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Intentions to use emergency contraception: The role of accurate knowledge and information source credibility

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Abstract

Background: Emergency contraception (EC) is a highly effective form of birth control that may lower rates of unintended pregnancy among young women. But efforts to disseminate EC to women are hampered by misinformation and inadequate information.

Purpose: The purpose of this study was to determine the sources from which young women learn about EC (including health care providers, friends/interpersonal sources, media sources, or no information sources), and to examine source credibility with the accuracy of EC knowledge and intentions to use EC.

Method: Using a computer-based survey, 339 college women (M age = 18.4) reported their EC information sources, knowledge about EC, and behavioral intentions to use EC.

Results: In total, 97% of participants had heard of EC from at least one source and 49% indicated they were highly likely to use EC in the future if needed. Results demonstrated that EC knowledge mediated the relationship between EC information source credibility and intentions to use EC.

Discussion: This study contributes important insights to a scarce literature on EC information sources and the factors that predict intentions to use EC.

Translation to Health Education Practice: Future EC promotion efforts should target health education sources instead of media or interpersonal sources to promote EC knowledge and use among young, sexually at-risk populations.

Keywords

Emergency contraception; intentions; source credibility; health communication; reproductive health

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INTRODUCTION

It is estimated that emergency contraception (EC), commonly referred to as the “morning-after pill,” has the capability to reduce the rate of unintended pregnancies and abortions among teens and young adults in the United States by as much as half.¹ EC may be a particularly useful tool for preventing unwanted pregnancies among college women, a population among whom 80% are currently sexually active² and for whom rates of unprotected sex are high.³ Notably, in 2013, EC became readily available for purchase without the need for a prescription and with no age restriction,⁴ making it an accessible method of pregnancy prevention.

Despite the strong promise of EC to prevent unintended pregnancies, knowledge about EC is generally poor among young women.⁵ For example, research suggests that young women often have inaccurate knowledge about the overall effectiveness of EC, the time frame in which EC is effective, the availability of EC, the prescription laws surrounding EC, the difference between EC and RU-486 (known as the “abortion pill”), and the effects of EC on fertility and preexisting pregnancies.^{6–11} This type of misinformation may inhibit access to and impede the accurate use of EC.

One possible contributing factor to women’s limited and often inaccurate knowledge is the information sources from which women learn about EC. Previous research has demonstrated that the most common sources of women’s information about emergency contraceptives are peers, school curricula, and the media, with less than 10% of women reporting health care providers as their primary information source.^{7, 8, 12} This is problematic, given that healthcare providers are most likely to be accurate, reliable, and credible sources of information about EC to young women.¹³ We hypothesize that women who have learned about EC from more credible sources, including health care providers, should have more accurate information about EC than women who have relied exclusively on friends or media reports to obtain information about EC; however, this hypothesis has yet to be explicitly examined.

Additionally, an adequate understanding of young women’s intentions to use EC in emergency situations is lacking. Only two studies have directly assessed women’s intentions to use EC, and these studies found that just over half of women would be likely to use EC in the event of contraceptive failure.^{7, 14} Thus, additional research is urgently needed to better understand the factors that may affect intentions to use EC. Accurate knowledge about the availability, effectiveness, and proper use of emergency contraceptives may be a strong predictor of women’s intentions to use EC. Indeed, some theories of health behavior and

sexual decision-making, such as Fisher and Fisher's Information, Motivation, and Behavioral Skills Model, suggest that knowledge is a critical antecedent to future intentions and behavior.¹⁵ However, this assertion has not been directly tested in relation to EC intentions.

Research questions and hypotheses

This study sought to accomplish two objectives: first, to assess college women's current knowledge about EC and intentions to use EC, and second, to determine associations among college women's sources of information about EC, EC knowledge, and intentions to use EC. We anticipated that women who reported having heard of EC from more credible sources, such as health information or education sources (i.e. healthcare providers), would have more accurate knowledge about EC and greater intentions to use it, compared to women who had heard from less credible sources (i.e., interpersonal sources or media), or from no source. Furthermore, we predicted that EC knowledge would mediate the relationship between EC information sources and intentions to use EC.

METHODS

Participants and procedure

Participants were 339 college women enrolled in psychology courses at a large university in the southeastern United States. Participants were recruited through the psychology department's participant pool as a part of a larger study on young women's communication and health (reference removed for masked review). To be eligible to participate, participants had to identify as biologically female, be 18 or 19 years old, and read English. The study focused on 18–19 year olds given the importance of focusing on young women's transition to college, which may involve risky behaviors.¹⁶ Participants had the option of signing up for the studies they found interesting and were not required to participate in specific studies.

