



# 2015 Risk and Facilitating Factors of Contraception Use among Female Methadone Clinic Patients, Ages 18-45

A Report to the Tennessee Department of Health

Knox County Health Department

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## Executive Summary

**Introduction:** More than half (52.1%) of Tennessee babies diagnosed with NAS in 2014 were from the Eastern area. Knox County reported 103 NAS babies, accounting for 11% of Tennessee babies diagnosed with NAS. Over a quarter of the women who gave birth to babies diagnosed with NAS (27.7%) had prenatally used only prescribed opioids (TDOH, 2015); this figure includes women enrolled in a medication assisted treatment (MAT) for opioid addiction. Prevention of unintended pregnancies for women enrolled in MAT will assist in reducing the number of babies diagnosed with NAS.

**Objectives:** This study addresses three objectives. First the characteristics of the women enrolled in MAT are examined. Next, their current and past contraception use are described. Finally, the association of birth control related knowledge and attitudes with birth control use are analyzed.

**Methods:** Survey data were collected from 291 respondents at two behavioral health clinics in Knoxville.

**Results:** A third of the women (33.1%) reported their general health as poor or fair. Contraception knowledge (percent correct for knowledge questions) was very low (mean 23.0%; median=22.2%). The most frequently cited contraception failure included the pill (64.4%), condom (26.7), and Depo Provera (25.6%). In selecting the barriers to contraception use, the respondents most frequently indicated insurance coverage. In assessing factors related to current contraception use, cigarette use decreased the likelihood of current contraception use by 59% ( $p<.05$ ). Women who ever had a medical visit related to contraception were 3.5 times more likely to be currently using contraception.

**Conclusion:** Strategies must be taken to ensure that all women enrolled in medication-assisted treatment (MAT) for opioid addiction have affordable care that is responsive to their complicated and oftentimes traumatic histories. Educating women about contraception possibilities that do not require a pelvic exam and securing grants and sponsorship to provide free contraception options may enhance the likelihood of contraception use. If Tennessee were to enforce the Federal mandate, this could potentially decrease the contraceptive challenge that insurance has been presenting for women enrolled in MAT.

## Introduction

### Purpose

Prevention of unintended pregnancies for women who are challenged with opioid addiction will assist in reducing the number of babies born with Neonatal Abstinence Syndrome. Toward this end, we examined the barriers and facilitators of birth control use for women enrolled in a clinic providing pharmacotherapy (i.e., methadone or suboxone) to persons addicted to opioids. First the characteristics of the women who participated in the study will be reviewed. Next, their current and past contraception use will be described. Finally, the association of birth control related knowledge and attitudes with birth control use will be examined.

### NAS and Contraception Use among Women Addicted to Opioids

According to the Tennessee Department of Health's NAS Summary Archive, Knox County reported 103 NAS babies born in 2014, which accounted for 11% of Tennessee babies diagnosed with NAS. This was a rate of 22.6 per 1,000 live births. More than one-half (52.1%) of the NAS babies reported in Tennessee in 2014 were from the Eastern area of the state (Knox Metro: 10.6%, East Region: 27.1%, North East Region: 14.4%). Over a quarter of the women who gave birth to babies diagnosed with NAS (27.7%) had prenatally used only prescribed opioids (TDOH, 2015). This classification would include women who consistently followed their medication-assisted treatment (MAT) during their pregnancy.

## Methods

### Data collection process

Survey data were collected from 291 respondents at two Behavioral Health Group (BHG) clinics in Knoxville. Women met the criteria of the study if they were 18-45 years of age, currently enrolled in one of two Behavioral Health Group (BHG) clinics in Knox County from January 12 to February 13 (25 days total). The BHG clinics specialize in opioid-dependency and offer maintenance treatment of methadone or suboxone. Women were recruited through printed media (flyers and posters) and word of mouth from research and clinical staff.

Women 18-45 years who were currently in treatment at the two BHG clinics were asked to participate in the survey by paid, part-time Knox County employees while they waited in the clinics for their treatment services. At one clinic: BHG-Bernard, the women could take the survey on provided laptop computers or on paper behind privacy screens in a section of the lobby. At the second clinic: BHG-Citico, the women were asked to go to the third floor conference room in the building where they were met by a second research assistant who assisted them with the computer or paper entry. Recruitment was facilitated by small handbills, which were provided by the survey assistants and also left at the clinics for distribution. On the last week of the recruitment, signs were put up in the clinic lobbies while the surveys were being collected that advertised the survey. At the time of the study, 135 women were enrolled at the Citico site and an estimate for the Bernard site was not clearly determined.

All survey assistants were paid, part-time employees of the Knox County Health Department (KCHD), and carried KCHD ID badges. All the survey assistants were women with completed bachelor degrees (or higher) with research experience, who had completed trainings on survey recruitment ethics in vulnerable population and human subjects training (based on the Belmont Report). Recruitment usually took place between the hours of six to ten a.m. at both clinics Monday through Fridays. The hourly

schedule would vary based on availability of the researchers and other factors. The principal researchers: Drs. Brown, Meschke, and Prather and Alicia Verlinde MPH would fill in on some of these work recruitment shifts, when necessary.

Respondents could enter their responses to the 61-item survey directly into a secure Survey Monkey site or on paper to be entered into the database later.

## Sample

After data cleaning for partial responses (< 10%) and responses from women older than 45 years, 287 women were included in the final analysis.

## Results

### Characteristics of Women

**Demographics.** The women participating in the study resided primarily in Tennessee (97.1%) with 45.5% living specifically in Knoxville. A total of 22 TN counties and 2 KY counties were represented by the women with the top four being Knox (50.5%), Blount (11.1%), Sevier (7.3%), and Anderson (7.0%). Women from Kentucky and North Carolina (2.9%) were also represented in the study. The women were 18.5 to 45.9 years old (mean=33.9). Most of the women (94.3%) were white. Over a third of the women (37.6%) indicated that they were married. Other represented races included Native American, Asian, Black, and multiracial. Of the women, 2.4% were Hispanic. Almost two-thirds of the participating women had a high school degree or less (62.1%). A quarter of the participants (26.8%) had some college and 10.2% had finished a certificate, associates, bachelors, or some graduate level education.

A quarter of the women did not disclose their employment status. Of the remaining 215 women, more than a third were employed fulltime (38.6%) and nearly a quarter were employed part-time or temporary (23.3%) Almost half (49.5%) reported a household income of \$20,000 or less. Fewer than one in five (18.8%) had a household income of \$30,000 or more. Of the women, 41.1% had no insurance, 15.3% had private insurance, and the remaining 42.2% had public insurance.

**Health Concerns.** In general the women reported their overall health as good (42.2%) but a third viewed their health as poor or fair (33.1%; mean=2.85). Nearly one in five of the women (18.1%) experienced physical abuse in the past year and a third (32.4%) had had sex without giving consent in their lifetime. On a four- point depressed mood scale (see Appendix A) with 4 indicating high depressed mood in the past week, the women's responses ranged from 1-4 (mean=2.2; median=2.3). A score of three or higher was reported by 17.0% of the women.

Less than half of the sample shared how many drinks it takes to feel buzzed (n=127). Of these, the majority (60.6%) reported two and 39.4% reported three. An alcohol risk measure was created from three items, with a higher score (range of 0-3) indicated higher risk of alcohol misuse or abuse (see Appendix A). Of the 144 women who shared about their alcohol risk, 18.7% reported one or more concerns. It is interesting to note that half of the sample (n=143) did not answer any of these questions. Of the 275 women who shared, the majority smoked one or more cigarettes daily (80.1%), with almost two-thirds (64.0%) smoking 10-29 each day. Nicotine uptake was also achieved without smoking. Almost one in 10 (n= 26; 9.1%) reported currently using smokeless tobacco and 114 (39.7%) reported current use of e-cigarettes.

**Opioid use.** The source of the women's first opioid experience varied from a personal prescription (42.9%), a friend who had the drug (35.8%), family member's prescription (12.8%) to street contact who sold the drug (8.5%). The age of first opioid use ranged from 12 to 43 years (mean=20.3; median=19). Just over half of the women (53%) disclosed the year of their first methadone intake. This ranged from 1-18 years ago (mean=4.3; median = 2.5), with over 40% having their first methadone treatment intake one or two years ago.

**Reproductive Health.** Most of the women (57.1%) of the women were married or cohabitating. The majority of women (80.8%) indicated having had vaginal sex without a condom in the last two years. Most women (n=245; 85.1%) also reported one or more pregnancy (ranging from 1-10). Of the 245, over half of the women (52.6%) reported two or three pregnancies and almost a third (31.3%) had four or more pregnancies. Seventeen of the 287 women were pregnant at the time of the survey. Of women with a past pregnancy, 36.7% (n=90) reported getting pregnant while using birth control. The most frequently cited contraception failure related to these pregnancies included the pill (64.4%), condom (26.7), and Depo Provera (25.6%).

Of the 245 women reporting at least one current or previous pregnancy, nearly half had no planned pregnancies (43.3%). One of five (18.8%) had 100% planned pregnancies. An average of 36.9% (median=33.3%) of total pregnancies were unplanned (0-100%). The number of unplanned pregnancies ranged from zero to six with an average of 1.0 planned pregnancies for women with one or more pregnancies. Two-fifths of the women (42.6%) reported only unplanned pregnancies. Most women (67.9%) reported they never had an abortion. Of women with living children, 17.1% had had one or more child in Department of Children's Services' custody.

**Health Attitudes and Beliefs.** The women shared how much they agreed with four statements regarding NAS risk and concern on a five point scale (see Appendix A). Higher levels of agreement indicated greater perceived risk. The responses ranged from 1.75 to 5.0 (mean=4.3; median=4.3). Of the women, 76.2% responded at a level of agreement of 4.0 or greater, indicating a high level of perceived risk. A quarter of the women (26.6%) strongly agreed with all scale measures (i.e., mean=5).

Contraceptive knowledge was calculated through 27 true/false questions. Each woman was given a percentage score based on the number correct and total number answered (see Appendix A). Contraception knowledge was very low (mean 23.0%; median=22.2%) for the 280 women who responded to 1-27 of these questions (mean=20.5; median=21). The percent answered correctly ranged from 0-66.7%. Greater knowledge of contraception increases the likelihood of contraception use, so these figures indicate an opportunity for improvement.

### Past and Current Birth Control Use

Birth control use and its necessity were used to categorize the women in relation to susceptibility to becoming pregnant while enrolled at the methadone clinic. The first category included women who reported current birth control practice or women for whom birth control was not necessary for pregnancy prevention (e.g., currently pregnant, hysterectomy, partner with vasectomy, inability to conceive, or no intercourse with men). The second category included women who were at risk of pregnancy and were not using birth control. Women shared information about their current use and their use in the past five years.

Of the women not currently pregnant and not trying to get pregnant (n=276), 75.4% reported currently using one to four types of birth control (mean=.88; median=1). Due to high failure rates, contraception use did not include douching, withdrawal, or rhythm methods. The majority of the women reported only one method (64.1%) with the most common being tubal ligation (37.0%) and the condom (21.4%). A sharp drop then occurred to the next most used — Depo-Provera (7.6%), IUD (7.2%), and the pill (6.9%).

Birth control use in the past five years was also examined. Here 85.7% of the women reported using some type of birth control as necessary to prevent conception. The number of birth control methods used in the past five years ranged from 1 to 6 (mean=1.3; median=1.0). Condom (39.4%), surgical sterilization (31.1%), and the pill (24.0%) were the most common birth control methods. Depo-Provera (20.2%) and IUD (8.7%) followed next but much further behind.

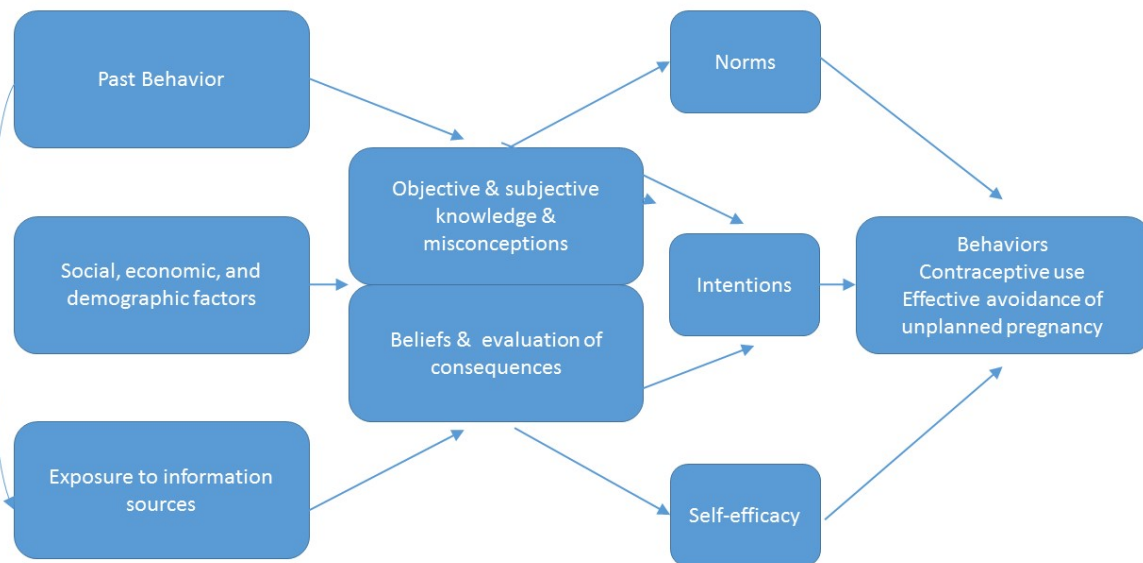
The women also shared reasons for missing or not making an appointment for birth control in the past year. Of the 287 women, 190 answered this question with 21 women (1.11%) shared they never missed an appointment for birth control. The more frequent reasons for missing birth control appointments included: tubes tied (43.7%), forgot (11.6%), and discomfort with the exam (10%). The remaining reasons were selected by fewer than 10% of the women.

