Title

RACIAL DIFFERENCES IN SIDE EFFECTS DURING THE FIRST YEAR OF LEVONORGESTREL 52MG INTRAUTERINE SYSTEM USE

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System in Burkina Faso, we conducted a household survey that included novel survey questions on three subdomains of contraceptive autonomy: 1) informed choice; 2) full choice; and 3) free choice. Using these results, we calculate descriptive statistics of each of these subdomains and then show two possible calculations of the final contraceptive autonomy indicator. We then use multiple logistic regression to explore possible sociodemographic correlates and predictors of contraceptive autonomy.
Results: In all, 62.6% of women in our sample had an informed choice, 94.9% had full choice, and 95.5% had free choice. Levels of general family planning knowledge and access were high, but knowledge about risks, disadvantages and side-effects and access to LARC removal were lower than access to method provision and knowledge of FP benefits. Overall contraceptive autonomy was 52% using an "all-or-nothing" approach to calculation, and 88% using an approach that allows for partial credit. Factors significantly associated with autonomy in the regression model include education, marital status and parity.
Conclusions: More work is needed to validate this indicator, but this proof-of-concept is an important step toward creating a population-based FP indicator that measures dimensions of rights-based and patient-centered care.

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PREDICTORS OF SEVERE PAIN ASSOCIATED WITH LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM PLACEMENT IN NULLIGRAVIDAS

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Objectives: The aim of this study was to identify sociodemographic and clinical factors associated with severe pain at the 52mg levonorgestrel-releasing intrauterine system (LNG-IUS) placement in nulligravidas.
Methods: This is a secondary analysis of a randomized controlled trial that evaluated lidocaine intracervical block for pain during LNG-IUS placement. We assessed the association of severe pain at LNG-IUS insertion in nulligravidas with sociodemographic and clinical characteristics (depression and anxiety screening scales, uterine length by uterine sounding, position of the uterus, body mass index, history of dysmenorrhea, difficult IUS insertion, and receiving a lidocaine intracervical block). Severe pain was defined as reporting a visual analog scale (VAS) score equal or greater than seven cm at device placement. Multiple logistic regression analysis was used to determine predictors of severe pain at LNG-IUS placement.
Results: Of 300 nulligravidas who had a successful LNG-IUS insertion, 137 (45.7) reported severe pain at LNG-IUS insertion. The multiple regression analysis showed that receiving lidocaine intracervical block reduced the risk of reporting severe pain at IUS insertion (adjusted relative risk, 0.55; 95% CI, 0.37–0.80), while having a history of dysmenorrhea increased the risk of reporting severe pain at IUS insertion (1.36; 1.08–1.72).
Conclusions: For nulligravidas, having a history of dysmenorrhea was positively associated and receiving a lidocaine intracervical block was negatively associated with severe pain at LNG-IUS placement.

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INTEGRATING REPRODUCTIVE GOALS ASSESSMENT WITH CONTRACEPTIVE-DECISION SUPPORT IN PRIMARY CARE: A PILOT TEST OF THE MYPATH TOOL

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Objectives: This study was conducted to pilot test MyPath, a patient-facing web-based decision support tool integrating reproductive goals assessment, pre-pregnancy health education, and contraceptive-decision support, in Veterans Health Administration primary care.
Methods: We performed a pilot study among female veterans aged 18–44 scheduled for a visit with 8 primary care providers. A control group (n=28) was recruited prior to, and an intervention group (n=30) recruited after, introducing MyPath into the clinic. Intervention participants used MyPath on iPads in the clinic before their visit. We assessed acceptability and feasibility by surveying intervention participants and providers. Occurrence of family planning (contraceptive and/or pre-pregnancy health) discussions; changes in pre/post visit family planning knowledge, communication self-efficacy, contraceptive decisional conflict; and change from non-prescription/no method to prescription methods (pill, patch, ring, injection, implant, intrauterine device) were compared between groups with t-tests or chi-square tests as appropriate.
Results: Nearly all participants who used MyPath reported they learned new information (97%) and 93% reported they would recommend it to other veterans. No providers reported that the tool significantly increased their workload. A greater proportion of intervention participants than of controls reported having family planning discussions during their visit (93% vs. 68%; p=.02). Compared with controls, intervention participants experienced greater increases in knowledge (+1.7 vs. +0.2; p<.001) and communication self-efficacy (+0.8 vs. +0.2; p=.02), and trends toward greater reduction in decision conflict (−23% vs. −7%; p=.11) and change to prescription methods (+13% vs. +4%; p=.20).
Conclusions: MyPath was highly acceptable to female veterans, and increased family planning discussions and improved decision quality without increasing providers' perceived workload. A larger randomized evaluation of effectiveness is warranted.