At preselected times, small groups of participants came to our research office to complete the study. Spacing equivalent to two seats between the participants was used to help ensure confidentiality in the small group sessions. Written informed consent was first obtained from each participant, and then data were collected via an online survey which was completed on laptop computers. Expected time of completion for the surveys was 1 hour, and participants were awarded 1 hour of course credit for their participation. Data collection occurred over three months: September through November 2014. The University of North Carolina Institutional Review Board approved all study procedures.

Measures

Demographics and Sexual History.

We asked a series of questions to capture basic demographic information (age, current year in school, race/ethnicity, sexual orientation), as well as relevant sexual history information (sexual activity status, age at first vaginal sex, pregnancy history, and history of EC use).

EC Information Source Credibility.

Prior to answering questions related to EC, the following description of EC was provided: “Emergency contraception is a birth control method that can be used to prevent pregnancy up to 5 days after unprotected sex takes place. The next few questions ask about emergency contraception, also known as the ‘morning-after pill’ (e.g., Plan B).” The descriptors “morning after pill” and “Plan B” were included in the description to optimize student recognition of emergency contraception.^{7, 9, 12, 17} A single item assessed whether students had ever heard about EC; response options were “yes” or “no.”

For participants who had heard of EC, three items assessed whether they had heard of EC from the following three information sources: 1) health information or education source (e.g., doctor, pharmacist, health class, sex education class, campus health services); 2) interpersonal source (e.g. friend, classmate, dating partner, or family member); or 3) media source (e.g., advertisements, news, entertainment TV, social media). Using responses to these items, we created a source credibility score where 0 = *no sources*, 1 = *low credibility* (for those who report having heard of EC from *only* media and/or interpersonal sources), and 2 = *high credibility* (for those who report having heard of EC from a health information source).¹

Knowledge of EC.

Previous research has assessed knowledge of EC through quiz-like questions that ask participants about EC facts, such as “Is EC the same as the RU-486 pill?” and “Do you need a prescription to obtain EC?”^{7, 8, 17} Review of these previous studies revealed that questions addressed two types of knowledge: knowledge on the mechanisms of EC and knowledge on accessibility of EC. Therefore, to assess EC knowledge, this study adapted this previous research and created six items that assessed the accuracy of participants’ knowledge about EC. Three of the items asked about EC drug mechanisms (e.g., “EC is an abortion pill”) and three items asked about EC accessibility regulations (e.g., “A prescription is needed to purchase EC”). See Table 2 for a list of items. Response options were “True,” “False,” or “I Don’t Know.” “I Don’t Know” responses were recoded as incorrect, and responses were summed to reflect the total number of EC knowledge questions participants answered correctly with a possible range of 0 to 6.

Intentions to Use EC.

Previous research has asked participants about their risk of pregnancy and the value of obtaining EC, i.e. “Risk of pregnancy is low enough that it is not worth it to obtain EC.”⁷ This item informed our approach to directly asking participants if they intended to use EC if a situation arose in which EC use was appropriate because their risk of pregnancy might be high. Specifically, participants were asked the following question to assess their intentions to use EC: “If you were in a situation where EC would reduce your risk of an unintended pregnancy (e.g., you had unprotected sex), how likely would you be to use emergency contraception?” Responses were rated on a 7-point Likert scale ranging from “*extremely*

¹Only two women reported having heard of EC exclusively from a health information source; the remaining women in the high credibility source group had heard from a health information source along with media and/or interpersonal source.

unlikely” to “*extremely likely*.” This 7-point scale was an intention score that ranged from 1–7.

Data Analysis

To address our hypotheses we analyzed our data in three stages. First, descriptive analyses were conducted to identify participants’ sexual history, previous use of EC, intentions to use EC, EC knowledge, and the percentage of individuals who had received information about EC from each information source. Next, we conducted two one-way ANOVAs to examine differences in EC knowledge and intentions between women in each of the categories of EC information source credibility. Finally, to test whether EC knowledge mediated the relationship between EC sources and intentions to use EC, we employed bias-corrected bootstrapping methods to estimate indirect effects using the SPSS macro PROCESS.¹⁸ All analyses were conducted using SPSS version 22.