### Barriers and Facilitators of Contraception Use

The barriers and facilitators of contraception use were examined based on a theoretical framework of factors associated with contraception use and unintended pregnancy (Kaye, et al., 2009; see Figure 1). Survey measures were available for all factors in the framework with the exception of intention. Given the limited number of participants, it was not feasible to assess the overall model, but instead a series of regression analyses were conducted.

Figure 1.

Framework of Factors related to Contraception Use and Unintended Pregnancy.





The category of predictors and associated measures are listed in Table 1.

Table 1.  
Measures used in Regression Models

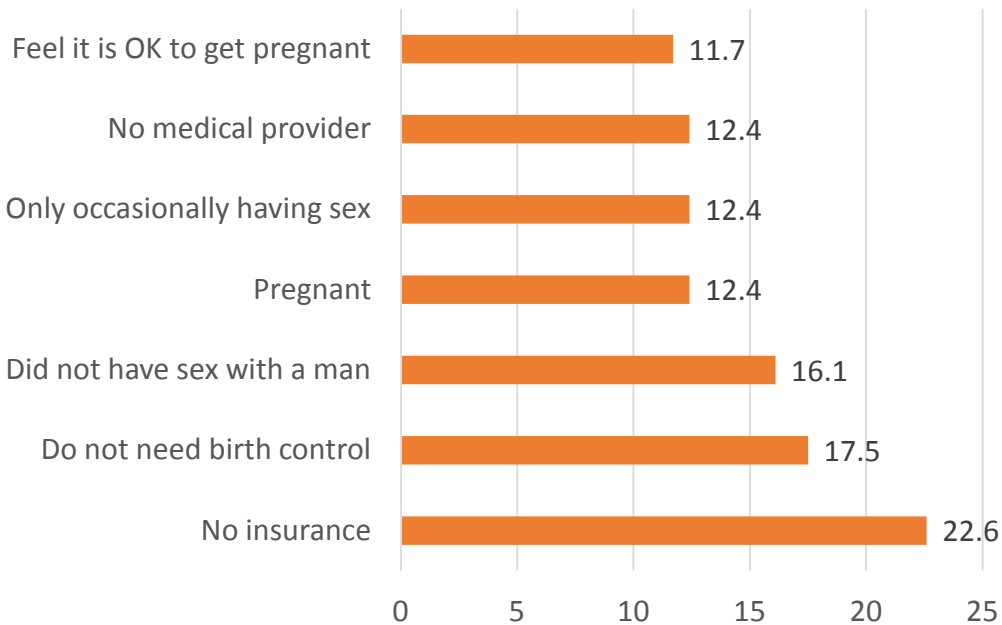
<i>Category</i>	<i>Survey Measure(s)</i>
Past behavior	<ul style="list-style-type: none"> <li>• Percent of unplanned pregnancies</li> <li>• Cigarette use (yes/no)</li> <li>• Past BC use</li> </ul>
Demographics	<ul style="list-style-type: none"> <li>• Married (yes/no)</li> <li>• More than HS education (yes/no)</li> <li>• Insured (yes/no)</li> </ul>
Exposure to contraceptive information	<ul style="list-style-type: none"> <li>• Past birth control visit</li> </ul>
Contraception knowledge or misconceptions	<ul style="list-style-type: none"> <li>• Percent answered correctly</li> <li>• Trust of drug companies</li> <li>• Trust of government</li> </ul>
Consequences	<ul style="list-style-type: none"> <li>• NAS risk</li> <li>• Women enrolled in methadone treatment should be required by law to use long lasting birth control (e.g., Depo-Provera or IUD).</li> </ul>
Self-efficacy	<ul style="list-style-type: none"> <li>• Birth control challenged due to arousal</li> <li>• Fate determines pregnancy</li> <li>• Partner determines use of birth control</li> </ul>
Contraception	<ul style="list-style-type: none"> <li>• Current birth control use</li> <li>• Tubes tied (bilateral tubal ligation; yes/no)</li> </ul>
Unplanned pregnancy	<ul style="list-style-type: none"> <li>• Percent of unplanned pregnancy</li> <li>• Unplanned pregnancy (yes/no)</li> </ul>

Due to the limited sample size only one slice of the overall model were included in each regression model. Three models for each of the four outcomes (2 contraception and 2 unplanned pregnancy): (1) Demographics, past behavior, and exposure to contraceptive information; (2) Demographics and contraception knowledge or misconception; and (3) Demographics, consequences, and self-efficacy.

### Contraception Use

In an initial descriptive analysis, the women cited various reasons for not using birth control on occasion in the past year (Figure 2). The majority of women did not select a reason (n=150). Of the remaining 137 women, they selected one to five reasons for not using birth control (mean=1.5; median=1). The most frequently selected responses included: 'no insurance' (22.6%), 'did not need' (17.5%), 'did not have sex with a man' (16.1%), 'pregnant' (12.4%), 'only occasionally had sex' (12.4%), 'no medical provider' (12.4%), and 'OK to get pregnant' (11.7%). The remaining reasons were selected by less than 10% of the 137 women.

Figure 2: Self-reported barriers to birth control use in the past 12 months  
N= 137



**Current Contraception Use.** For the purpose of determining which factors were significantly related to current birth control use all pregnant women were excluded from the analysis. Women who self-identified as using birth control (excluding abstinence), who underwent a tubal ligation, or who were partnered with a man who had had a vasectomy were considered active birth control users. All other women were considered as not actively using contraception.

The Past Behavior model for current contraception use was significant ( $p < .01$ ) with cigarette use significantly decreasing the likelihood of current contraception use by 59% ( $p < .05$ ). Also women who had ever visited a physician or women’s health care clinic for birth control were 3.5 times more likely to be currently using contraception. The Knowledge model was not significant for current contraception use. The Consequences and Self-Efficacy model also was approaching significance ( $p < .10$ ). For every unit increase in agreement with the statement, “It doesn’t matter whether you use birth control or not, when it is your time to get pregnant, it will happen”, the likelihood of currently using contraception decreased by 25% ( $p < .05$ ).

**Bilateral Tubal Ligation.** Given that nearly a third of the women (32.8%) reported having undergone tubal ligation, predictors of effective, long-lasting birth control method were also examined. Only the Consequences and Self-Efficacy model was significant ( $p < .01$ ). For each unit increase of agreement with the statement, “Women enrolled in methadone treatment should be required by law to use long lasting birth control (e.g., Depo-Provera or IUD)”, the likelihood of having one’s tubes tied increased by 38% ( $p < .01$ ).

#### Unplanned Pregnancy

**Ever had Unplanned Pregnancy.** None of the three logistic regression models were significant in predicting ever having had an unplanned pregnancy.

*Percent of Unplanned Pregnancies.* None of the three hierarchical regression models were significant in predicting the percent of pregnancies that were unplanned.

## Conclusions

The study provides a comprehensive description of women, ages 18-45, who are enrolled in MAT. Based on this data set composed of participants from Knox County and surrounding counties, the characteristics of these women leave much cause for concern. In addition to opioid addiction, the women are often times facing a variety of other challenges including low education, lack of health insurance, and histories of physical and sexual abuse. Four out of five women smoked daily and 80% reported at least one unplanned pregnancy. Thus not surprising, a third of the women reported their general health as poor. The comorbidity of physical and emotional challenges encourages access to a multidisciplinary team in health promotion, including the promotion of contraception use to decrease the risk of offspring diagnosed with NAS

Given the multi-faceted nature of these women's challenges, care must be given to the promotion of and access to contraception. Lack of insurance and histories of sexual abuse may make gynecological visits financially or emotionally out of reach. Strategies must be taken to ensure that all women enrolled in MAT have affordable care that is responsive to their complicated and oftentimes traumatic histories. Educating women about contraception possibilities that do not require a pelvic exam and securing grants and sponsorship to provide free contraception options may enhance the likelihood of contraception use.

The results also indicated that not all contraception is equally effective. Over a third of women with a past pregnancy reported at least one pregnancy while using birth control. They most frequently related this event to the pill (64.4%), condom (26.7%), and Depo Provera (25.6%). These contraception devices' efficacy is dependent on personal responsibility and consistency in administration. The women's reports encourage greater adoption of long-acting reversible contraception (LARCs) such as IUDs, as

LARCs' efficacy is less dependent on consistent, reliable administration

### RECOMMENDATIONS

- Provide reproductive healthcare responsive to complex and challenging lives of women enrolled in MAT
- Encourage adoption of long-acting reversible contraception
- Integrate contraception information in health promotion efforts, e.g., smoking cessation
- Enhance access to reproductive health care at MAT clinic through clinical collaborations
- Include contraception in TennCare coverage
- Investigate decision process related to bilateral tubal ligation

In examining the barriers and facilitators of contraception, cigarette use was related to lower contraception use. This relation could be associated with environments with limited or no health promotion messages, models of challenged self-care, or an individual's impulsivity. Regardless of the possible common influences, cigarette use could be utilized to screen women of particularly high risk of not using contraception. Smoking cessation programs offered through the MAT clinic could also include content to promote contraception. The self-efficacy and empowerment of overcoming tobacco addiction could also

generalize to empowerment to discuss and use contraception with partners.

The importance of medical care in relation to contraception was emphasized in the regression analysis; a history of a medical appointment related to birth control increased the likelihood of current contraception use by 3.5 times. The impact of medical care on current contraception use is something that can be capitalized upon through partnerships between health clinics and public health organizations. MAT clinic collaborations with other medical practitioners would provide the opportunity for women of childbearing age to access medical care for both MAT and contraception at the same clinic site. Collaborations with local public health departments or nonprofits with specialization in women's health could support such policy. Funds for staffing, educational materials, and the possibility of providing long-acting contraception for women who could not otherwise afford it would also be beneficial. This study's findings provide justification for these funding proposals. This is indeed an exciting opportunity.

More than a third of the women in the study reported having had bilateral tubal ligation. This far exceeds the general US population; 2002 data revealed that 27% women have undergone this procedure (Mosher, et al., 2004). In relation to tubal ligation, only one significant factor emerged – greater agreement that women in MAT should be legally mandated to use long-lasting contraception facilitated the adoption of tubal ligation. This poses an interesting opportunity for policy development. Policy at the MAT clinic could mandate annual contraception appointments or educational session for women of childbearing age. Bilateral tubal ligation would be included in such discussions. Given the other characteristics associated with the participating women, issues such as insurance coverage and abuse histories should be taken into consideration when structuring opportunities for contraception education and access.

Further qualitative investigations of the experiences of women who have experienced tubal ligation is also warranted. What factors influenced their decision? What professional and personal supports were encouraging? How was the tubal ligation situation in relation to other reproductive health events and experiences? Was the procedure affordable and if so, why or how? Such information will help us better understand how to support women who are considering tubal ligation, so they are confident and at peace whether or not they choose to undertake tubal ligation.

The women of the study most frequently indicated insurance coverage as a barrier to contraception use. Insurance coverage was subsequently included as a predictor of current contraception use in the regression analysis, but was not significant. This seeming contradiction may reflect that not all states – including Tennessee – are not complying with the ACA mandate that contraception be covered by insurance (Levy, 2015). With that, it may be that although the women have insurance coverage, this alone is not enough to allow them to afford contraception. If Tennessee were to enforce the Federal mandate, this could potentially decrease the contraceptive challenge that insurance has been presenting for women enrolled in MAT.

Public health opportunities also are presented by our findings in relation to the promotion of contraception use by this population. The more women agreed that pregnancy was largely influenced by fate per se, the less likely they were to be currently using contraception. Educational efforts can be made to promote the development of women's self-efficacy related to their reproductive health. Dissemination of such information could occur in presentations, websites, or published materials. Regardless of the format, sensitivity to health literacy considerations must be applied, particularly given

the women's average education level, overall low contraception knowledge, and discomfort in talking with medical providers and their partners about contraception.

