Contraception Management at Point of Care for Emergency Contraception

Submitted in Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice

By

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2013

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2013
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Executive Summary

Nearly half of the 6.7 million pregnancies in the United States are unintended and 43% of the unintended pregnancies ended in an abortion in 2006 (Finer & Zolna, 2006). Unintended pregnancies are associated with delayed prenatal care, premature birth and negative mental or physical effects in children. The United States Department of Health and Human Services’ Healthy People 2020 campaign wants to reduce the rate of unintended pregnancies from 49% to 44% in 10 years (Healthy People 2020, 2013). Unfortunately, many barriers exist for gaining access to longer acting forms of contraception for women; accessing emergency contraception is a woman’s last chance to prevent an unintended pregnancy. The intent of this project was to determine if women who were purchasing emergency contraception, are also thinking about gaining access to a longer acting form of contraception. The project was intended to determine if women are aware of the prescriptive form of emergency contraception, ulipristal acetate (Ella®).

A survey was developed and distributed to women over 18 who presented to two Planned Parenthood® centers in Central Ohio requesting to purchase emergency contraception (EC). These women were asked to complete a survey while the medication was being obtained for them.

Fifty one percent of women presenting to Planned Parenthood® for EC were interested in staying for an appointment to gain access for a longer acting form of contraception. Seventy two percent of women were not aware of ulipristal acetate (Ella®), a safe and effective progesterone receptor modulator that can be used up to 120 hours or five days after unprotected intercourse.
These findings suggest that women who present for emergency contraception may be ready to begin a longer acting form of contraception. There is a challenge in the health care community to increase contraception access for women of childbearing age. Women’s health clinics may consider offering same-day appointments to enhance acquisition of longer acting forms of contraception for women who have a need to acquire emergency contraception. Additionally, women may need more education about the five day emergency contraception, ulipristal acetate (Ella®).
CONTRACEPTION MANAGEMENT AT POINT OF CARE FOR EMERGENCY CONTRACEPTION

Introduction

Yearly, unintended pregnancy affects 3.2 million women in the United States, resulting in increased healthcare costs for abortions, delayed prenatal care and premature births (Guttmacher, 2012). In 2006, two-thirds of the 1.6 million births resulting from unintended pregnancies were primarily paid for by public funds and were associated with adverse maternal and fetal outcomes (Guttmacher, 2012). For these reasons, the United States Department of Health and Human Services (USDHHS), Healthy People 2020 campaign goal is to reduce unintended pregnancy by 10% by 2020 (Healthy People 2020, 2013).

Currently, women come to Planned Parenthood and pick up emergency contraception (EC) without needing a prescription, but must present identification that documents they are 17 years of age or older. Gaining access to EC is a last opportunity to prevent an unintended pregnancy. Women presenting for emergency contraception are often in a state of emotional crisis and would like to have an opportunity to discuss contraception methods to avoid repeated use of EC. A planned and preventative approach to contraception may result in fewer unplanned pregnancies and needed crisis interventions. Nettleman, Brewer, and Ayoola (2007) write that access to a health care provider is a barrier that prevents women from gaining a more consistent and effective form of prescriptive contraception. Ideally, Planned Parenthood® and other clinics where emergency contraception is available would offer a same-day appointment with a provider when the woman comes to access emergency
contraception. The offer of a same day appointment can increase access to a more reliable and longer acting form of contraception. It would also increase access for women if contraception counseling and prescriptive counseling were available in all settings offering same-day health care services such as retail health clinics, neighborhood clinics and urgent care facilities. Additionally, ulipristal acetate (Ella®) may be more effective in preventing pregnancy than levonorgestrel for them to prevent a pregnancy, but is currently only available with a prescription (Kim & Bridgeman, 2011).

Significance of the Problem

Currently, 48% of pregnancies in the United States are unintended (Finer & Henshaw, 2006), and 43% of them will end in termination for some high risk groups. Abortions are the most common medical intervention undergone by women in the United States of reproductive age (Guttmacher Institute, 2011). Barriers exist for women to gain access to a reliable, long acting prescriptive contraception.

