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Title

Use of the CDC US medical eligibility criteria for contraceptive use among primary care physicians

Permalink

<https://escholarship.org/uc/item/13q2x1dz>

Journal

Contraception, 86(3)

ISSN

0010-7824

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Publication Date

2012-09-01

DOI

10.1016/j.contraception.2012.05.077

Peer reviewed

family planning knowledge, including the development of novel platforms for technology-based learning.

Conclusions: Countrywide consultations have informed the development of an innovative 10-year program research agenda to enable improvements in equitable access to high-quality family planning, particularly for vulnerable women and families throughout Canada.

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CANADIAN RURAL COMPARED TO URBAN FIRST- AND SECOND-TRIMESTER ABORTION SERVICES: FINDINGS OF THE BRITISH COLUMBIA ABORTION PROVIDER SURVEY

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Objectives: Rural hospital-based abortion service, although increasingly less common than urban clinic-based service, remains more accessible for a significant portion of women in British Columbia (BC). Little is known of the techniques of rural abortion service. This study assessed practice among rural and urban abortion providers in BC.

Methods: A self-administered, previously published survey instrument was distributed to all BC abortion providers on the provincial referral registry. This analysis reports on first- and second-trimester abortion techniques.

Results: The 46 respondents included 90% of urban and 82% of rural providers. Overall, 90% of first-trimester and 98% of second-trimester abortions were performed in 3 urban areas where only 57% of reproductive age women live. Early medical abortions (15% of all abortions) were available from most rural providers (73%) and two of seven urban facilities. Rural versus urban techniques of surgical abortion differed in use of diagnostic testing, cervical preparation, anesthesia, instrument techniques, examination of products and antibiotic prophylaxis. Medication abortion practices differed by medications employed and antibiotic prophylaxis. Rural providers performing abortions for fewer than 15 years reported techniques similar to those of urban providers. Second-trimester inductions were offered in 41% of rural facilities, and surgical abortions at gestations of more than 16 weeks were offered by 4% of rural providers, both only for fetal indications. Rural services were predominantly operating-room based, usually employing general anesthesia, while urban abortions occurred primarily in outpatient settings utilizing local anesthesia and conscious sedation. **Conclusions:** Rural abortion services have limited accessibility, lower gestational limits and a greater range of individual practice techniques than urban abortion services in BC.

P32

EXPERIENCES OF RURAL VERSUS URBAN ABORTION PROVIDERS IN BRITISH COLUMBIA: INTERVIEW FINDINGS FROM THE BC ABORTION PROVIDERS SURVEY

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Objectives: In Canada, abortions are increasingly performed in large urban clinics. In British Columbia (BC), the number of rural abortion providers has declined by 68% since 1998. Our objective was to explore and compare the experiences and challenges faced by rural and urban abortion providers in BC.

Methods: The mixed methods BC Abortion Providers Survey employed self-administered paper surveys distributed to current and past abortion providers, with optional follow-up interviews, the latter reported here. Interview probes focused on the challenges faced by providers and on issues relating to future abortion provision in their communities. Transcribed interviews were analyzed using cross-case and thematic analysis.

Results: Surveys were completed by 85% of current registered abortion providers in BC. A total of 71% of these providers volunteered for semi-structured in-person or telephone interviews. Emerging themes differed between urban and rural providers. Most urban providers reported a supportive environment and few barriers to provision. Rural providers exclusively performed abortions within community hospitals and reported significant barriers to provision, including insufficient operating room time, anesthesiologist and nursing logistic issues, high demand and professional isolation. Many rural providers identified a need to “fly under the radar” in their community. With respect to future provision in their communities, many rural providers described a lack of resources and a scarcity of potential successors.

Conclusions: We present the first study comparing the experiences of rural and urban abortion providers in Canada. This study identifies significant challenges faced by rural providers and a role for focused support initiatives that could address administrative and hospital logistic barriers and the training of replacement providers.