RESULTS

Sample characteristics

Among the final sample of 339 college women, the mean age of the sample was 18.4 years, and 76% of women were first-year college students. The majority of participants identified as heterosexual (94%). The ethnic composition of the sample was 67% White, 11% Black, 10% Asian, 5% Hispanic, and 5% mixed race participants. Initial analyses revealed that results from the ANOVAs and the mediation analysis did not differ when demographic variables such as age, race, and sexual orientation were included as control variables. As a result, the final analyses do not include control variables.

Regarding sexual history, over three-quarters of the sample ($n=272$) reported previous engagement in sexual activity. Of the women who reported being sexually active, 80% had engaged in sexual intercourse, of which the average age at first vaginal sex experience was 16.8 years (range 13 to 19). Additionally, three of the participants who reported previous sexual intercourse had ever been pregnant, while another four were unsure if they had ever been pregnant. Finally, nearly a quarter of the sample ($n=84$, 24.8%) reported having previously used EC. Of the women who reported previous EC use, 57% used EC only one time, 21.5% used it two times, and 21.5% used it three or more times.

Descriptive information: Source credibility, EC knowledge, and EC intentions

As shown in Table 1, 3% of respondents ($n=10$) had never heard of EC (“no sources”), 27% ($n=90$) had heard of EC from *only* media and/or interpersonal sources (“low credibility sources”), and 70% of respondents ($n=239$) had heard of EC from health information sources (“high credibility sources”). Regarding EC knowledge, as shown in Table 2, knowledge about drug mechanisms, availability, and laws surrounding EC was limited. Although 94% of women knew they could purchase EC without a prescription, the percentage of women who correctly answered each of the other EC knowledge questions varied considerably. Specifically, 19% of women knew EC would not harm a fertilized egg and 36% of women knew that a person could purchase EC even if she was under the age of 18. Out of a possible 6 points, the mean score on the knowledge scale was 3.6 ($SD=1.34$).

Regarding EC use intentions, 49% ($n=166$) of participants indicated they would be “*extremely likely*” to use EC if needed in the future, and an additional 25% ($n=85$) reported being “*very likely*” to use EC. Further, 8% ($n=27$) indicated they would be “*very unlikely*” or “*extremely unlikely*” to use EC in the future. The range of scores on the EC use intentions scale was 1–7 with a mean of 5.89 ($SD=1.59$).

Comparisons of EC Knowledge and Intentions by Source Credibility

One-way ANOVAs were used to examine differences in EC knowledge and EC use intentions between women in each of the categories of EC information source credibility. As shown in Table 3, there were significant differences in both EC knowledge and EC use intentions by source. Posthoc comparisons revealed that respondents who had heard of EC from a high credibility information source had significantly higher knowledge scores ($M=3.77$, $SD=1.20$) than respondents who had heard of EC from a low credibility information source ($M=3.33$, $SD=1.54$; 95% CI [0.34, 2.39]) and respondents who had never heard of EC ($M=2.40$, $SD=1.78$; 95% CI [0.04, 0.82]). Similarly, respondents who heard of EC from high credibility information sources had significantly higher intentions to use EC ($M=6.13$, $SD=1.30$) than respondents who had heard of EC from low credibility information sources ($M=5.26$, $SD=2.04$; 95% CI [0.41, 1.33]); this significant difference did not hold for those who had never heard of EC ($M=5.80$, $SD=1.87$; 95% CI [−0.87, 1.33]).

Mediation Analyses

To test whether EC knowledge mediated the relationship between EC sources and intentions to use EC, we utilized bias-corrected bootstrapping methods to estimate indirect effects.¹⁸ Bootstrapping is a nonparametric resampling procedure where a large number of samples (1000 for this study) are drawn with replacement from the full data set.¹⁹ Bias-corrected bootstrapping within tests of mediation has a number of benefits, including maintaining statistical power, minimizing Type 1 error, and allowing for accurate estimates of variables (including indirect effects) that are not normally distributed.^{19–21} The bootstrap procedure was conducted using the SPSS macro PROCESS.¹⁸ An indirect effect was considered significant if zero was not included in the 95% bias-corrected confidence interval.¹⁸

