

Improving Access to Abortion Medication and Contraception

Findings from the California Pharmacist Survey

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EXECUTIVE SUMMARY

Despite state legislative efforts to increase access to sexual and reproductive health (SRH) services through pharmacists, current research suggests that the potential impact of these policies has not been fully realized. To better understand implementation barriers to the provision of SRH services, including abortion medication, emergency contraceptives, and self-administered hormonal contraceptives (e.g., the pill, patch, ring, or injection), we conducted an online survey of California pharmacists (N=919). Main findings include the following:

- Three-quarters (75%) of pharmacists would be willing to prescribe abortion medication if allowed by law. Looking ahead to this future potential authority, less than half were confident in their knowledge of medication abortion (44%) or their ability to prescribe abortion medications if allowed by law (41%).
- Over 90% of pharmacists agreed that providing access to contraception is important, including emergency contraception (e.g., Plan B, Ella).
- Less than one-third (29%) of pharmacists believed that parental consent should be required before providing emergency contraception to minors.
- Three-quarters (75%) of pharmacists were willing to prescribe hormonal contraception, such

as birth control pills taken regularly to prevent pregnancy, to patients regardless of age.

- Very few pharmacists reported religious (9%) or moral (7%) objections to prescribing hormonal birth control.
- Many pharmacists were confident in their knowledge of hormonal contraception (72%) and their ability to prescribe contraception (61%).
- More than three-quarters (79%) of pharmacists working in community pharmacies indicated that their pharmacies provided levonorgestrel emergency contraception (e.g., Plan B, One-Step) without an outside provider's prescription (i.e., over the counter or pharmacist-prescribed).
- Despite having the authority in California, slightly less than half (46%) of pharmacists worked in community pharmacies that offered pharmacist-prescribed self-administered hormonal contraception (e.g., the pill, patch, ring, or injection).
- Pharmacists most frequently endorsed these reasons for why the pharmacies where they worked did not offer pharmacist-prescribed contraception: inadequate staff or time to add new services (42%), lack of knowledge or training about hormonal contraception (32%), and lack of coverage for the service even if the medication is covered (24%).

Findings suggest a need to expand payment for pharmacist-provided SRH services—beyond the cost of medication—and to expand SRH training opportunities for pharmacists.

INTRODUCTION

Given their geographic accessibility, community pharmacies, including independent pharmacies and corporate chain pharmacies, have become logical and critical venues for the delivery of preventative care, including immunizations, blood sugar monitoring, and blood pressure checks. Nearly 90% of Americans live within five miles of at least one pharmacy.¹ Pharmacists are increasingly being recognized as important players in the health care delivery system who can improve health care access through an expanded scope of practice. In 2002, California law (SB 1169) allowed emergency contraceptive (EC) pills to be prescribed by pharmacists,² and, starting in 2016, California pharmacists were able to directly prescribe self-administered hormonal contraceptive pills, patches, rings, and injections under SB 493.³

Despite legislative efforts to increase access to sexual and reproductive health (SRH) services through pharmacies, including HIV prophylaxis (i.e., [PrEP/PEP](#)), available research suggests that provision of SRH resources and services through pharmacies is still limited. A 2017 survey of Los Angeles County pharmacies found that 77.4% had Plan B available in their stores.⁴ Also in 2017, one year after the implementation of SB 493, only 11% of California pharmacies provided hormonal contraception without an outside provider's prescription.⁵

Current statewide access to emergency contraception such as Plan B and hormonal contraception through pharmacist prescription is unknown. In order to understand current implementation practices and barriers to the provision of SRH resources and services across the state, we conducted an online survey of California pharmacists in the fall of 2022. Details about study methods are provided in the Appendix.