P33

MEDICAL CONTRAINDICATIONS IN WOMEN SEEKING COMBINED HORMONAL CONTRACEPTIVES

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Objectives: To evaluate the prevalence of medical contraindications in a large group of women seeking combined hormonal contraceptives (CHCs). **Methods:** The Contraceptive CHOICE Project is a large prospective cohort study designed to promote the use of long-acting reversible contraceptive methods to reduce unintended pregnancies in the St. Louis region. Participants are provided reversible contraception of their choice at no cost. During baseline enrollment, participants were asked about their desired methods of contraception and medical history. Potential medical contraindications were defined as self-reported history of hypertension, heart attacks, strokes, migraines with aura, thromboembolism, liver disease or smoking in women older than 35. We reviewed all charts of women with medical contraindications to verify all conditions. Binomial 95% confidence intervals (CI) were calculated around percentages.

Results: Of the 5,088 women enrolled into the CHOICE project between August 2007 and December 2009, 1,010 (19.9%) women desired CHCs at baseline. Sixty-eight (1.34%, 95% CI 1.04%–1.69%) women were defined as having a medical contraindication to CHCs at baseline. After reviewing the 68 charts, only 7 (0.14%, 95% CI 0.06%–0.28%) of these participants were found to have true medical contraindications to CHCs, including 2 with uncontrolled hypertension, 2 with migraines with aura and 3 smokers older than 35.

Conclusions: The prevalence of medical contraindications to CHCs was very low in this sample of reproductive age women. This low prevalence of contraindications is further evidence to support the safety of providing CHCs without a prescription (over the counter).

P34

USE OF THE CDC US MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE AMONG PRIMARY CARE PHYSICIANS

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Objectives: In May 2010, the Centers for Disease Control and Prevention (CDC) released the US Medical Eligibility Criteria for Contraceptive Use (CDC MEC) to provide evidence-based guidance on contraceptive safety in US women with medical conditions. This study evaluates use of the CDC

MEC by physicians who have completed residency training and prescribe contraception.

Methods: US obstetrician/gynecologists (OBGs), family medicine physicians (FPs), and internists (IMs) were surveyed at national conferences specific to each specialty between April 2011 and September 2011.

Results: The 754 respondents included 190 OBGs (25%), 326 FPs (43%), and 239 IMs (32%). Fewer than half ($n=295$, 39%) of respondents had heard of the World Health Organization MEC, CDC MEC, or both, and only 175 (23%) had previously used either or both MECs; among the 120 respondents (16%) who had previously used the CDC MEC, rates of use differed significantly by specialty (27%, 12%, and 13%, respectively, $p<.0001$). Board-certified physicians were less likely to have used the CDC MEC previously, even when accounting for age and time in practice (OR 0.25, 95% CI 0.12–0.52). Working in a university practice was associated with a higher likelihood of using the CDC MEC (OR 1.66, 95% CI 1.27–2.8).

Conclusions: Although the CDC MEC is designed to be used regularly by primary care and specialty physicians, relatively few primary care physicians have used it since its release. More work must be done to disseminate the CDC MEC, especially to physicians who are not in a university setting.

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PERCEIVED COUNSELING REGARDING CONTRACEPTION AND PREGNANCY AMONG WOMEN WITH SICKLE CELL DISEASE

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Objectives: Increased maternal mortality among women with Sickle Cell Disease (SCD) underscores the need for the use of effective contraceptives. Women with SCD have multiple health care providers potentially counseling them about contraception. This can create confusion and contribute to non-usage. The purpose of this study is to identify perceptions of counseling and reasons for contraceptive non-usage among women with SCD in the greater Los Angeles area.

Methods: Women with SCD aged 15–44 registered through the Los Angeles branch of the Sickle Cell Disease Foundation of California or attending the Los Angeles County+University of Southern California Medical Center Sickle Cell Disease Clinic completed an anonymous, self-administered 76-item reproductive health survey between March and September 2010.

Results: Of the 43 participating women, 40 (95%) were advised not to conceive secondary to SCD. Seventeen women (40%) also reported being advised against specific contraceptives (including condoms, depot medroxyprogesterone acetate, implants, oral contraceptive pills, and intrauterine devices). Fourteen women (33%) who did not desire pregnancy reported unprotected intercourse. Reasons for contraceptive non-use included concern about side-effects or complications related to SCD, difficulty obtaining a method and inconvenience.