There is a challenge in the health care community to use a variety of approaches to increase contraception access for women of childbearing age. Flexible scheduling with evening hours and same-day appointments are ways to increase access to a health care provider. Use of a variety of health care providers, such as nurse practitioners, physician assistants and pharmacists, to deliver care has enhanced access to health care for many Americans. Private practices, retail clinics, neighborhood health centers and clinics like Planned Parenthood® need to explore ways to increase access to contraception for women of childbearing age.

Finer and Henshaw (2006) write that one in twenty American women has an unintended pregnancy each year with the heavier burden falling on women who are ages 18-24, low
income, cohabitating, and minority. Disparities suggest policy efforts to reduce unintended pregnancies should focus on improvement of access to contraceptives, particularly for high risk groups (Finer & Henshaw, 2006). Providers should be helping women plan pregnancies with the use of effective and well-suited contraception such as reversible long-term methods like intrauterine devices (Finer & Henshaw, 2006). Decreasing barriers to access effective contraception methods would help prevent unintended pregnancies.

Unintended pregnancies are associated with adverse outcomes for the child and mother. Women with unintended pregnancies are: less likely to seek prenatal care, more likely to use tobacco and alcohol during pregnancy and are more likely to experience violence and physical abuse during the pregnancy (Santell et al., 2003). Additionally, women who experience physical and sexual abuse in pregnancy are more likely to have low birth weight infants with shortened gestations (Santel et al., 2003). Unfortunately, there are many barriers that exist for women to attain a reliable, long acting form of contraception. Fear, anxiety, myths about side effects, health risks, and misbeliefs about oral contraception are prevalent (Lee & Jezewski, 2007). An appointment with a health care provider can address these potential barriers and allow women to have questions answered with accurate information. Cost and perception about perceived risk of getting pregnant (Nettleman, Brewer, & Ayoola, 2007), a false belief that emergency contraception is causing an abortion and feeling embarrassed or judged with each purchase (Corbett, Mitchell, Smith-Taylor, & Kemppainen, 2006) are other barriers that are mentioned in the literature. Parrish, Katz, Grove, Maddock, & Myhre (2009) found that more education is needed to increase the use of and access to emergency contraception and effective primary contraception methods.
Additional barriers to contraception identified include, limited access to public funded services, limited insurance coverage for contraception, limited clinic hours, lack of awareness of family planning services among "hard-to-reach" populations, transportation barriers, lack of youth-friendly services and minimal services for men (Nettlemen, Brewer, & Ayoola, 2007). The analysis by Kavanaugh, Williams, and Schwarz (2011) suggests that EC use has doubled since 2002 and remains dependent on counseling given by the health care provider. One study of 7,356 women (Kavanaugh et al., 2011) found that 9.7% of women had used EC in the past, with 43% stating they had been counseled about it in a family planning clinic or Planned Parenthood®, 26% at a community health clinic and 16% at a private doctor’s office. Lee, Ahonen, Apling, and Bork (2012) write that there are also gaps of knowledge about emergency contraception in nurse practitioner students. This suggests that providers lack information about emergency contraception and its mechanisms of actions, indications and contraindications.

EC became available to women in Ohio and much of the United States “over the counter” or “behind the counter”, without a prescription, in September, 2006. It became available for those 17 and older in 2009 (National Conference of State Legislators, 2012). EC can be obtained with a valid identification. Before that time, women had to see a provider and get a prescription for EC. Now, women are missing that one-on-one contact with a provider. They may be missing the opportunity to tell the story of getting raped or being checked for a sexually transmitted infection. Some women are frightened and alone or may be embarrassed or feel guilty when gaining access to EC. Speaking with a provider can potentially decrease some of those feelings and allow for questions to be answered and
referrals to be initiated. They may also discuss with the provider the possibility for a more long term plan for contraception.

Conversations with a provider may increase women’s ability to move from a contemplation stage of thinking about contraception to an action phase of gaining long term contraception. The Health Belief Model may be applied in the situation for gaining EC. This model was developed in the 1950’s by a group of psychologists in an attempt to explain widespread failures of persons to participate in programs to detect and prevent diseases (Janz, Champion, & Strecher, 2002). The components of the model have been used to explain health behaviors for preventative actions.

