

by teenagers and young women in an online anonymous questionnaire on Facebook. Duplicate responses were ignored.

A total of 842 women (mean age 21.5 (SD 1.7) years) completed the questionnaire; 236 smoked cigarettes, 177 had graduated from university, and 13 were parous.

Table 1 shows the procedures required before prescription in the whole series, by prescribing doctor and by age of the woman. Overall, medical history was required in 58% of cases (95% CI 53.1 to 63.5), blood pressure in 20% (95% CI 17.1 to 23.5), pelvic examination in 79% (95% CI 73.4 to 85.2) and blood tests in 70% (95% CI 64.6 to 76.0).

Overall, 60% of gynaecologists, 38% of general practitioners (GPs) and 63% of family planning (FP) clinic doctors took a medical history. About 20% of all groups of doctors measured blood pressure. Eighty-eight per cent of gynaecologists, 29% of GPs and 75% of FP doctors did a pelvic examination, the difference in frequency between GPs and the two other groups being significant (χ^2 GPs vs gynaecologists=181.47, $P<0.001$; GPs vs FP doctors=43.90, $P<0.001$). Seventy-one per cent of gynaecologists, 82% of GPs and 50% of FP doctors asked for blood tests, the difference in frequency between gynaecologists and FP doctors being significant (χ^2 GPs vs gynaecologists=6.41, $P<0.01$; GPs vs FP doctors=24.32, $P<0.001$). The age of the woman did not affect the results.

We found that most women (around 80%) reported having a pelvic examination. GPs seemed to require it less often because most GPs in Italy do not perform bimanual pelvic examination. In contrast, for example in California one-third of clinicians reported that they always require a pelvic examination when prescribing OCs.⁵ In that report, a similar proportion of gynaecologists and family physicians reported that they always required a pelvic examination when prescribing OCs, but advanced practice nurses specialising in reproductive health were less likely to require the examination.⁵

Although not formally representative of the Italian population, our web-based study implies poor adherence in Italy to international guidelines and WHO medical eligibility criteria for the prescription of OCs.¹ This lack of adherence is a barrier to accessing contraception,

Women's recall of requirements for oral contraception prescription in Italy

In Italy the use of oral contraceptives (OCs) is low in comparison with other countries,¹ possibly because bimanual pelvic examination and laboratory tests are required before they can be prescribed. Such requirements may stop OCs being used, particularly by teenagers and young women, and so should be considered only in selected cases.²⁻⁴ We investigated the recall of these requirements,

Table 1 Clinical checks before prescription of oral contraceptives by doctor and age of woman*

	Medical history	Blood pressure	Pelvic examination	Blood tests	None
All women (n=842)	488	169	668	590	32
Doctor					
Gynaecologist (n=640)	385	126	561	455	16
General practitioner (n=101)	39	20	30	84	11
Family planning clinic doctor (n=101)	64	23	77	51	5
Age of woman (years)					
<21 (n=418)	255	81	336	290	13
≥21 (n=424)	233	88	332	300	19

*Values in table are numbers of women.

especially for teenagers and young women.

Francesca Mulas,¹ Fabio Parazzini,^{1,2,3}
Alessandro Bulfoni,² Tiziano Motta²

¹Department of Clinical Sciences and Community, Midwifery School, University of Milan, Milan, Italy

²Department of Obstetrics and Gynaecology, Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico, Milan, Italy

³Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico, Milan, Italy

Correspondence to Dr Fabio Parazzini, Department of Clinical Sciences and Community, Midwifery School, University of Milan; Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico, Milan, Italy; fabio.parazzini@unimi.it

Correction notice Since this letter was first published online, the initials IB in the contributor statement have been updated to FP.

Contributors FM coordinated the data collection and wrote the letter. FP analysed the data. TM and AB designed the study. All the authors discussed the results and discussed the text. FP helped in the analysis and discussed the text.

Competing interests None declared.

Provenance and peer review Not commissioned; internally peer reviewed.

© Article author(s) (or their employer(s) unless otherwise stated in the text of the article) 2018. All rights reserved. No commercial use is permitted unless otherwise expressly granted.



BMJ Sex Reprod Health 2018;**44**:147–148.
doi:10.1136/bmjsex-2017-101843

REFERENCES

- 1 World Health Organization (WHO). *Medical eligibility criteria for contraceptive use*. Geneva: WHO, 2009. http://www.spdc.pt/files/publicacoes/5_11292_2.pdf (accessed 2 Nov 2017).

- 2 World Health Organization (WHO). *Family planning. A global handbook for providers. Evidence-based guidance developed through worldwide collaboration*. Baltimore and Geneva: Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, and WHO, 2011. http://apps.who.int/iris/bitstream/10665/44028/1/9780978856373_eng.pdf (accessed 2 Nov 2017).
- 3 Faculty of Family Planning and Reproductive Health Care (FSRH) Clinical Effectiveness Unit. *First prescription of combined oral contraception*. London: FSRH, 2006.
- 4 Black A, Francoeur D, Rowe T, *et al*. SOGC clinical practice guidelines: Canadian contraception consensus. *J Obstet Gynaecol Can* 2004;**26**:219–96.
- 5 Henderson JT, Sawaya GF, Blum M, *et al*. Pelvic examinations and access to oral hormonal contraception. *Obstet Gynecol* 2010;**116**:1257–64.