the way, and encouraging the heart are five practices that set apart a well-intentioned and hard-working educator from a public health leader. A leader must be not only willing to follow these practices, but be committed to personal growth and development within them. Creating an identity as a leader can be an intimidating thought; however, recognizing that an educator is one step closer to creating real change by just stepping up to call out an issue can be used as inspiration to continue to strive to be better and achieve more. The more one recognizes that he/she is already a leader, the more others will accept them in that position as well.

Conclusion

Women in America are having many unwanted pregnancies, despite contraceptives like ECP being available. Some of the major factors contributing to

the lack of ECP usage are the US culture surrounding sex, misunderstandings of the mechanism of action, women's misperceptions of their own risk-taking behaviors, difficulties obtaining ECP, and lack of provider provision, education and discussion. Despite the increase in availability of ECP over the past decade and especially since 2006, research shows little decreases in unintended pregnancies. Health educators are positioned in the perfect place to take a leadership role in eliminating unwanted pregnancies. Following the five practices of Kouzes and Posner (1995), a committed health educator can emerge as a leader and to begin an initiative to prevent unwanted pregnancies, childbirths and abortions.

References

- Allen, R.H. & Goldberg, A.B. (2007). Emergency contraception: a clinical review. *Clinical Obstetrics and Gynecology*, 50(4), 927-936. .
- Bilma Schwarz, E., Gerbert, B., Gonzales, R. (2007) Need for emergency contraception in urgent care settings. *Contraception*, 75(4), 285-288.
- Fagan, E.B., Boussios, H.E., Moore, R., & Galvin, S. (2006) Knowledge, attitudes, and use of emergency contraception among rural western North Carolina women. *Southern Medical Journal*, 99(8), 806-810.
- Gibson, J.D., Koenig, M.A., Hindin, M.J. (2008) The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Studies in Family Planning*, 39(1),18-38.
- Harper, C.C., Weiss, D.C., Speidel, J., & Raine-Bennett, T. (2008) Over-the-counter access to emergency contraception for teens. *Contraception*, 77(4), 230-233.
- Hodes, M.R. (2005). *College women's experience with emergency contraception* (Doctoral dissertation, Columbia University). Retrieved from ProQuest, LLC.
- Jaccard, J. (2009). Unlocking the contraceptive conundrum: reducing unplanned pregnancies in emerging adulthood. The National Campaign to Prevent Teen and Unplanned Pregnancy, Washington, DC. Retrieved February 8, 2011 from http://www.thenationalcampaign.org/resources/pdf/pubs/Unlocking_Contraceptive.pdf.
- Kavanaugh, M.L., Saladino, R.A., & Gold, M.A. (2007). Emergency contraception services for adolescents: a national survey of children's hospital emergency department directors. *Journal of Pediatric and Adolescent Gynecology*, 22(2), 111-119.
- Kavanaugh, M., & Bilma Schwarz, E. (2008). Counseling about and use of emergency contraception in the United States. *Perspectives on Sexual and Reproductive Health*, 40(2), 81-86.

Kouzes, J.M. & Posner, B.Z. (1995). *The leadership challenge: how to keep getting extraordinary things done in organizations*. (2nd ed.). San Francisco: Jossey-Bass.

Kuroki, L.M., Allsworth, J.E., Redding, C.A., Blume, J.D., Peipert, J.F. (2008). Is a previous unplanned pregnancy a risk factor for a subsequent unplanned pregnancy? *American Journal of Obstetrics and Gynecology*, 199(5), 517e1-517.e.

Logan, C., Holcombe, E., Manlove, J., Ryan, S. (2007). *The consequences of unintended pregnancy: a white paper*. Retrieved February 8, 2011 from <http://www.thenationalcampaign.org/resources/pdf/consequences.pdf>.

Mollen, C.J., Barg, F.K., Hayes, K.L., Gotcsik, M., Blades, N.M., Schwarz, D.F. (2008). Assessing attitudes about emergency contraception among urban, minority, adolescent girls: an in-depth interview study. *Pediatrics*, 122(2), e395-e401.