Given the focus on Knox County MAT clinics and reflection of a sample of convenience, care must be taken in generalizing this study to Knox County and surrounding counties or the state of Tennessee. Nonetheless, this study begins to provide insight into the characteristics, reproductive health, and barriers and facilitators of contraception use among women enrolled in MAT for opioid addiction. The potential application of these findings to further reduce the prevalence of NAS in Tennessee is encouraging. Future studies will assist in better understanding the processes of personal decisions about contraception use and the consistency of such use.

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## Appendices

### Appendix A: Table of Measures

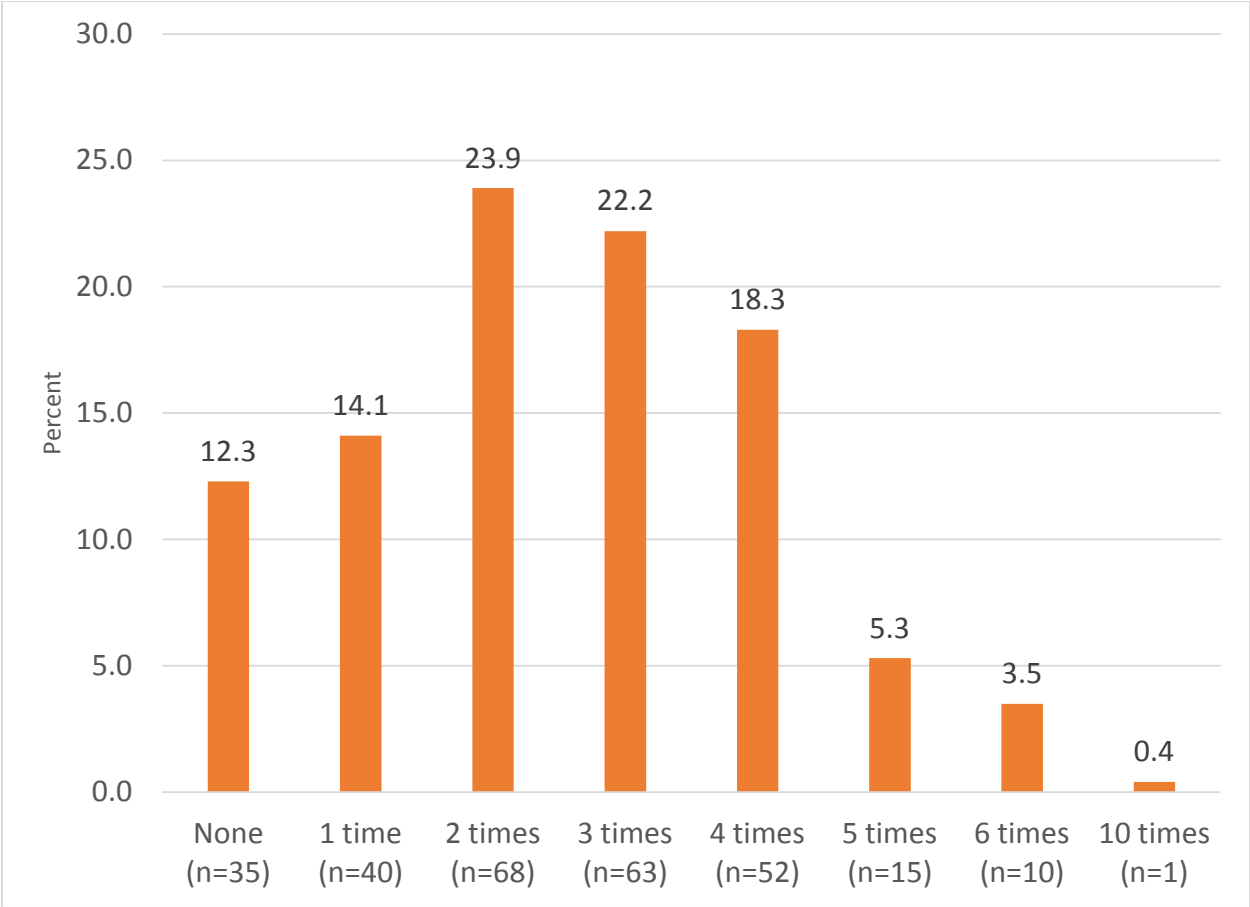
<i>Scale (type)</i>	<i>Variables included</i>	<i>Scale</i>
NAS Risk (mean)	<ul style="list-style-type: none"> <li>• Methadone use during pregnancy can affect the fetus</li> <li>• Taking prescription painkillers during pregnancy can affect the fetus</li> <li>• Pregnant women should not use painkillers</li> <li>• Community members are concerned about women using painkillers during pregnancy</li> </ul>	1=strongly disagree 2=Disagree 3=Neither agree nor disagree 4=Agree 5=Strongly agree
Depression (mean)	Think about the past week. How often have you experienced the following? <ul style="list-style-type: none"> <li>• You felt depressed</li> <li>• You felt that everything you did was an effort</li> <li>• You felt hopeful about the future (reversed)</li> <li>• You were happy (reversed)</li> </ul>	1=rarely or not at all 2=Some of the time 3=Often 4=Most of the time
Alcohol Risk (sum)	<ul style="list-style-type: none"> <li>• Have people annoyed you by criticizing your drinking?</li> <li>• Have you felt you ought to cut down on your drinking?</li> <li>• Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?</li> </ul>	0=no 1=yes
Contraception Knowledge (Percent correct of total attempted)	<ul style="list-style-type: none"> <li>• It is okay to use the same condom more than once.</li> <li>• Condoms have an expiration date.</li> <li>• When putting on a condom, it is important to leave a space at the tip.</li> <li>• It is okay to use petroleum jelly or Vaseline as a lubricant when using latex condoms.</li> <li>• When using a condom, it is important for the man to pull out right after ejaculation.</li> <li>• Wearing two latex condoms will provide extra protection.</li> <li>• Birth control pills are effective even if a woman misses taking them for two or three days in a row.</li> <li>• Women should “take a break” from the pill every couple of years.</li> <li>• If a woman is having side effects with one kind of pill, switching to another type or brand might help.</li> <li>• Birth control pills reduce the chances that women will get certain types of cancer.</li> <li>• After a woman stops taking birth control pills, she is unable to get pregnant for at least two months.</li> <li>• In order to get the birth control pill, a woman must have a pelvic exam.</li> <li>• A young woman can use an IUD, even if she has never had a child.</li> <li>• Women who use IUDs cannot use tampons.</li> <li>• To obtain an IUD, a woman must undergo a surgery.</li> </ul>	True or False 1=correct answer 0=wrong answer

	<ul style="list-style-type: none"><li>• An IUD cannot be felt by a woman's partner during sex</li><li>• IUDs can move around in a woman's body</li><li>• Women using the birth control shot, Depo-Provera, must get an injection every three months.</li><li>• Even if a woman is late getting her birth control shot, she is still protected from pregnancy for at least 3 months.</li><li>• Women using the vaginal ring, or Nuva Ring, must have it inserted by a doctor or health care provider every month.</li><li>• Long-acting methods like the implant or IUD cannot be removed early, even if a woman changes her mind about wanting to get pregnant.</li><li>• After giving birth, a woman can get pregnant even before she has her first period</li><li>• Douching (washing the vagina) after sex can prevent pregnancy.</li><li>• A woman who is still breast feeding cannot get pregnant</li><li>• Pregnancy is much less likely to occur if a couple has sex standing up.</li><li>• The only way to completely prevent pregnancy is by not having sex.</li><li>• During a woman's monthly cycle, there are certain days when she is more likely to become pregnant if she has sex.</li></ul>	
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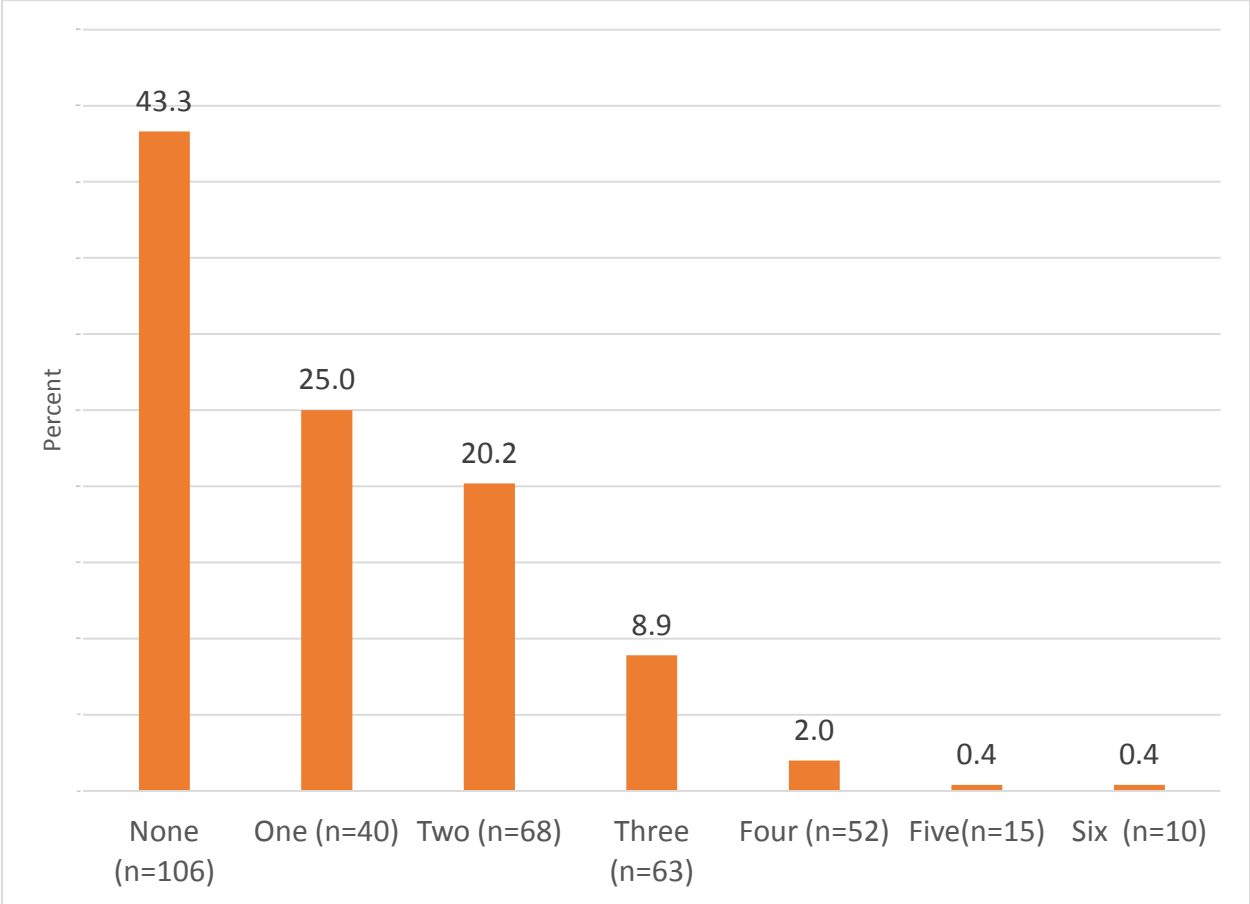