In general, it now is believed that people will take action to prevent, to screen for, or control ill-health conditions if they regard themselves as susceptible to the condition, if they believe it would have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition, and if they believe that the anticipated barriers to (or costs of) taking the action are outweighed by its benefits (Janz, Champion, & Strecher, 2002, pp. 47-48).

For example, if a woman thinks she can get pregnant and feels that a pregnancy is a perceived threat, and believes EC can reduce or take away the threat, it puts her into action to gaining it. The Health Belief Model also recognizes that there are perceived barriers (like cost, side effects of treatment, time needed or availability of an appointment) that prevent an action. The threat of an unintended pregnancy may precipitate a spring to action of purchasing EC and thinking about the need for a longer acting contraception, to avoid a potential pregnancy at a later date. The Health Belief Model also identifies many other
variables, like demographics or socio-psychological variables that may affect a behavior readiness. Educational attainment may be an influential force of perception of barriers and benefits of an action (Janz, Champion, & Strecher, 2002).

Problem Statement

Barriers exist for women gaining access to a reliable, long acting prescriptive contraception. The survey was completed to determine if women who enter a family planning clinic in Central Ohio to purchase EC would desire an appointment with a health care provider in order to obtain a longer acting contraception. The survey will determine if the clinic should ask women if they would like an appointment when they come to purchase emergency contraception and determine their knowledge of ulipristal acetate.

Project Implementation

The 13-question survey was developed and reviewed by a panel of experts in women’s health care. The survey was revised and was approved by the student committee members. Objectives were to determine if women planning to take EC were interested in obtaining a form of longer acting contraception and to determine their knowledge of ulipristal acetate. Approval for this study was obtained from the Otterbein University Institutional Review Board in March of 2012. Additionally, the information about the survey and letter to recruit the subjects was reviewed and approved by the clinic administration. It was determined that the questionnaire and recruitment letter presented was exempt from the clinics Institutional Review Board Approval. The 13-question survey was distributed to women over the age of 18 who presented to two family planning clinics in central Ohio requesting to purchase emergency contraception. A letter explaining the survey was attached to every questionnaire that participants received (See Appendix A). Participation to answer the
survey was strictly voluntary. Participation by filling out the questionnaire was considered informed consent. Staff and managers at both clinics were oriented about the process of asking clients to participate, and all materials were provided for both clinics. The budget for the survey included copies of surveys and self–sealing envelopes. This cost was $40.58. Additionally, $10.00 gift cards were given to the staff for assisting with the surveys. Five consistent staff at each survey site were given the gift cards in June, July and August. Total cost for the gift cards were $300.00. Total cost of the survey implementation was $348.58.

The pilot questionnaires were distributed at two clinic offices from May 9, 2012 to June 1, 2012. During this pilot, there were 14 clinical days with 25 returned surveys. Twelve completed surveys were obtained from one site and 13 from the second site. The pilot surveys were reviewed and a few minor changes were made to the survey. Those changes included:

1. The end of the survey asked participants to review the survey and make sure that they answered all 13 questions.
2. Intrauterine device was added as a method of choice to question number three.
3. The trade name of Next Choice® was added to question number seven.
4. Questions three and five that asked about forms of contraception were put in same order for both questions for consistency and flow (See Appendix B for the complete survey).

The final convenience sample data collection ran from June 18, 2012 to September 18, 2012. The project surveyed women over 18 who came to purchase EC at two family planning clinics in Central Ohio. The 13-question survey was developed to identify demographic data, use of contraception and emergency contraception in the past, general knowledge of EC, and desire an appointment to obtain a prescription for a longer acting
method of birth control. Seventy-five surveys were collected. See Appendix B for the complete survey. Three surveys were deleted due to incomplete responses to the questions.