Conclusions: Most women with SCD are appropriately counseled against pregnancy. However, although benefits of contraceptive use outweigh the risks for such women, many report being counseled against using acceptable contraceptive methods. More consistent messaging concerning contraception is needed among health care providers who may encounter women with SCD.

P36

THE INFLUENCE OF DEPRESSION AND STRESS SYMPTOMS ON YOUNG WOMEN'S CONSISTENCY OF CONTRACEPTIVE USE

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Objectives: Depression and psychological stress contribute to high-risk sexual behavior and medication misuse, yet their influence on contraceptive use patterns is unknown. We examined relationships between young women's psychological symptoms and consistency of contraceptive use.

Methods: Women aged 18–19 years ($n=1250$) participating in a longitudinal cohort study completed weekly journals assessing contraceptive, reproductive, relationship and health characteristics and outcomes. Excluding journals in which women were pregnant or sexually inactive, we examined 7829 pairs of journals (weeks) from 12 months follow-up ($n=639$). Our outcome was consistency of contraceptive use during the last week (dichotomous). Predictors were baseline depression (CESD-5, range 0–15) and stress (PSS-4, range 0–16) scores and moderate/severe psychological symptoms (standardized score cutoffs). Analyses used random effects multivariate logistic regression models.

Results: Mean depression and stress scores were 2 ± 3 and 6 ± 3 points; 26% and 25% of the sample met criteria for moderate/severe depression and stress symptoms, respectively. Consistent contraceptive use was reported for 72% of weeks. Proportions of consistent contraceptive use were lower among women with moderate/severe depression and stress symptoms than those without (64% vs. 74% and 61% vs. 76%, respectively; $p<.001$). When covariates were controlled, the odds of consistent contraceptive use were reduced by 12% and 15% for each one-point increase in depression (OR 0.88, CI 0.81–0.96; $p=.004$) and stress (OR 0.85, CI 0.78–0.92; $p<.001$) scores. Women with moderate/severe stress symptoms were less likely to use contraceptives consistently than were those without stress (OR 0.35, CI 0.20–0.63; $p<.001$).

Conclusions: Psychological symptoms predict subsequent inconsistent contraceptive use patterns among young women.

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CHALLENGES IMPLEMENTING INFORMED CONTRACEPTIVE DECISIONS FOR WOMEN WITH EPILEPSY: A QUALITATIVE INVESTIGATION

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Objectives: This study aims to explore how women with epilepsy make contraceptive decisions in light of potential interactions between epilepsy medications, hormones and hormonal contraceptives, which can lead to changes in women's seizure patterns and contraceptive efficacy.

Methods: This study consists of analysis of 50 reproductive health-focused conversations posted to online forums used by women with epilepsy and 30 in-depth telephone interviews with women of reproductive age with epilepsy. Framework analysis methods were used to analyze the data; after becoming familiar with the data, a thematic framework was identified and the data were coded, charted, and interpreted.

Results: Most participants reported challenges implementing informed contraceptive decisions due to lack of individual and health care provider knowledge about potential interactions between epilepsy medications and hormonal contraceptives, the segregation of neurological and reproductive health care, and the costs of preferred contraceptives. Women experiencing these challenges often reported dissatisfaction with their health care provider, level of seizure control and contraceptive method. Many women reported that taking hormonal contraceptives affected their seizure patterns; increases or decreases in seizure occurrence appeared to be related to both their contraceptive choice and their specific seizure disorder. Also, a small number of women attributed their experiences with breakthrough bleeding or unplanned pregnancy to simultaneous use of epilepsy medications and hormonal contraceptives.

Conclusions: Findings suggest that women with epilepsy face challenges making informed contraceptive decisions that put them at increased risk for seizures and unplanned pregnancies. Interventions that jointly consider women's neurological and reproductive health are needed to ensure optimal health outcomes for this population.