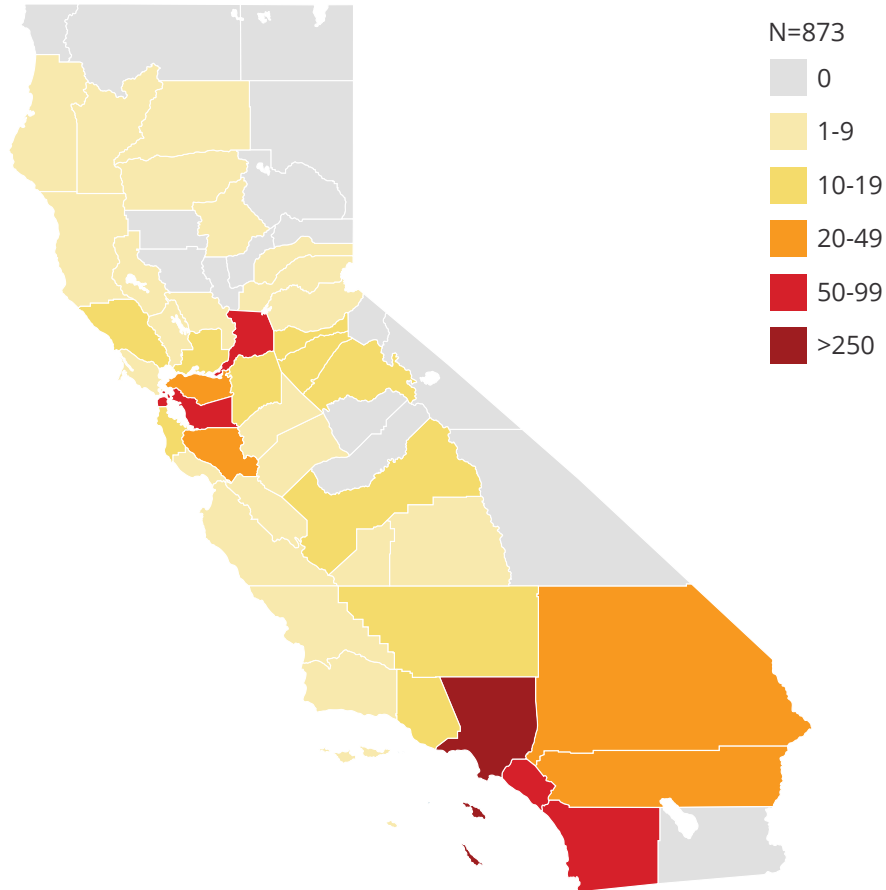
FINDINGS

CHARACTERISTICS OF THE STUDY POPULATION

Consistent with the underlying population of California pharmacists,^{6,7} many survey participants (N=919) were female (cisgender) (64%) and/or were of Asian ancestry (64%). Pharmacists had a mean age of 39 years (Appendix, Table 1). Most participants (84%) were currently practicing licensed pharmacists; 9% were pharmacy students and 7% were non-practicing pharmacists.

Just over half of participants currently or most recently worked at pharmacies located in Los Angeles County (29%) or the San Francisco Bay Area (23%) (Figure 1).