Managers were sent emails weekly to remind the staff to ask clients to complete the survey. The student was also present in the clinics weekly as a provider to remind staff as well to ask clients to complete surveys when requesting EC. Barriers for this survey were numerous. This summer, the local organization merged with Northern Ohio to be named the current Planned Parenthood of Greater Ohio. This merger created anxiety for all of the staff. Another project barrier that was significant was the resignation of a 19 year veteran lead clinician at one clinic site, where the surveys were to be distributed. The final barrier was the advent of a new computer system that started July 1, 2012, which affected the registration and billing process for all clients. The changes described put much stress on all staff working at both centers. All this change during the designated survey collection may have affected the number of surveys collected. Having a clearly marked box with clipboards, envelopes, attached pens and surveys in a contained, organized box probably aided positively in survey collections. The gift cards and may have also incentivized the staff to ask potential subjects. The gift card and student presence as a provider may have also positively enhanced the number of surveys collected during this period of time.

Outcomes and Analysis

The sample consisted of 75 respondents with 3 deleted because they were incomplete. There were 42 completed surveys returned from the clinic one and 30 from clinic two. Clinic two is a Title X clinic, and most clients receive discounted services, based on their income. Clinic one is a fee-for-service clinic. Both clinics take clients with insurance,
including all state Medicaid programs. The cost for emergency contraception is the same at both clinics.

Participant ethnicity, marital status, age, and education are presented in Table 1.

Table 1. Patient Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N=72</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>47</td>
<td>63</td>
</tr>
<tr>
<td>African American</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Asian</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>American Indian</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>50</td>
<td>69.44</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>2.78</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>4.17</td>
</tr>
<tr>
<td>Separated</td>
<td>11</td>
<td>15.28</td>
</tr>
<tr>
<td>Engaged</td>
<td>6</td>
<td>8.33</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-22</td>
<td>28</td>
<td>38.89</td>
</tr>
<tr>
<td>23-27</td>
<td>28</td>
<td>38.89</td>
</tr>
<tr>
<td>28-32</td>
<td>11</td>
<td>15.28</td>
</tr>
<tr>
<td>33-37</td>
<td>4</td>
<td>5.56</td>
</tr>
<tr>
<td>38-55</td>
<td>1</td>
<td>1.39</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-11th grade</td>
<td>4</td>
<td>5.56</td>
</tr>
<tr>
<td>High school</td>
<td>13</td>
<td>18.06</td>
</tr>
<tr>
<td>Some college</td>
<td>28</td>
<td>38.89</td>
</tr>
<tr>
<td>College graduate</td>
<td>22</td>
<td>30.56</td>
</tr>
<tr>
<td>Post graduate</td>
<td>5</td>
<td>6.94</td>
</tr>
</tbody>
</table>

Twenty-four (33%) of participants bought EC for the first time, 26 (36%) used EC 1-2 times in the past 12 months, 7 (9%) used EC 3-4 times in the past 12 months, and 2 (3%) reporting using it 5 times or more in the past 12 months. Thirteen (18%) reported they had not used EC in the past 12 months, but have done so in the past. For survey question #2
(see Appendix B for survey questions), participants may have had more than one answer with 28 participants reported needing EC due to an unexpected intercourse, 11 respondents had a problem with their primary form of contraception, 20 reported condom breakage, 18 reported missing pills or did not use a primary form of contraception, and one reported buying EC for a future date. Most women had used some form of contraception in the past and most (34/72) would want a pill form of contraception if they could have been seen that day to obtain another form of contraception. Thirty-seven (51%) of women buying EC expressed a desire to see a health care provider to obtain another form of contraception. Thirty-five (49%) declined an appointment the same day they purchased EC. See Figure 1 for the types of contraception that would be desired, if they could see a provider that day. Overall, women reported time and money as a barrier for scheduling an appointment at the time they picked up EC. Another 18 reported not needing another form of contraception in the near future. Sixty-eight (96%) were aware that the EC they were purchasing was most effective if using within 72 hours after an unplanned intercourse event and four (6%) were not aware. Interestingly, 52 (72%) were not aware of ulipristal acetate, whereas 20 (28%) conveyed being aware of ulipristal acetate.
As shown in Table 2, a Chi Square was completed to determine if there was a statistical difference between the respondents of Clinic one, a fee- for- service clinic and the respondents of clinic two, a Title X clinic. There was (at the 95% confidence level) not a statistically significant difference, between the clinic one and clinic two survey respondents in the desire to have an appointment with a health care provider to discuss options for longer acting forms of contraception.