Appendix B: Figures

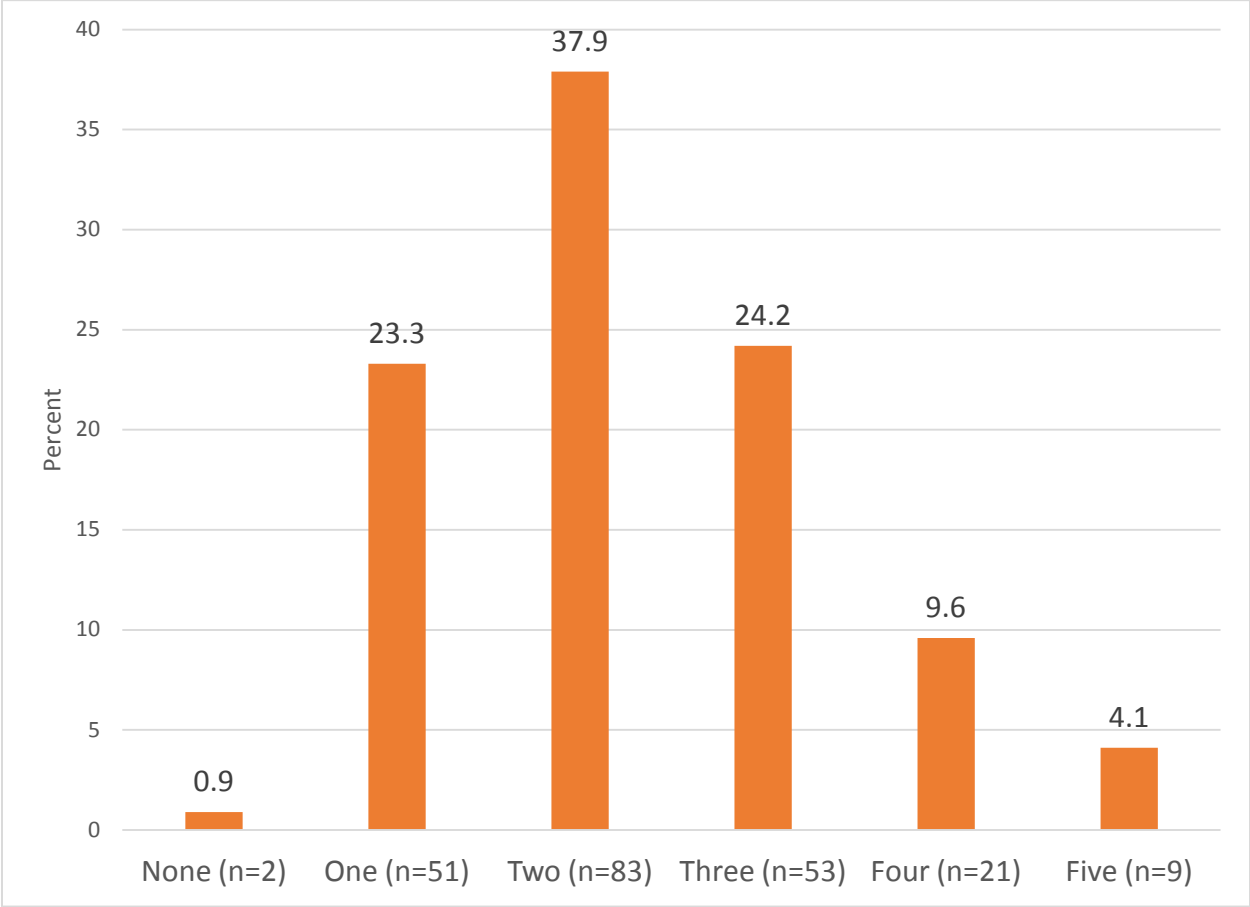
B1. Number of Pregnancies



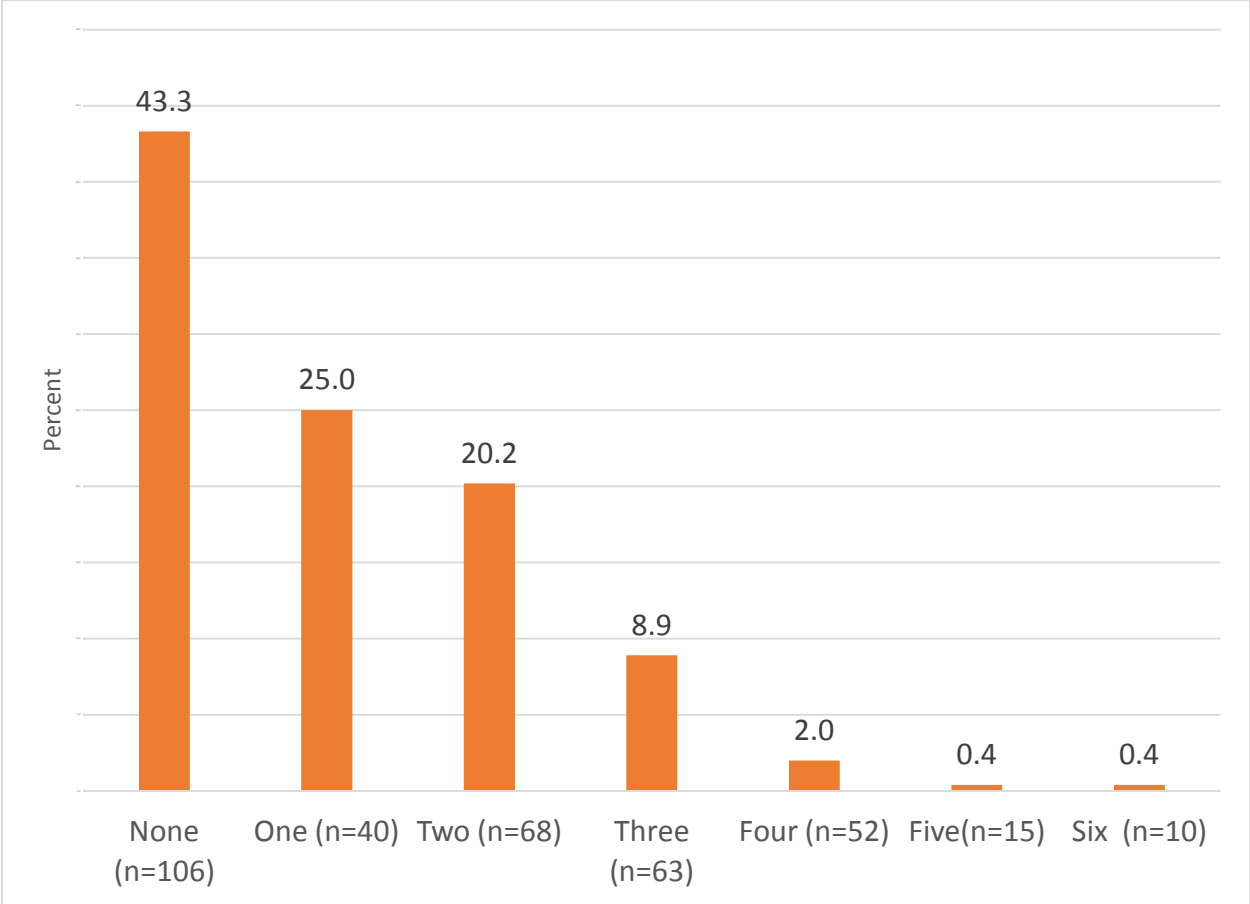
B2. Planned Pregnancies



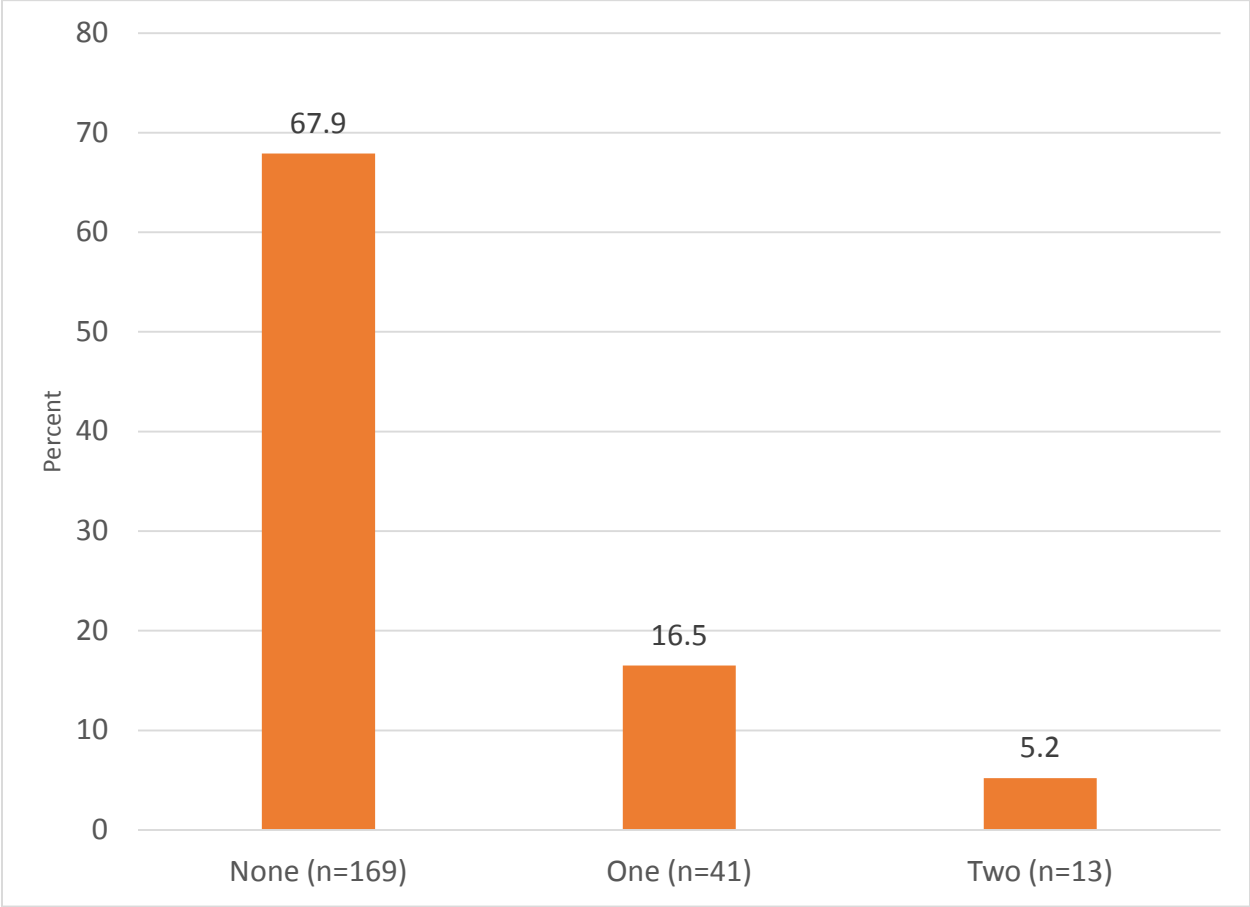
B3. Number of Living Children