Figure 1. Location of participants' pharmacies

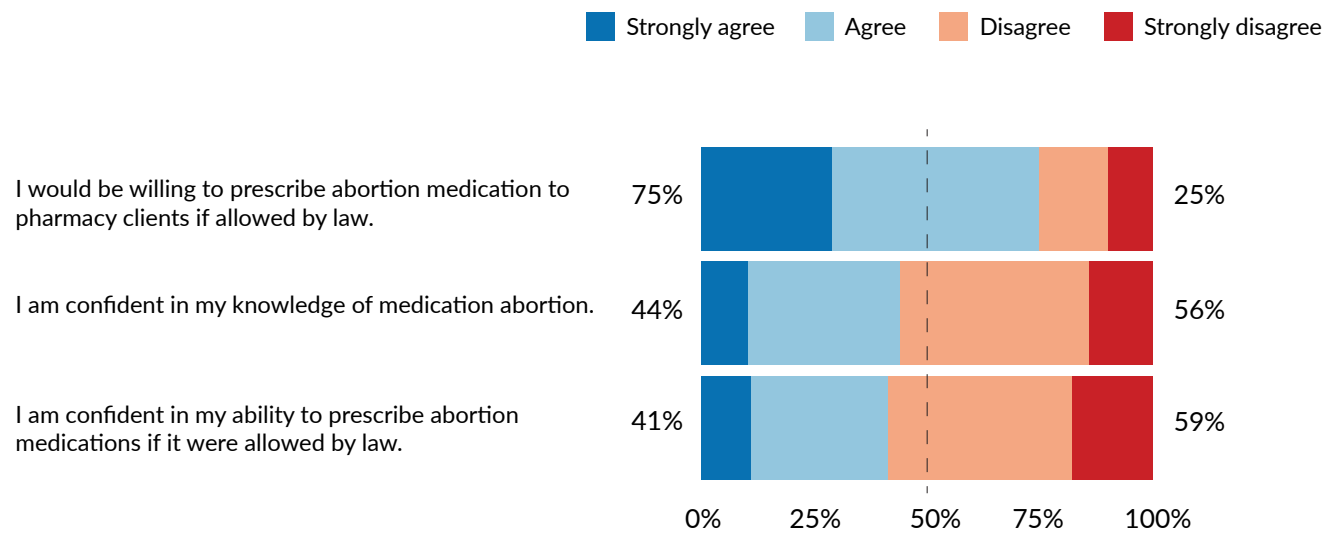


Most participants reported working in community pharmacies (43%), hospitals (28%), or clinic or ambulatory care settings (16%). Among those who worked in community pharmacies, 55% worked at a national chain pharmacy and 38% worked at an independent pharmacy.

ATTITUDES ABOUT PHARMACIST PROVISION OF MEDICATION ABORTION

Most participants (75%) would be willing to prescribe abortion medication to pharmacy clients if allowed by law, but less than half were confident in their knowledge of medication abortion (44%) or their ability to prescribe abortion medications if allowed by law (41%) (Figure 2).

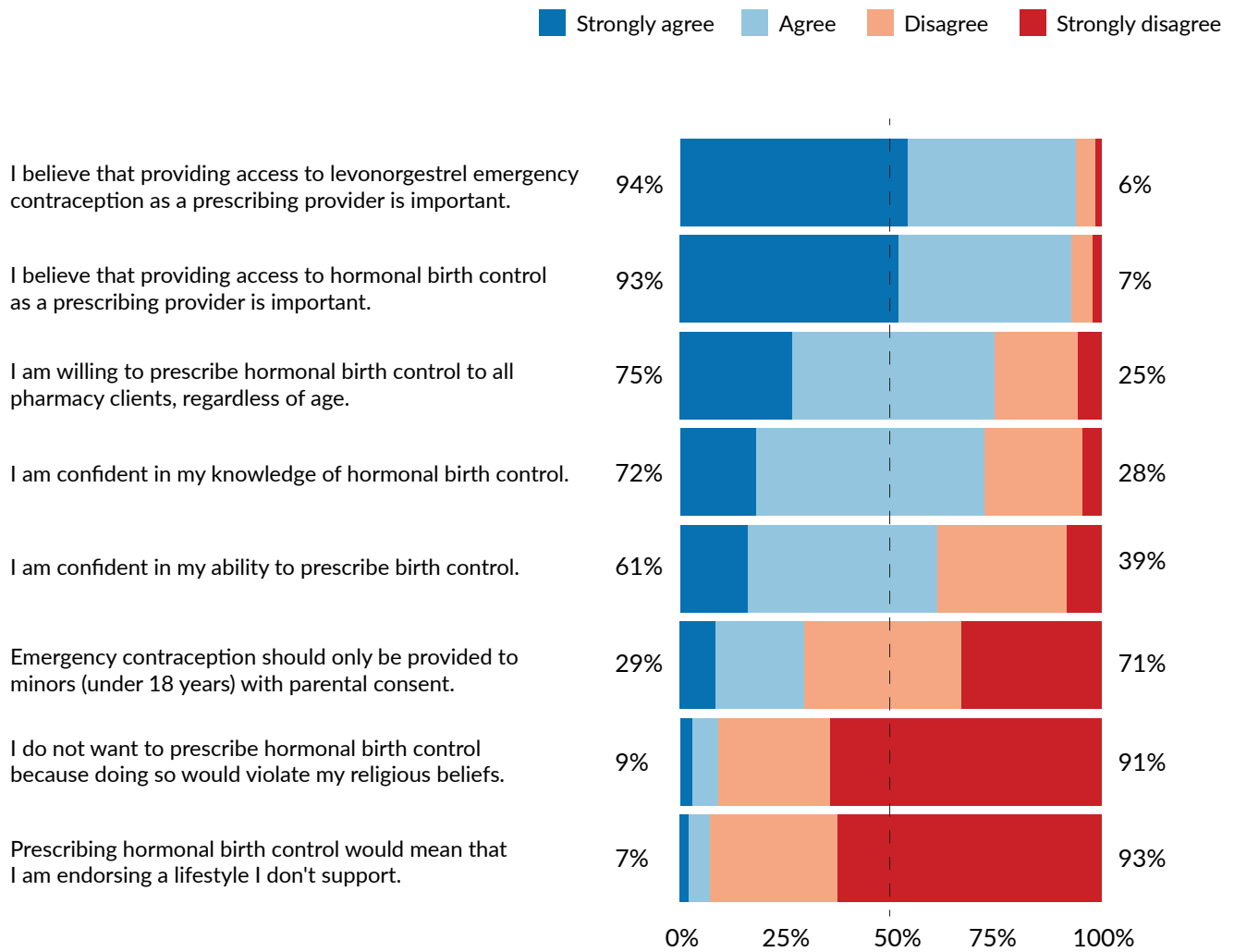
Figure 2. Participant attitudes about medication abortion provision