Table 2. Responses for a desire to have an appointment with a health care provider.

<table>
<thead>
<tr>
<th></th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17</td>
<td>20</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>15.42</td>
<td>21.58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.163</td>
<td>0.0116</td>
<td>Yes Responses</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>22</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>14.58</td>
<td>20.42</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.172</td>
<td>0.123</td>
<td>No Responses</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>42</td>
<td>72</td>
</tr>
</tbody>
</table>

Chi-Square = 0.573, DF = 1, p-value = 0.449
Conclusion, Summary & Recommendations

Findings of this survey are limited due to sample size, short time for data collection and convenience sampling. Not all persons buying EC wanted to complete the survey or they may not have been asked to participate. The thought of an unintended or undesired pregnancy prompts many women daily to spring into action and get EC at health care clinics and pharmacies each day. The action of purchasing EC may prompt a desire to begin a long-acting form of contraception. Despite the survey limitations, the findings do contribute to the body of knowledge on this topic and can hold implications for practice. Women are gaining access to EC and that is imperative. However, lack of access for longer-acting contraception can be a problem for many patients. This survey suggests that many women are thinking about and are interested in gaining access to a longer-acting form of contraception at the time they purchase EC. This survey also suggests that many women are not aware of the prescriptive form of EC, ulipristal acetate, and need more education about it. Family planning is within the scope of practice for many nurse practitioners. Many nurse practitioners attempt to focus on prevention measures for patients, which include contraception counseling, prescribing and placing contraception devices. Health care clinics and providers are mindful that unplanned and untimely pregnancies put many women and families in crisis. Healthcare sites offering EC may need to go one step further and ask the woman if she has a desire at the time of purchase to make an appointment with a health care provider. The woman may need ulipristal acetate prescribed because of its long effectiveness or may desire a longer-acting form of contraception before she leaves the office. Counseling may be the pivotal component to reducing the elevated rate of
unintended pregnancies in the United States. Additionally, with retail clinics increasing across the nation, obtaining contraception at your corner drug store may be an answer for contraception care for many women. Allowing nurse practitioners to practice to the fullest extent of their training may improve a practice culture where expanded consideration for contraception access will be enhanced.

Family planning to reduce unintended pregnancies is a national goal. Utilizing Health Belief Models that identify an individual's readiness for action and allowing access to healthcare providers may help individuals reach their goal of reducing unintended pregnancy. As health care providers we need to optimize that window of time when women are ready to make a change for preventive health care decisions. As America works to redesign health care, increasing same-day appointments needs to be considered in that plan.


My name is Dana Buechner and I am a doctoral student at Otterbein University. I am conducting a survey in partial fulfillment of my educational program.

You were selected as a potential participant for a research study "Contraception Management at the Point of Care for Emergency Contraception" because you have requested emergency contraception at this Planned Parenthood office.

If you agree to participate, I will need you to read this information letter and complete the survey questions. Your completion of the survey conveys consent to participate in the research study. You will place the completed survey in the self-sealing envelope provided. There will be no further requirements.

There are no anticipated risks involved in completing this survey. You may or may not feel some discomfort answering the questions.

All information obtained about you in the survey is confidential. The information will be reviewed only by myself and faculty assisting with the data analysis. No identification will be provided on the forms to link your answers to you. You will not provide your name on any forms. All data reported will be group data.

Your participation will provide information related to the health care needs of women seeking emergency contraception and may lead to additional services provided here at Planned Parenthood of Central Ohio. Your participation is greatly appreciated.