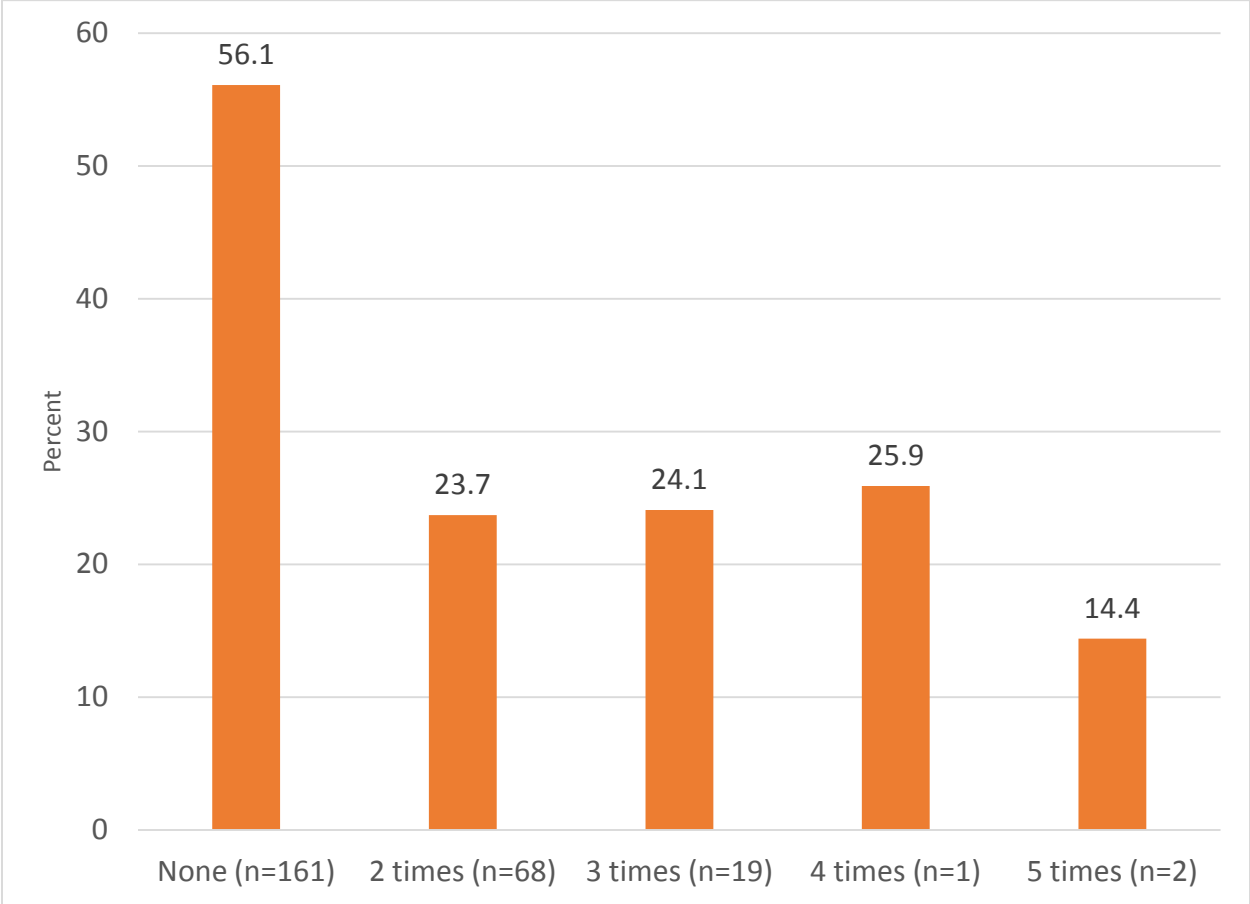
B4. Miscarriages



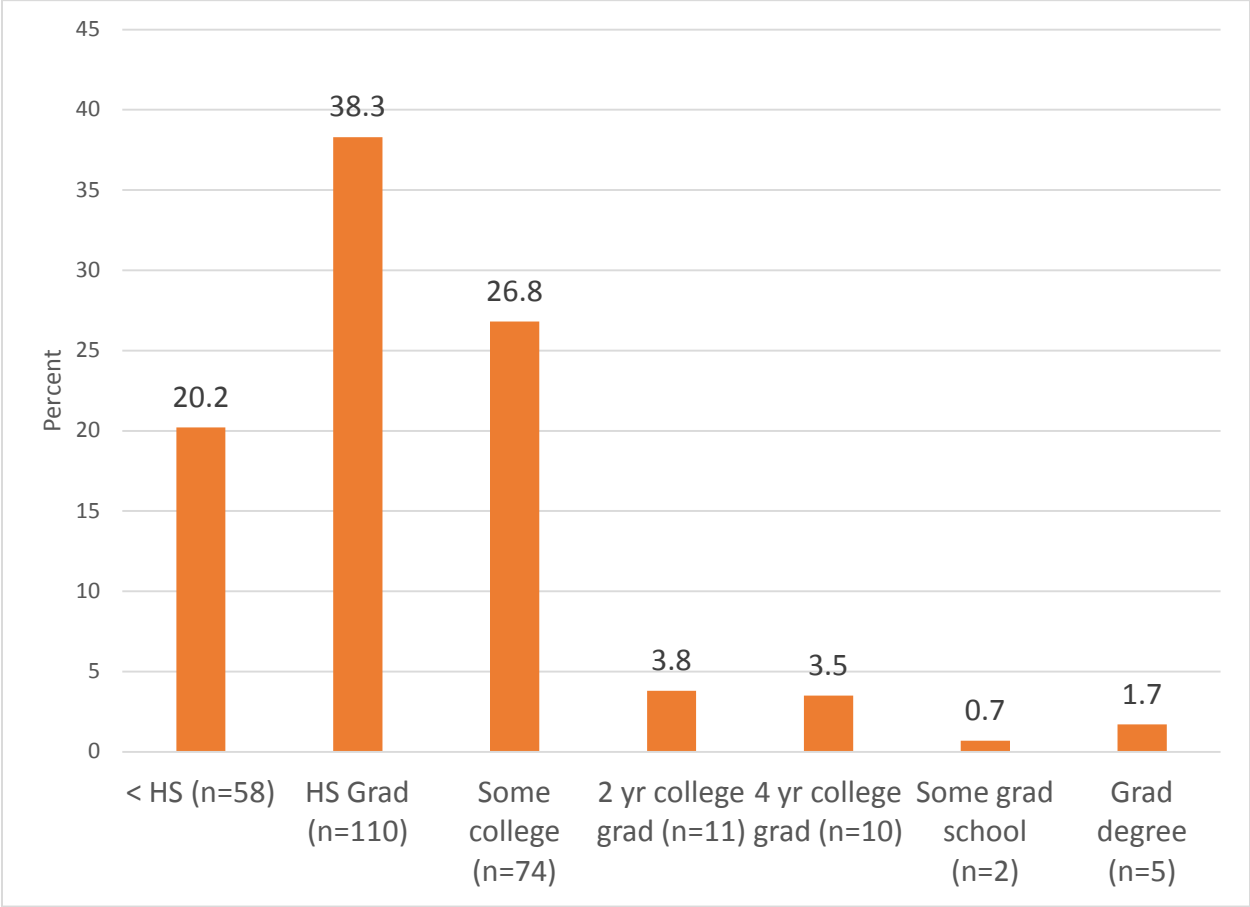
B5. Abortions



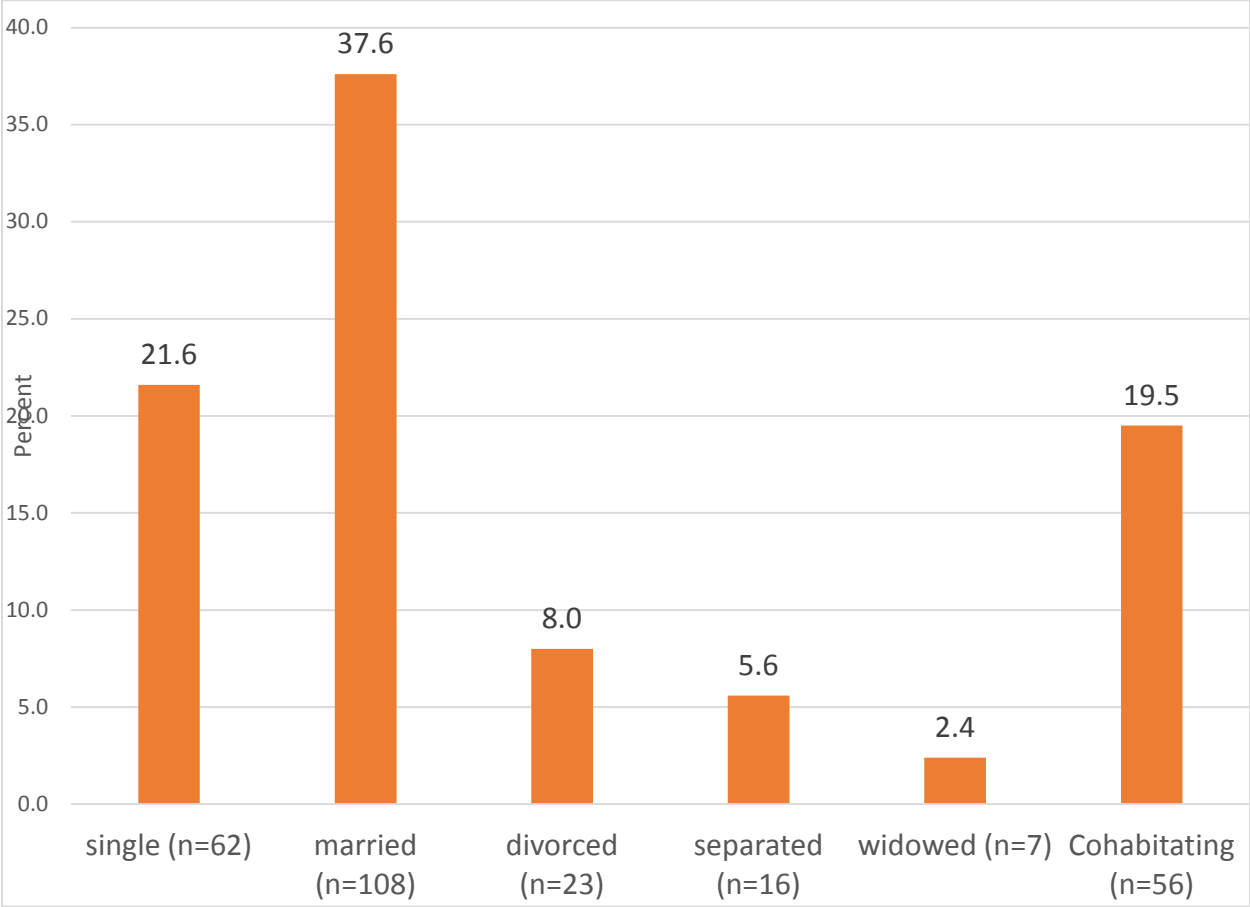
B6. Number of Pregnancies while on Birth Control