KNOWLEDGE OF AND ATTITUDES ABOUT PHARMACIST PROVISION OF HORMONAL CONTRACEPTION

More than 90% of participants agreed that providing access to levonorgestrel emergency contraception and hormonal contraception is important, and 75% were willing to prescribe hormonal contraception to pharmacy clients regardless of age (Figure 3). A majority were confident in their knowledge of hormonal contraception (72%) and their ability to prescribe contraception (61%). Less than one-third (29%) of pharmacists believed that parental consent should be required before providing emergency contraception to minors. Few reported religious (9%) or moral (7%) objections to prescribing hormonal birth control.

Figure 3. Participant attitudes about contraceptive provision



CURRENT CONTRACEPTIVE PROVISION

More than three-quarters (79%) of pharmacists working in community pharmacies indicated that their pharmacies provided levonorgestrel emergency contraception (e.g., Plan B, One-Step) without an outside provider’s prescription (i.e., over the counter or pharmacist-prescribed). Only a fifth (19%) reported working in community pharmacies offering pharmacist-prescribed ulipristal acetate emergency contraception (e.g., Ella) which is a form of emergency contraception that is more effective than levonorgestrel (Plan B)—particularly for people who weigh more than 165 pounds (and less than 195 pounds).⁸ Slightly less than half (46%) of pharmacists worked in community pharmacies that offered pharmacist-prescribed self-administered hormonal contraception (e.g., the pill, patch, ring, or injection).

HORMONAL CONTRACEPTION IMPLEMENTATION BARRIERS AND FACILITATORS

Participants working in pharmacies that did not offer pharmacist-prescribed self-administered hormonal contraception were asked to select all applicable barriers to provision from a list. The most selected barriers were inadequate staff or time to add new services (42%), lack of knowledge and/or training about hormonal contraception (32%), no coverage for the service even if the medication is covered (24%), liability concerns (20%), and low demand for hormonal contraception among clients (16%). The least commonly selected barrier was personal beliefs (4%).

DISCUSSION

Despite California's concerted efforts to expand access to essential sexual and reproductive health services through pharmacies, findings from this study indicate that opportunities to expand implementation remain. In our survey, California pharmacists believed that access to SRH services is important, and most were willing to provide these services — including medication abortion if it becomes allowed by law. Although many (79%) pharmacists working in community pharmacies reported that levonorgestrel EC (e.g., Plan B) was available at their pharmacy, less than one-fifth (19%) indicated that ulipristal acetate EC (e.g., Ella) was available through a pharmacist-provided prescription. Reduced access to Ella will disadvantage people who weigh over 165 pounds and for whom levonorgestrel EC (e.g., Plan B) is less effective.