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RACIAL DIFFERENCES IN SIDE EFFECTS DURING THE FIRST YEAR OF LEVONORGESTREL 52MG INTRAUTERINE SYSTEM USE

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Objectives: This study describes differences by race in reported side effects over the first year of levonorgestrel 52mg intrauterine system (IUS) use.
Methods: Women aged 16–45 years enrolled in a trial evaluating a levonorgestrel 52mg IUS. Investigators asked participants at each contact about side effects or other concerns. We evaluated potential IUS-related side effects during the first year of use by race, excluding

women who did not report race during screening and those using an IUS in the month prior to enrollment. We compared side effects reported by white and black women with a multivariable analysis designed a priori to adjust for hormonal contraceptive use in the month before IUS placement, parity, obesity, and age.
Results: The population included 1242 (80.6%) white, 208 (13.5%) black, 63 (4.1%) Asian and 27 (1.7%) other women. In univariate analysis including all women, side-effect reporting differed significantly ($p<.05$) by race for acne, vaginal bacterial infection, headache, and leukorrhea. In multivariable analysis including only white and black women, white women more frequently reported mood changes (5.4% vs. 1.9%, aOR=3.3 [95% CI=1.2–9.2]) and acne (13.5% vs. 5.3%, aOR=2.1 [95% CI=1.1–4.0]). Black women more frequently reported leukorrhea (10.1% vs. 2.7%, aOR=4.1 [95% CI=2.2–7.5]), dysmenorrhea (3.4% vs. 1.0%, aOR=3.8 [95% CI=1.5–9.8]), vaginal bacterial infection (25.0% vs. 8.1%, aOR=3.1 [95% CI=2.1–4.6]), dyspareunia (9.1% vs. 5.5%, aOR=1.9 [95% CI=1.1–3.4]), mastalgia (7.7% vs. 4.3%, aOR=1.9 [95% CI=1.0–3.6]) and headache (10.6% vs. 5.9%, aOR=1.8 [95% CI=1.1–3.0]).
Conclusions: Women of different races using a levonorgestrel 52mg IUS may report similar types of side effects but with a difference in frequency, suggesting a need for tailored counseling of women planning IUS use.

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PROVIDER PERSPECTIVES ON BARRIERS AND FACILITATORS OF LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC) USE IN A LARGE HEALTH SYSTEM IN WESTERN PENNSYLVANIA

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Objectives: Though a primary goal of the ACA mandate was to eliminate cost as a barrier to accessing the full range of contraceptive methods, including LARCs, only 10% of women in the United States utilized LARC methods in 2015–2017. Qualitative interviews were conducted with obstetrics/gynecology providers to understand perceived barriers and facilitators to LARC access.
Methods: Thirty interviews were conducted with "high-uptake" (>42 LARCs administered in 2017 [median administration rate]), and "low-uptake" (<42 LARCs administered) providers. Interviews were recorded and transcribed. Two coders developed a codebook based on an iterative review of transcripts and then applied themes to remaining transcripts, holding regular meetings to adjudicate coding disagreements. Directed content analysis was utilized throughout the analytic process.
Results: Providers emphasized insurance pre-authorization processes and provider preferences for menstruation, STI testing, multiple pregnancy tests, and use of misoprostol around timing of LARC placement as barriers to LARC access. Almost half of providers delayed difficult IUD placements/removals due to not having ultrasound or hysteroscope capabilities at their practices. Two-thirds of providers reported their practice keeps LARCs in stock and stated this was beneficial for same-day placement. Clinic-level facilitators included extending office hours, having pre-assembled LARC insertion kits, and training all staff on how to prepare LARC consent forms.
Conclusions: Understanding the diversity of barriers and facilitators is vital for optimizing LARC provision. These findings demonstrate heterogeneity across participating providers and practices regarding their LARC provision policies and may provide guidance for organizational changes that support standardized guidelines for LARC provision.

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ARE BIRTHS FOLLOWING LARC USE MORE LIKELY TO BE INTENDED?

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Objectives: Long-acting reversible contraceptive (LARC) methods have been promoted as an effective means of protection against unintended pregnancy and for increasing the proportion of pregnancies that are intended. Whether births following LARC use are more likely to be intended than births following use of other reversible contraceptive methods has yet to be examined at a population-based level.
Methods: Drawing on nationally representative data for 3023 women aged 15–44 who reported a live birth in the 3–4 years prior to the 2006–10, 2011–13, and 2013–15 National Survey of Family Growth (NSFG), we estimated the intendedness ratio by last reported contraceptive method used before the birth. In addition to LARC, we distinguished between moderately effective (e.g., hormonal pill) and less- effective (e.g., condom, withdrawal) contraceptives. Binary logistic models regressed intendedness status on contraceptive type while adjusting for key sociodemographic background factors.
Results: In bivariate analysis, 79.1% (95% CI: 68.5–86.9) of births following LARC use were intended, compared with 61.4% (57.1–65.6) and 62.3% (58.7–65.8) of births following moderately effective and less effective methods, respectively. Multivariate models confirm that births following LARC use are more likely to be intended (OR=2.2; 95% CI: 1.2–4.0) than those following use of a moderately effective method. No significant difference in intendedness was found between use of a less-effective and use of a moderately effective method (OR=1.1; 95% CI: 0.9–1.4).
Conclusions: We find strong evidence that, at a population-based level, births following LARC use are more likely to be intended than births following use of other reversible methods.

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VALIDATION OF THE INTERPERSONAL QUALITY OF FAMILY PLANNING SCALE IN A RURAL INDIAN SETTING

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Objectives: Family planning (FP) providers influence contraceptive choice, knowledge, and satisfaction. Dehlendorf et al. established the