B7. Education

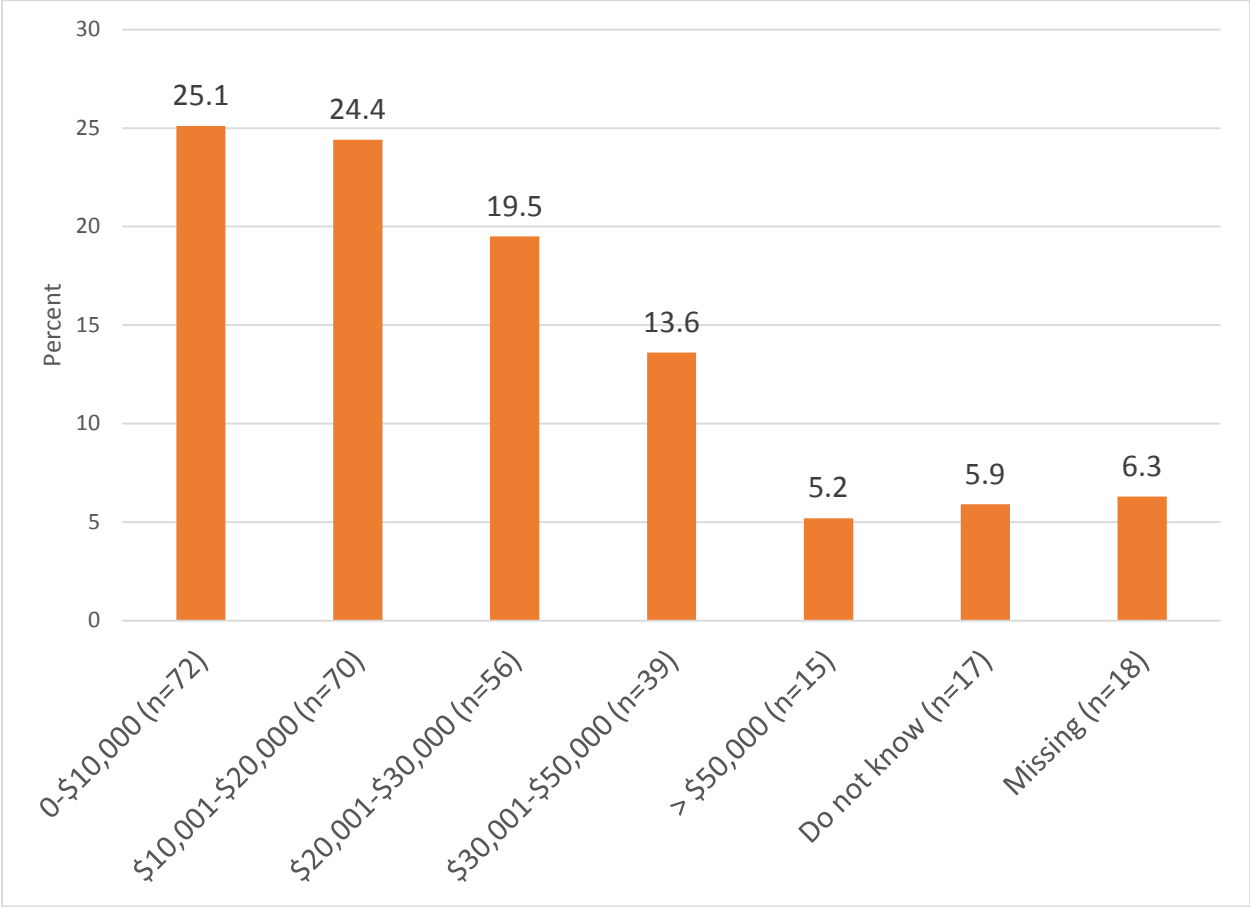


B8. Marital Status

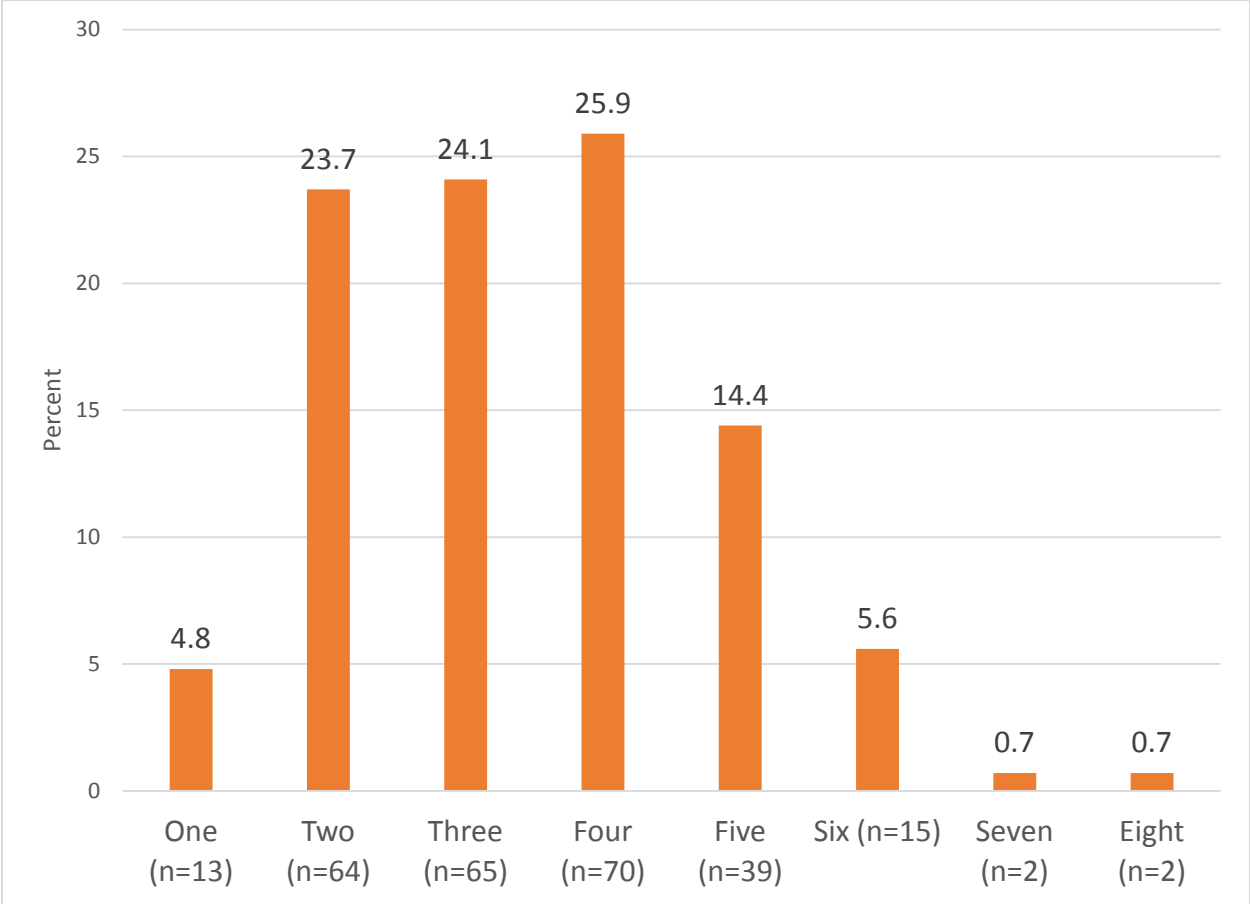




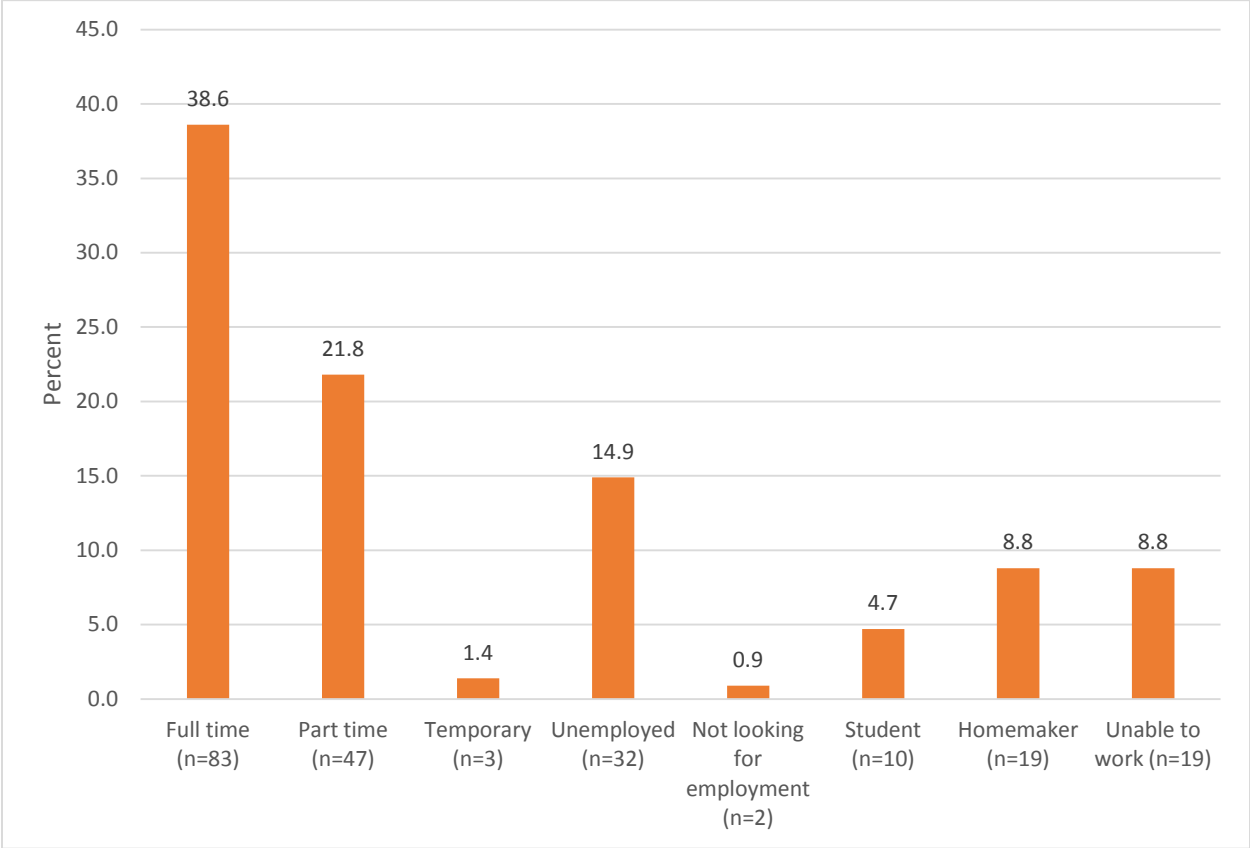
B9. Household Income



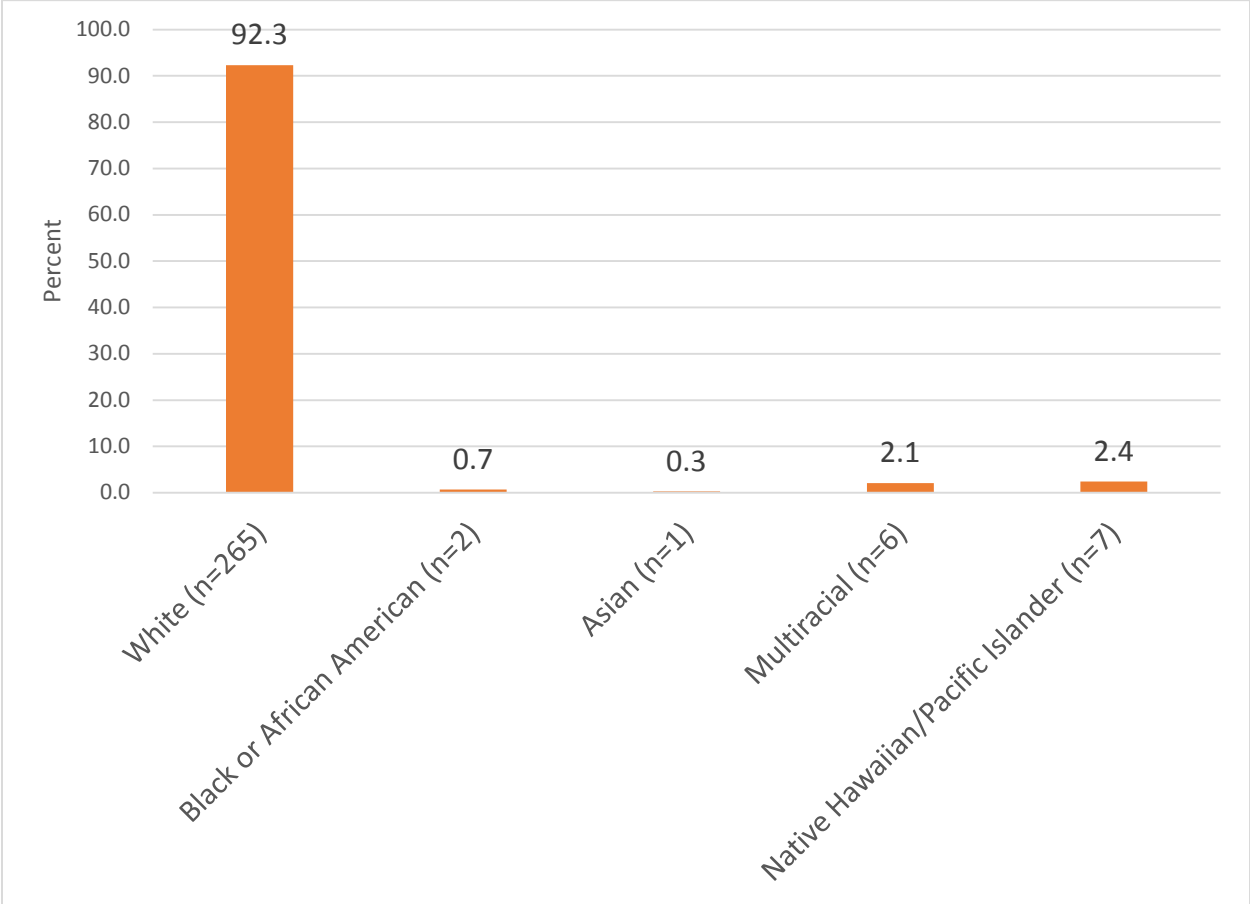
B10. Number in Household



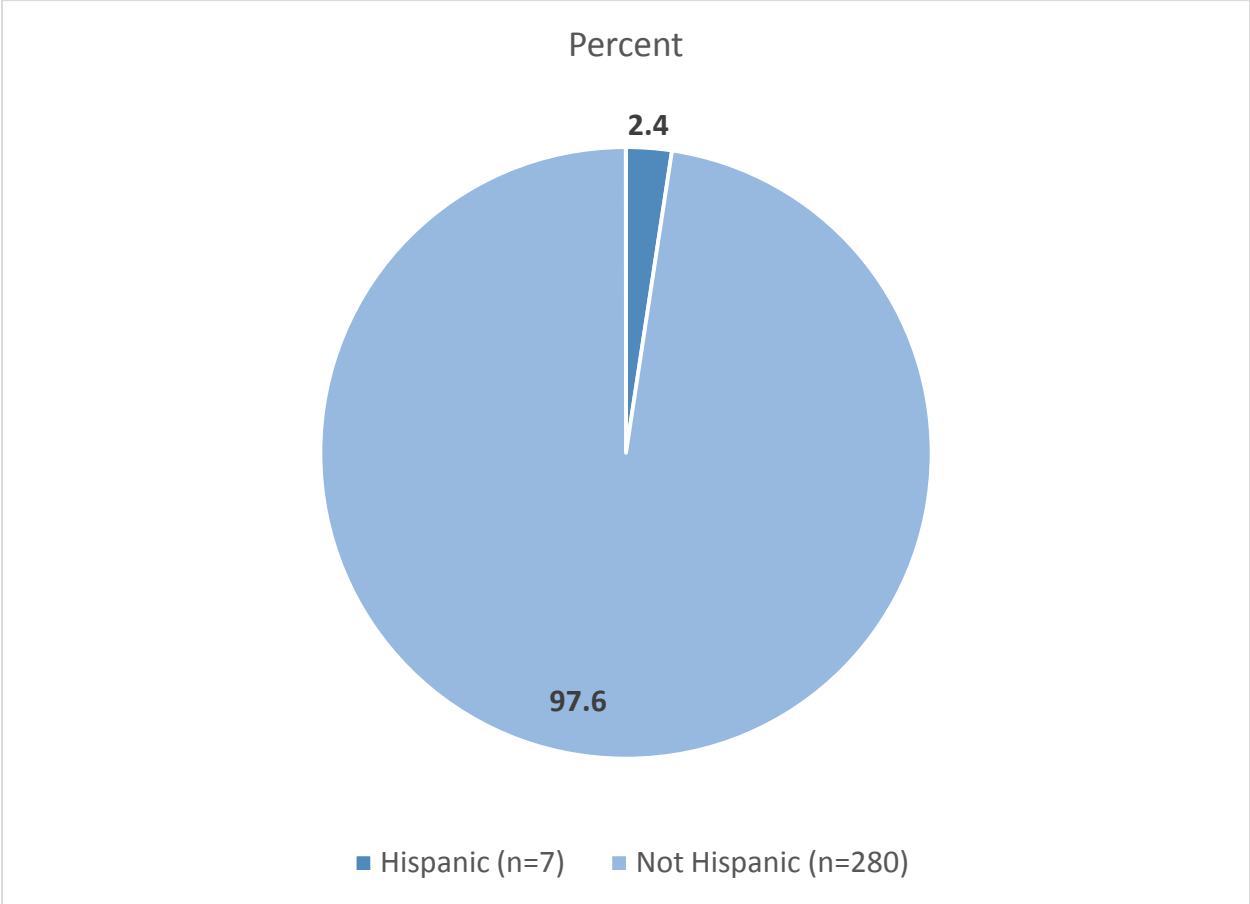