Several years after pharmacists were able to prescribe hormonal contraception, slightly less than half (46%) of community pharmacists reported working in a pharmacy where self-administered hormonal contraception (e.g., the pill, the patch, ring, or injection) is available and provided directly from the pharmacist. Pharmacists who worked at pharmacies that did not currently offer pharmacist-prescribed hormonal contraceptives indicated that lack of staff time to add new services, insufficient staff knowledge/training, and lack of insurance coverage for services provided were implementation barriers. Expanding payment for pharmacist-provided SRH services—beyond the cost of the medication—and additional training opportunities for pharmacists is recommended.

APPENDIX: STUDY METHODS

Between October 11 and December 20, 2022, we conducted a cross-sectional, online survey of California pharmacists and pharmacy students (hereafter referred to collectively as ‘pharmacists’) to understand their attitudes, knowledge, and preferences about the provision of SRH services in pharmacies, including contraception and medication abortion. We also assessed the implementation of policies enabling pharmacist-prescribed hormonal contraception. The study was approved by the Office of the Human Research Protection Program Institutional Review Board at UCLA with partner organizations holding reliance agreements.

STUDY POPULATION AND RECRUITMENT

Eligible participants in the survey were: 1) 18 years of age, 2) licensed pharmacists or pharmacy students, 3) currently residing in the state of California, and 4) willing to provide informed consent. Participants were excluded from the survey if they did not meet the inclusion criteria or were identified via security and quality control measures as being a duplicate or bot.

A multi-stage recruitment plan included both online and in-person recruitment. In the first phase, we recruited participants through the California Society of Health-System Pharmacists and California Pharmacists Association membership email listservs and newsletters. We also distributed information about the study through flyers and presentations at two conferences: the annual meetings of the American College of Clinical Pharmacy and the California Society of Health-System Pharmacists. The second phase included participant recruitment through the social media channels (i.e., Facebook, LinkedIn, and Twitter) of partner organizations and a focused recruitment effort to include diverse representation of California pharmacists. We identified and promoted the survey to professional groups on social media representing Black, Indigenous, and other People of Color pharmacists and pharmacists outside of major metropolitan areas in California (e.g., California’s rural Central Valley).

DATA COLLECTION

The self-administered survey was implemented via *Qualtrics* online survey software.⁹ Survey modules included: demographic information; professional information (years of experience, training, whether currently practicing); pharmacy information; and knowledge, attitudes, and implementation of PrEP, PEP, hormonal contraception, emergency contraception, and medication abortion. Upon completing the survey, participants had the option to enter their email address to receive a \$20 Amazon gift card and/or enter weekly (\$250) or grand prize (\$500) raffles. Only participants verified as valid were eligible for gift cards and raffle prizes.

DATA ANALYSIS

We present descriptive statistics for selected survey outcomes. Percentages were calculated excluding missing or “not applicable” responses from the denominators. When appropriate, results are limited to relevant subgroups (e.g., pharmacists working in community pharmacies). All analyses were conducted in *R statistical computing software*.¹⁰

Table 1. Participant sociodemographic characteristics in the California Pharmacist Survey, 2022

N=919	
Age, mean \pm SD	39.1 \pm 12.9
Gender, n (%)	
Cisgender female	518 (64.0%)
Cisgender male	289 (35.7%)
Transgender (of any gender identity)	3 (0.4%)
Race/ethnicity, n (%)	
American Indian or Alaska Native	4 (0.5%)
Asian	497 (64.3%)
Black	15 (1.9%)
Hispanic	36 (4.7%)
Native Hawaiian or Pacific Islander	1 (0.1%)
White	184 (23.8%)
Multiracial	17 (2.2%)
Other	19 (2.5%)

Missing values (excluded from %): n=76 age, n=109 gender, n=146 race/ethnicity.

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