Outcomes of the mediation test are shown in Figure 1. Three variables were included in this model: the independent variable was EC information source credibility, the mediator was EC knowledge, and the dependent variable was intentions to use EC. First, the path from EC information source credibility to EC knowledge was found to be significant ($b=0.52$, $SE=0.14$, $p<.001$, 95% CI [0.26 – 0.79]). Next, the path from EC knowledge to intentions to use EC was also found to be significant ($b=0.32$, $SE=0.06$, $p<.001$, 95% CI [0.20 – 0.45]). Finally, both the direct and indirect effects of EC information source credibility on intentions to use EC were tested. The direct effect was found to be significant ($b=0.45$, $SE=0.16$, $p<.005$, 95% CI [0.14 – 0.76]). In addition, the indirect effect of EC information source credibility on intentions to use EC via EC knowledge was significant ($b=0.17$, $SE=0.06$, 95% CI [0.08, 0.34]), providing evidence that EC knowledge mediates the relationship between EC information sources and intentions to use EC.

DISCUSSION

Misinformation about EC threatens ongoing efforts to stem unwanted and unintended pregnancies, especially among young women. A possible cause to such misinformation may be knowledge acquisition from non-credible sources. Based on this hypothesis, this study tested the relationship between young women's EC information sources and knowledge and their intentions to use EC. Importantly, nearly three-quarters of women (74%) in the current study reported they would be very or extremely likely to use EC if needed, a percentage higher than the 55% and 67% of women reported in previous research.^{7, 10, 14} It is possible that increased awareness and accessibility of EC may be contributing to greater EC use intentions among college women. However, nearly a quarter of the current sample did not report strong intentions for EC use, highlighting the ongoing need to understand factors that might influence women's intentions to use EC.

In terms of knowledge about EC, our findings parallel previous research demonstrating that many students are misinformed regarding EC's accessibility and its drug-based mechanisms.^{6, 9, 11} However, unlike in past research,^{7, 17, 22} the majority of women in this study reported knowing the accurate timeframe for EC use and could correctly identify that EC is not an abortion pill. Importantly, more accurate knowledge of emergency contraceptive was associated with higher intentions to use EC if needed.

The overarching factor that may help to explain levels of knowledge about EC and intentions to use it is the source through which women received their information about EC. Nearly three-quarters of respondents had heard of EC directly from a health information source, such as a doctor or school sex education program, and this high source credibility appears to have impacted women's knowledge and intentions. Specifically, compared to women who had not heard of EC or had only heard of EC through the media or interpersonal sources (e.g., friend or peers), women who had heard of EC from health information sources had significantly higher EC knowledge scores and higher intentions to use EC in the future. These findings are consistent with source credibility theory in that communications about EC from high credibility sources, such as doctors, should have more impact than communications from low credibility sources.¹³ Interestingly, there were no significant differences in intentions to use EC among women who had only heard of EC from interpersonal or media sources compared to women who had never heard of EC, although the sample size of the 'never' group was very small. Taken together, these findings demonstrate the need to increase the dissemination of EC information from highly credible (ideally health) sources. In addition, they suggest the need to identify possible misinformation being disseminated by less credible sources and to correct this misinformation where possible.

Finally, as anticipated, EC knowledge was found to mediate the association between EC information sources and intentions to use EC. Thus, having heard of EC from more credible sources was positively associated with accurate EC knowledge, and having more accurate EC knowledge was associated with young college women's intentions to use EC. However, there was also a direct effect of source on intentions to use EC. Thus, there may be two possible mechanisms by which high credibility sources impact intentions to use EC. First,

they may be more persuasive and therefore directly impact intentions to use EC based on young women's perceptions of their credibility. Second, they may more accurately communicate factual information about EC, and have influence through that transmission of information. Based on these findings, future EC awareness efforts targeted to college women should emphasize accurate EC information delivered by credible information sources, such as healthcare professionals. College campus health centers are an ideal venue to deliver this kind of accurate, highly credible information to young women; additional educational efforts from campus health centers to reach students with information about emergency contraception would be of great utility.

Limitations

While this study contributes important information to the very limited literature on EC intentions, it is not without limitations. First, this was a self-report study that utilized a convenience sample of college women. Results should be replicated and extended among more diverse samples of women from the community and other areas of the country. In addition, although our measure of health information sources allowed us to capture a variety of potential sources (e.g., doctors, sexual education classes), future research might examine such health information sources individually to determine if there could be differences in women's knowledge about and intentions to use EC based on the specific health information source. Future research should also aim to capture the specific aspects of messages that may be working to increase knowledge and intentions, such as message content, quality, frequency, and perceived credibility.^{13, 23} Finally, although the study employs statistical mediation analysis, the study is limited by its cross-sectional design, which does not allow for causal interpretations of the associations between variables. Future work should examine young women's knowledge and use of EC over time in longitudinal studies.