B11. Employment Status



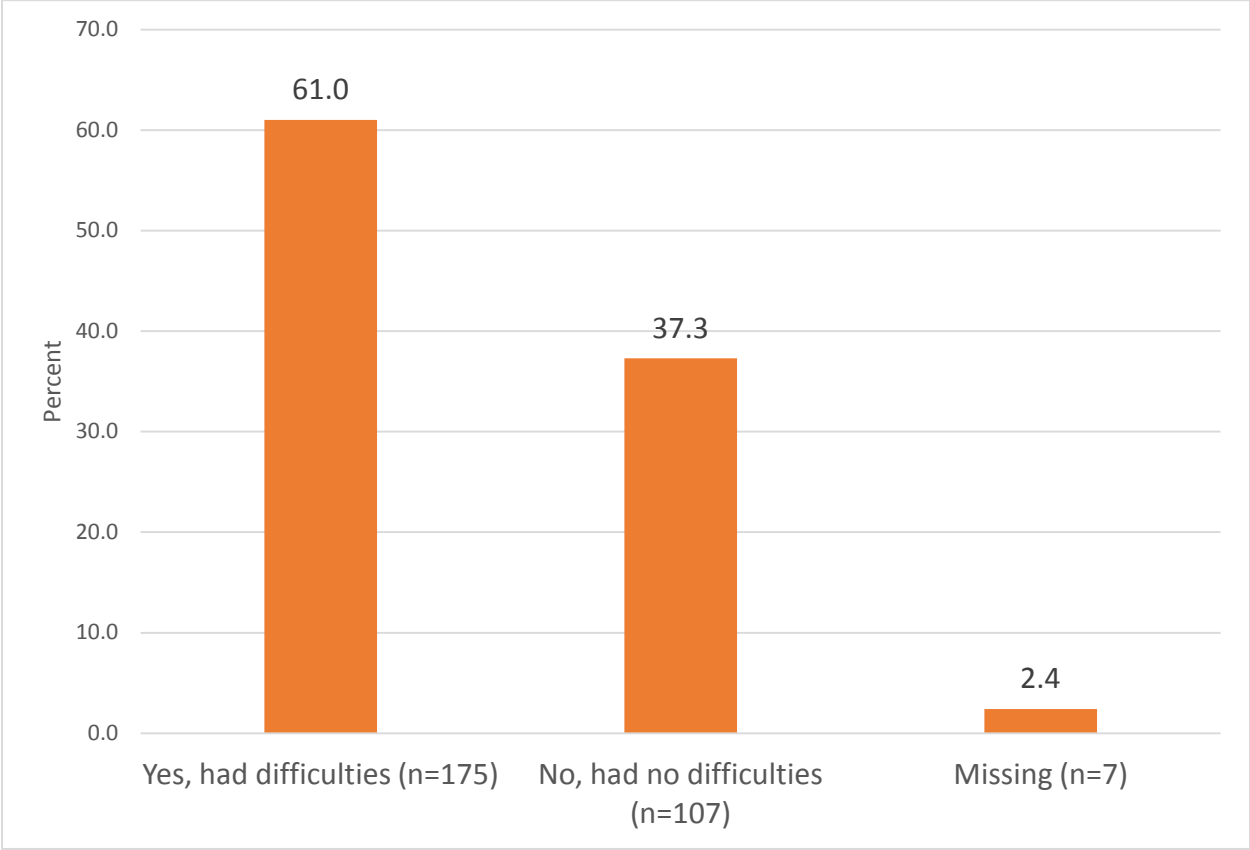
B12. Race



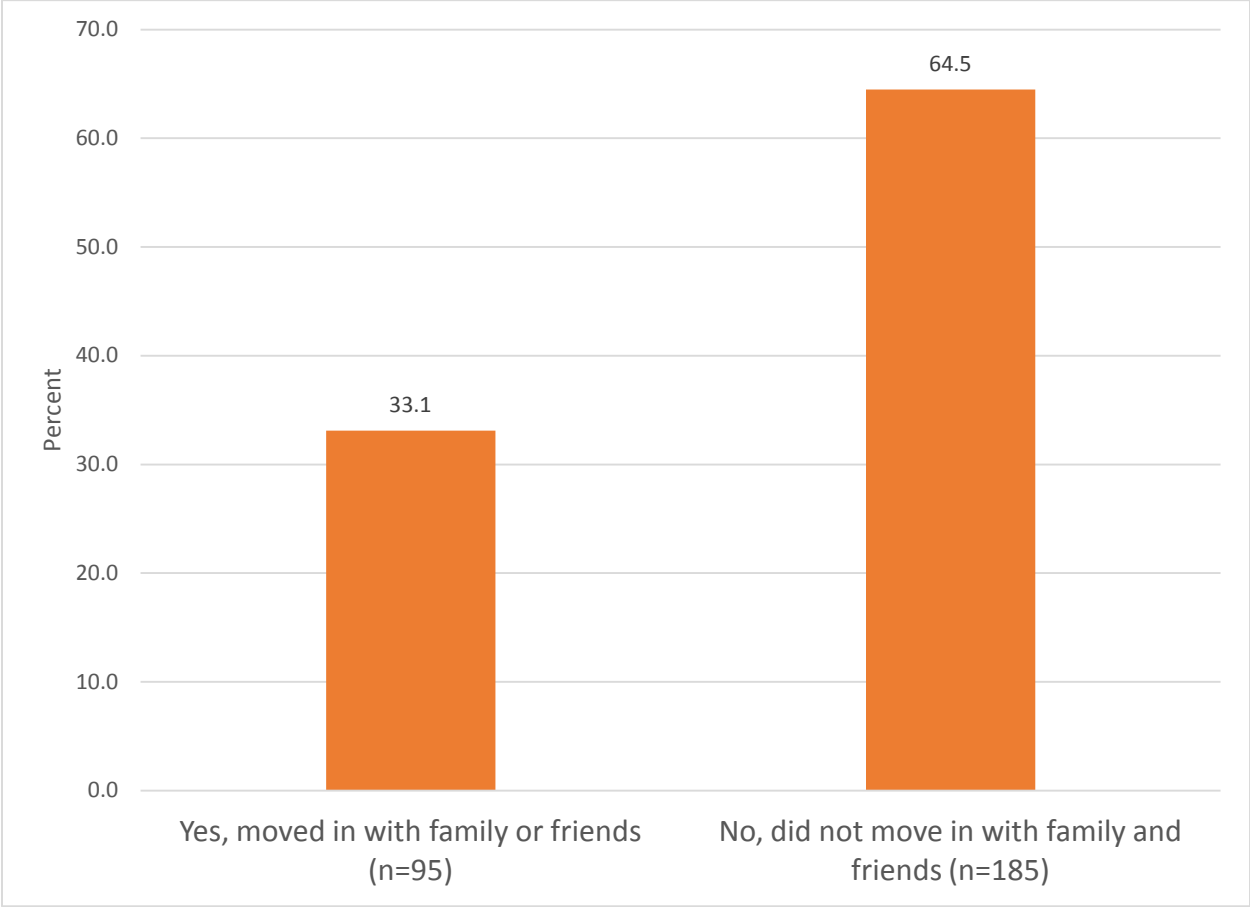
B13. Ethnicity



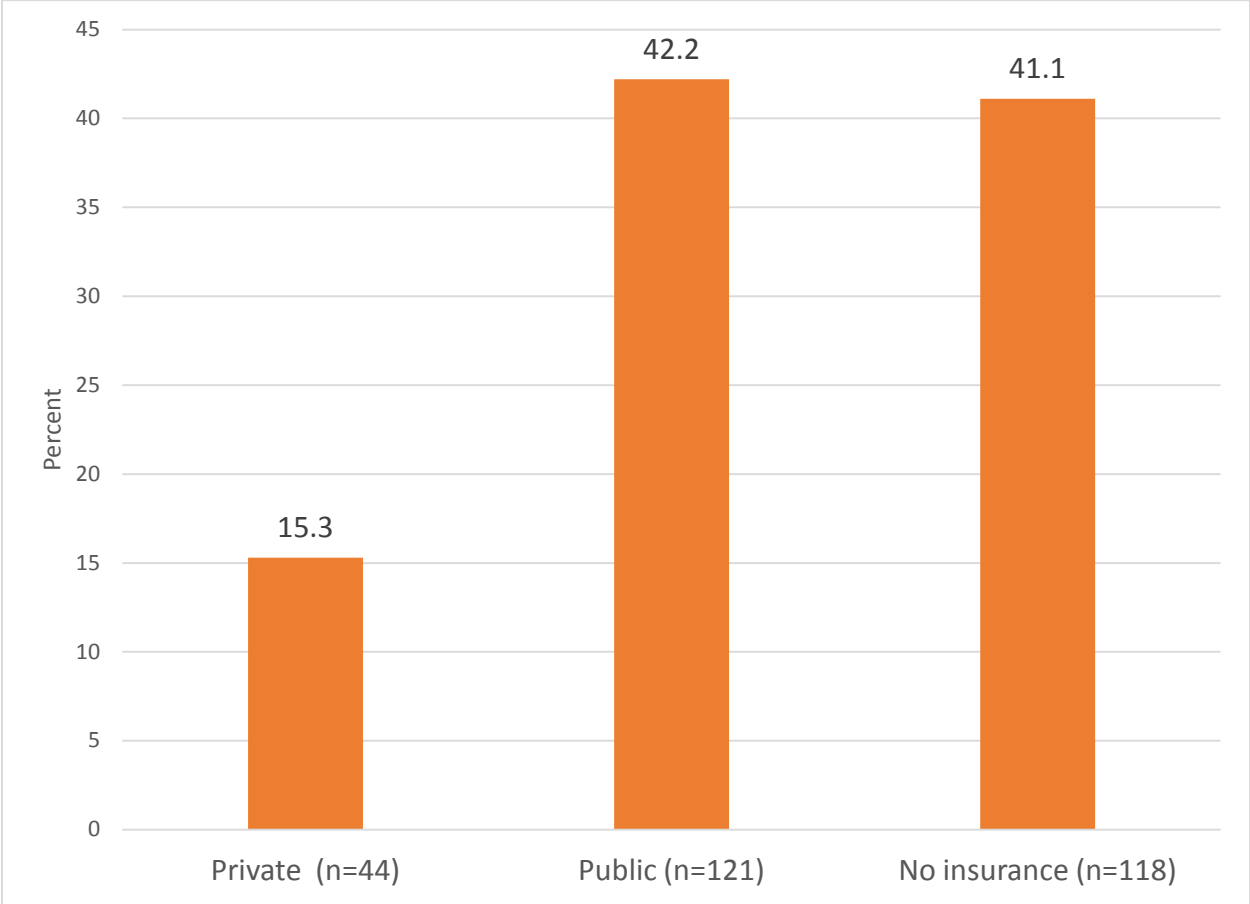
B14. Difficulty Paying Rent



B15. Housing Challenges

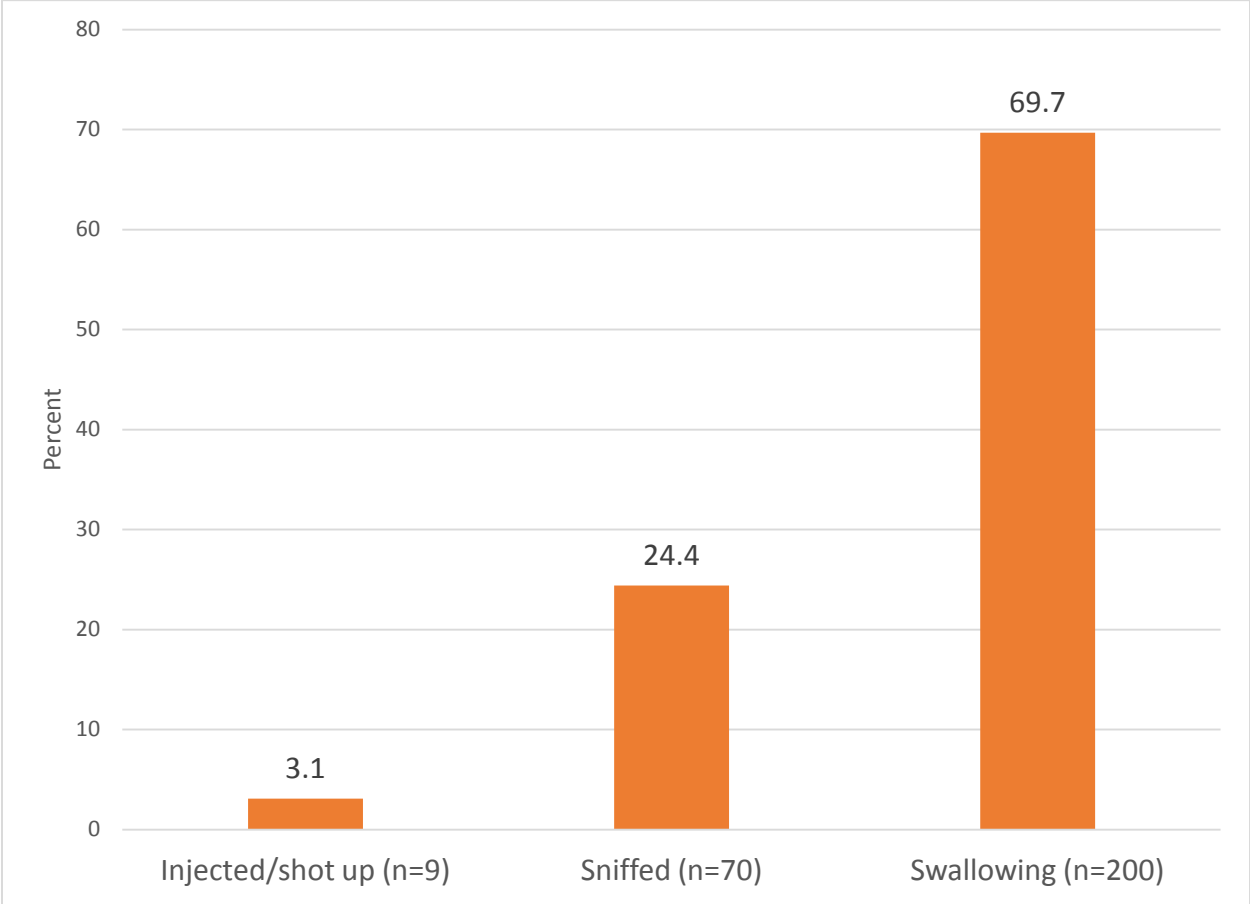


B16. Health Insurance