Your decision to participate or not will not prejudice your future relationship with Planned Parenthood of Central Ohio. If you decide to complete the survey, please answer all questions on the form provided and return it to the Planned Parenthood receptionist in the sealed envelope provided for you. If you decide to withdraw, simply place the materials in the sealed envelope and return it to the receptionist.

If you have questions about the survey, presently or in the future, I will be happy to answer those concerns. You can reach me at dbuechner@otterbein.edu. Thank you very much for your time.
Emergency Contraception Survey

Please mark an X on the line that most applies to you: (there are 13 questions)

1. Which best describes your use of Emergency Contraception (Plan B) in the Past 12 months?
   ___ This is my first time using an emergency contraception

   OR ___ I have used emergency contraception in the past year and I have used it:
       ____ 1-2 times in the past 12 months
       ____ 3-4 times in the past 12 months
       ____ 5 times or more in the past 12 months

   OR ___ I have not used Emergency Contraception the last 12 months, but I have used it in the past

2. Please mark an X to the best answer(s) that applies to you in your situation:
   ___ I have missed some pills from a pill pack or did not use my primary form of contraception
   ___ I had a problem with my primary form of contraception
   ___ Unexpected intercourse
   ___ Condom broke
   ___ I am obtaining emergency contraception today for a future date
3. What form of contraception have you used in the past? (Select all that apply)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>_Pill</td>
<td>_Spermicide (foam, cream, jellies)</td>
</tr>
<tr>
<td>_Condoms- rubbers (male or female)</td>
<td>_Nuva- Ring – vaginal ring</td>
</tr>
<tr>
<td>_The patch Ortho Evra</td>
<td>_Implant – in the arm</td>
</tr>
<tr>
<td>_DepoProvera – the shot, injectable</td>
<td>_Withdrawal or pull out method</td>
</tr>
<tr>
<td>_Rhythm method</td>
<td>_IUD- intrauterine device</td>
</tr>
<tr>
<td>_I have never used another form of birth control</td>
<td></td>
</tr>
</tbody>
</table>

4. If a health care provider were available to discuss and provide you with another form of contraception, would you want an appointment today?

- Yes
- No

5. If you could obtain an appointment today or in the next few days, what form of contraception do you think you would be interested in?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>_Pill</td>
<td>_Nuva-Ring – vaginal ring</td>
</tr>
<tr>
<td>_Condoms-rubbers (male or female)</td>
<td>_Implant – in the arm</td>
</tr>
<tr>
<td>_The patch Ortho Evra</td>
<td>_Referral for getting a tubal-ligation</td>
</tr>
<tr>
<td>_DepoProvera – the shot, injectable</td>
<td>_Referral for Essure</td>
</tr>
<tr>
<td>_Rhythm method</td>
<td>_I am not interested at this time</td>
</tr>
<tr>
<td>_IUD – Intrauterine Device</td>
<td></td>
</tr>
</tbody>
</table>
6. What would prevent you from staying for an appointment now, to get another form of contraception?

__Time

__Money

__I do not plan on needing another form of contraception in the near future

Please write down any other reasons why you would not want another form of contraception at this time:

______________________________________________________________________________

7. I am aware the Next Choice/Plan B emergency contraception is most effective if used 72 hours after an unplanned intercourse event.

__Yes

__No

8. I am aware that there is a newer emergency contraception called Ella ® or Ulipristal Acetate which is more effective for up to 120 hours after an unplanned intercourse event.

__Yes

__No

9. What is your age?

__18-22
__33-37

__23-27
__38-42

__28-32
__43-55

10. What is the highest grade of school you have completed?

__9-11th grade
High school graduate

Some College

College graduate

Post graduate

11. Have you had pregnancies in the past?

Yes

No

If yes, Number of children born alive ___ stillborn ____ miscarriage ____ abortions____

12. Which of these best describes your racial background? (Please mark all that apply)

Caucasian or White

African–American or Black

Hispanic

Asian

American Indian

13. What best describes your status?

Single

Married

Divorced

Separated

Engaged
Please go back and make sure you have answered all of the questions.

THANK YOU FOR YOUR TIME – Please place in the sealed envelope provided and hand it back to the Planned Parenthood receptionist.