Nelson, A.L. (2006). Recent use of condoms and emergency contraception by women who selected condoms as their contraceptive method. *American Journal of Obstetrics and Gynecology*, 194(6), 1710-1715.

Phipps, M.G., Matteson, K.A., Fernandez, G.E., Chiaverini, L., & Weitzen, S. (2008). Characteristics of women who seek emergency contraception and family planning services. *American Journal of Obstetrics and Gynecologists*, 199(2), 111.e1-111.e5.

Pitts, S.A.B. & Emans, S.J. (2008). Controversies in contraception. *Current Opinion in Pediatrics*, 20(4), 383-389.

Polis, C.B., Schaffer, K., Blanchard, K., Glaiser, A., Harper, C.C., & Grimes, D.A. (2007). Advance provision of emergency contraception for pregnancy prevention: a meta analysis. *Obstetrics and Gynecology*, 110(6), 1379-1388.

Raymond, E.G., Trussell, J., & Polis, C.B. (2007). Population effect of increased access to emergency contraceptive pills: a systematic review. *Obstetrics and Gynecology*, 109(1), 181-188.

Richman, A.R. (2008). *The role of pharmacists and emergency contraception: An assessment of pharmacy school curricula in the U.S. and the knowledge, attitudes, and dispensing practices of Florida pharmacists*. (Doctoral dissertation, University of South Florida). Retrieved from ProQuest, LLC.

Rocca, C.H., Schwarz, E.B., Stewart, F.H., Darney, P.D., Raine, T.R., Harper, C.C. (2007). Beyond access: acceptability, use and nonuse of emergency contraception among young women. *American Journal of Obstetrics and Gynecology*, 196(1), 29.e1-29.e6.

The National Campaign to Prevent Teen and Unplanned Pregnancy. (2007). *One in three: The case for wanted and welcomed pregnancies*. Retrieved February 8, 2011 from

<http://www.thenationalcampaign.org/why-it-matters/pdf/CaseStatement.pdf>.

The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). *Fast facts: the consequences of unintended pregnancy*. Retrieved February 8, 2011 from <http://www.thenationalcampaign.org/resources/pdf/fast-facts-consequences-of-unplanned-pregnancy.pdf>.

The National Campaign to Prevent Teen and Unplanned Pregnancy. (2010). *The DCR report*. Retrieved February 8, 2011 from http://www.thenationalcampaign.org/resources/dcr/NATC_DCRreport.pdf.

Trussell, J., Stewart, F., Guest, F., & Hatcher, R.A. (1992). Emergency contraceptive pills (ECPs): a simple proposal to reduce unintended pregnancies. *Family Planning Perspectives*, 24(6), 269-273.

Upadhya, K.K., Trent, M.E., & Ellen, J.M. (2009). Impact of individual values on adherence to emergency contraception practice guidelines among pediatric residents: Implications for training. *Archives of Pediatric and Adolescent Medicine* 163(10), 944-948.

Whittaker, P.G., Berger, M., Armstrong, K.A., Felice, T.L., & Adams, J. (2007). Characteristics associated with emergency contraceptive use by family planning patients: a prospective cohort study. *Perspectives on Sexual and Reproductive Health*, 39(3), 158-166.

Wynn, L.L., Erdman, J.N., Foster, A.M., & Trussell, J. (2007). Harm reduction or women's rights? Debating access to emergency contraceptive pills in Canada and the United States. *Studies in Family Planning*, 38(4), 253-267.

Xu, X., Vahratian, A., Patel, D.A., McRee, A.-L., & Ransom, S.B. (2007). Emergency contraception provision: a survey of Michigan physicians from five medical specialties. *Journal of Women's Health*, 16(4), 489-398.

Kara McGinnis (kmcginnis@mail.usf.edu) wrote this paper while an MPH student, Department of Community and Family Health, University of South Florida College of Public Health, Tampa, FL. This paper was submitted to the *FPHR* on February 8, 2011, revised and resubmitted, and accepted for publication on June 16, 2011. Copyright 2011 by the *Florida Public Health Review*.