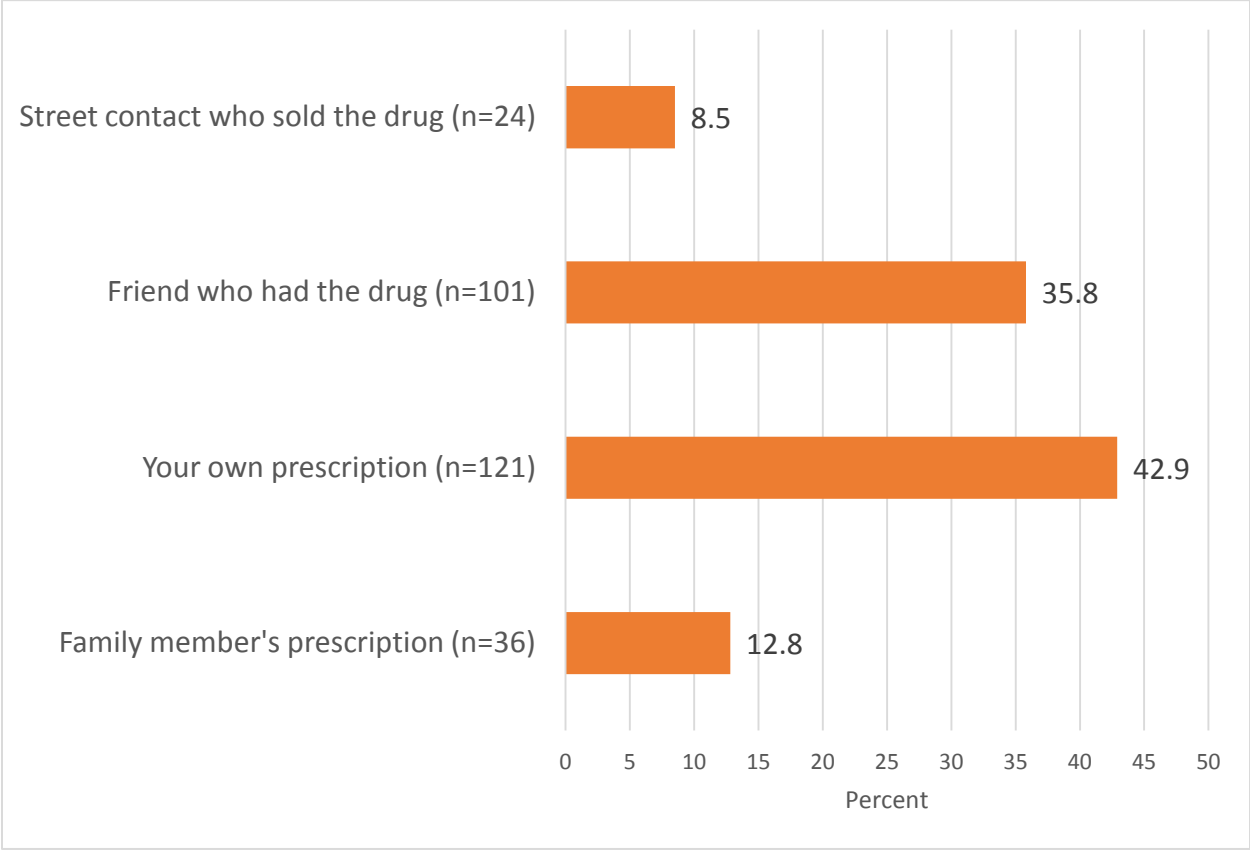




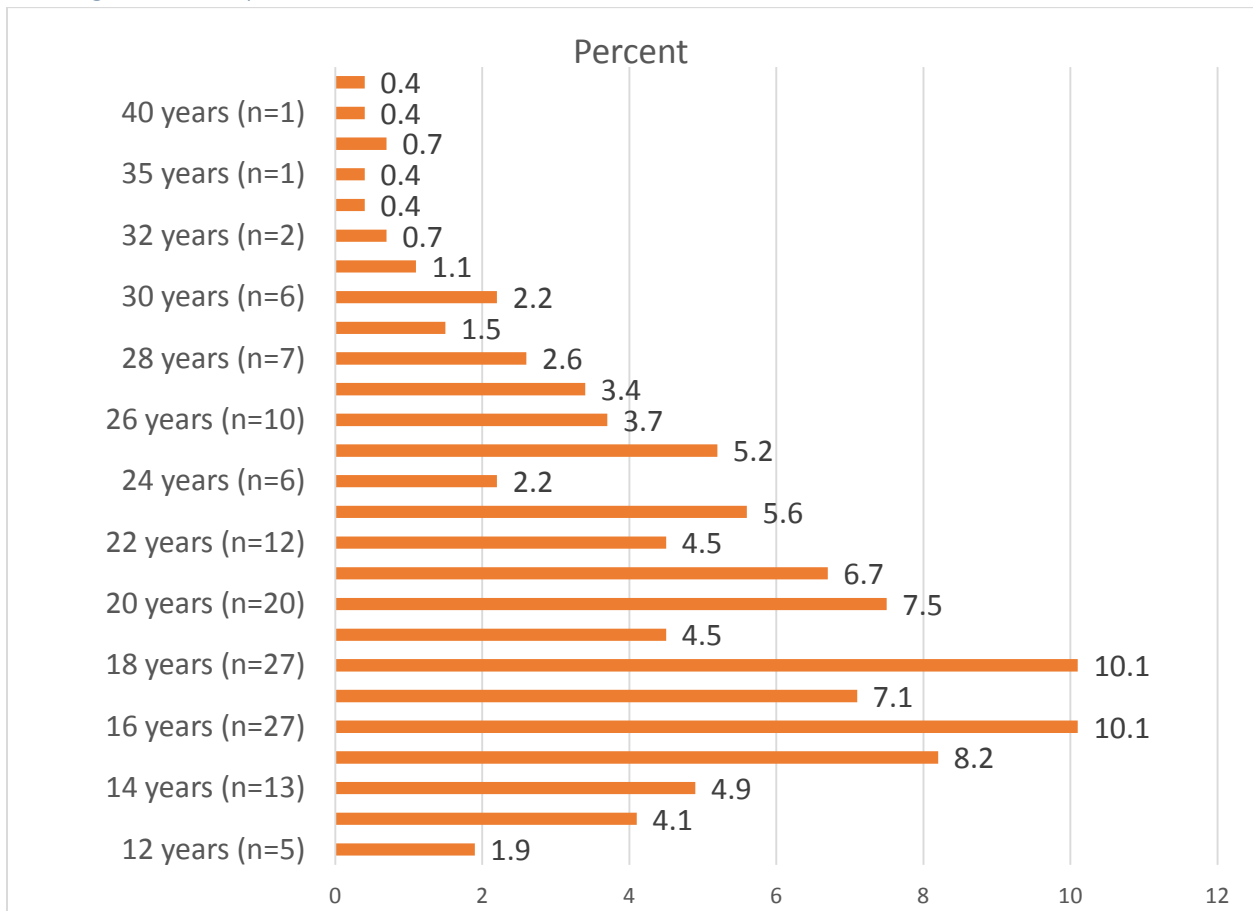
B17. Method of First Opioid Use



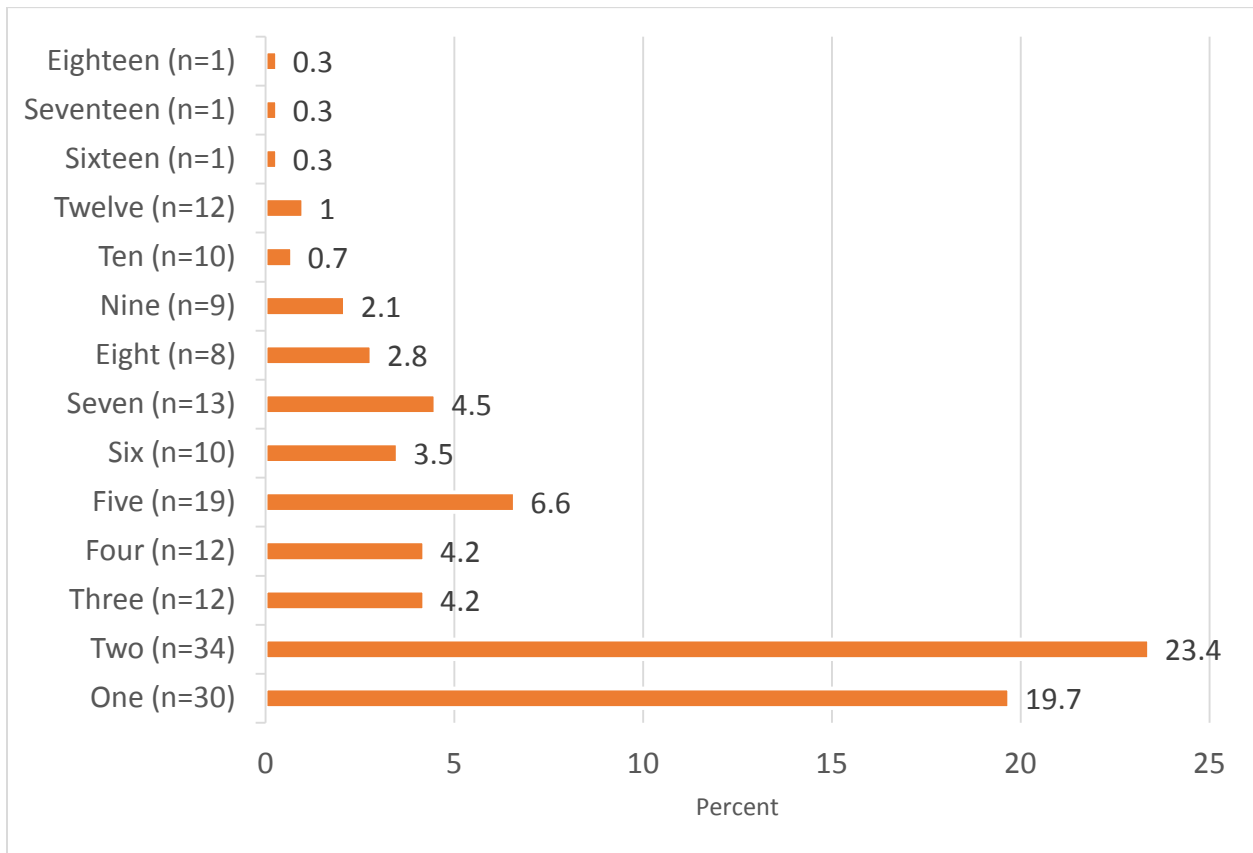
B18. Source of First Opioid



B19. Age of First Opioid Use



B20. Years Since First Methadone Intake



B21. General Health Status