Translation to Health Education Practice

EC has the potential to greatly reduce the rate of unintended pregnancies and abortions in teenagers and young adults.¹ For college women, 80% of whom are currently sexually active,² EC is now readily available without a prescription for purchase and use.⁴ But ensuring successful access and use of EC depends on having heard of the contraception from credible sources. Our study indicates that having heard of EC from more credible health information sources is associated with greater accuracy of EC knowledge and higher intentions to use EC. However, a sizeable percentage of this population reports having heard of EC from a lower credibility information source, which is associated with lower levels of EC knowledge and intentions to use EC. These findings present two opportunities for health education.

First, to correct these low levels of EC knowledge and EC use intentions, health education efforts should involve healthcare providers and other credible health information sources to promote information about EC. For young adults, campus health centers and their associated providers may be particularly important sources of accurate EC information given their direct access to young people on college campuses. Likewise, instructors of health-related

courses can serve as credible health information sources that can accurately educate about EC.

Second, this study suggests that EC education should focus on promoting accurate information about EC access and EC use. Our study revealed that a sizable portion of the population was unaware EC is available without a prescription and to persons under the age of 18, and that EC is incapable of harming an already fertilized egg. Thus, health education can correct for either misinformation or a lack of information on EC's availability and drug mechanisms. Health educators should also explain that this contraception is not to be used as a primary form of birth control and that it cannot prevent sexually transmitted diseases.^{4, 24} Health education of this kind will help promote safe and effective use of EC, as well as correct misinformation that may be hindering young adults' abilities to access or use EC.

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Figure 1:

Mediation of the association between EC information source and EC use intentions by EC knowledge among a sample of young college women ($n=339$)

Coefficients for the relationship between EC information sources and intentions to use EC as mediated by EC knowledge. The direct effect of EC information sources onto intentions to use EC is .45. The indirect effect of EC information source on intentions to use EC, via EC knowledge, is .17, shown in parentheses.

*Indicate the confidence intervals do not include 0, which shows significance.

Table 1. Emergency contraception information sources among a sample of young college-aged women ($n=339$)

Variable	<i>n</i>	%
<i>Ever heard of EC</i>		
Yes	329	97.1
No	10	2.9
<i>Heard of EC from media source</i>		
Never	33	9.7
Once	21	6.2
A few times	130	38.3
Many times	155	45.8
<i>Heard of EC from health source</i>		
Never	100	29.5
Once	66	19.5
A few times	143	42.2
Many times	30	8.8
<i>Heard of EC from interpersonal source</i>		
Never	46	13.6
Once	35	10.3
A few times	174	51.3
Many times	84	24.8
<i>Information Source Credibility Categories</i>		
No Sources/None	10	2.9
Low Credibility (only media and/or interpersonal)	90	26.5
High Credibility (health information source)	239	70.5

Table 2. Emergency contraception knowledge responses among a sample of young college-aged women ($n=339$)

Item (correct response)	Percentage correct	Correct
<i>You need a prescription to buy EC. (false)</i>	93.5	
<i>You must be over 18-years-old to purchase EC (false)</i>	36.0	
<i>EC is an "abortion pill" (false)</i>	77.3	
<i>EC could harm a pregnant woman's fertilized egg (false)</i>	19.2	
<i>EC cannot be sold on college campuses (false)</i>	55.8	
<i>EC can be taken up to 5 days after unprotected sex (true)</i>	79.4	

Table 3.

Emergency contraception knowledge and emergency contraception use intentions by information source credibility category ($n=339$)

	<u>No Sources($n=10$)</u>		<u>Low Credibility($n=90$)</u>		<u>High Credibility($n=239$)</u>		
	Mean	SD	Mean	SD	Mean	SD	One-Way ANOVA
Knowledge	2.40	1.78	3.33	1.54	3.77	1.20	$F(2,336)=7.90^{***}$
Intention	5.80	1.87	5.26	2.04	6.13	1.30	$F(2,336)=6.44^{**}$

Note. Knowledge scores ranged from 0–6. Intention scores ranged from 1–7.

***
 $p < .001$

**
 $p < .01$