Updates in Contraception: Advances in Technical and Interpersonal Care
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Disclosures
• No financial disclosures to report
• I discuss off-label use of some contraceptive methods.

Are you familiar with the US Medical Eligibility Criteria for Contraception?
  a. Yes
  b. No

Can my patient use this method?
US Medical Eligibility Criteria (MEC)

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<th>Can use the method</th>
<th>Should not use method</th>
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<tbody>
<tr>
<td>1</td>
<td>No restrictions</td>
<td>Theoretical or proven risks generally outweigh advantages</td>
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<tr>
<td>2</td>
<td>Advantages generally outweigh theoretical or proven risks.</td>
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<tr>
<td>3</td>
<td>Should not use method unless no other method is appropriate or acceptable</td>
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<td>4</td>
<td>Unacceptable health risk</td>
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A 35 year-old woman comes to you for contraception counseling. She has a h/o of migraines without aura. Can she use an estrogen containing method?

Can a woman with migraines without aura use estrogen-containing contraceptives?

a. Yes  
b. No  
c. It depends
Women at risk for sexually transmitted disease no longer a separate category with more concerns with IUDs
- States “risk for PID with risk factors for STDs is low”
- IUDs now a category 2 for women with AIDS (from 3)

Addition of recommendations for women with:
- Cystic fibrosis (Depo is.category 2)
- Multiple sclerosis (CHCs are category 2 with immobility)
- Use of SSRIs and St. John’s wort (CHC and implant a 2 for SJW)

Revisions to the recommendations for:
- Women with:
  - Dyslipidemias (now included in women with multiple cardiovascular risks)
  - Migraine headaches
- Women who are receiving antiretroviral therapy (CHCs now category 2 with Ritonavir-boosted ARVs)

Recommendations based on systematic review of six studies (1 RCT and 5 cohort studies) of women with bipolar disorder or depression
- Overall poor to fair quality studies
**Can over a million Danish women be wrong?**

- Prospective cohort study of 1,061,997 women in Denmark
  - Users (within the last six months) of combined hormonal contraception/progestin only contraception had:
    - An RR of 1.23 (95% CI 1.22-1.25)/1.34 (95% CI 1.27-1.40) for first use of an antidepressant
    - An RR of 1.1 (95% CI 1.08-1.14)/1.2 (95% CI 1.04-1.31) for diagnosis of depression
  - RR decreased with age of the user

**Does this make sense?**

- Previous literature did not show a definitive association for any methods
- Some biological evidence supporting progestin and estrogen influence on mood
- HOWEVER, we know that some women report mood changes with methods, and many are worried about effects on their mood
  - Research on women’s experiences during counseling documents that many feel their concerns are dismissed without due consideration

**How do we put this all together?**

- While high quality study, not randomized
  - Confounding by unmeasured characteristics of individuals?
  - Confounding by relationship context? (No data on non-hormonal contraceptive method (e.g. copper IUD) provided as comparison)
  - Therefore, cannot draw definitive causal conclusion
  - Definitive evidence is unlikely, given difficulty (ethics?) of randomizing contraception
  - If it is real, what is the magnitude?
    - 1.7% vs. 2.2% overall – NNH of 200

**Where do you find the US MEC?**

- We need to honor women’s concerns/experiences around mood effects of contraception, acknowledging the lack of definitive data
- We can provide reassurance that at worst, few women are impacted
You determine a method is safe. Now what?

- MEC is NOT designed to provide insight into what method is right for a given patient
- Contraceptive counseling involves education and decision support to help patients understand their options and make a selection
- Documented impact of contraceptive counseling on method selection and continuation

What is the best approach to contraceptive decision making?

a. Encourage women to choose the most highly effective methods
b. Give them information about all methods and let them decide for themselves
c. Give them whichever method they say they want
d. None of these

Contraceptive Counseling: LARC First?

- Increasing emphasis on/promotion of LARC methods in family planning
- Examples
  - Tiered effectiveness: Present methods in order of effectiveness
  - Motivational interviewing: Patient-centered approach to achieving behavior change

Is “LARC First” counseling patient-centered?

- Women have strong and varied preferences for contraceptive features
- Relate to different assessments of potential outcomes, such as side effects
- Also relates to different assessments of the importance of avoiding an unintended pregnancy
Is an unintended pregnancy always a bad thing?

a. Yes
b. No

How do women think about pregnancy?

- **Intentions**: Timing-based ideas about if/when to get pregnant
- **Plans**: Decisions about when to get pregnant and formulation of actions
- **Desires**: Strength of inclination to get pregnant or avoid pregnancy
- **Feelings**: Emotional orientations towards pregnancy

A Multidimensional Concept

Plans ≠ Intentions ≠ Desires ≠ Feelings

- All different concepts
- Women may find all or only some meaningful
- Often appear inconsistent with each other

Planning May Not Be Desirable

“I guess one of the reasons that I haven’t gotten an IUD yet is like, I don’t know, having one kid already and being in a long-term committed relationship, it takes the element of surprise out of when we would have our next kid, which I kind of want. I’m in that weird position. I just don’t want to put too much thought and planning into when I have my next kid.”
“I don’t want more kids... We can’t afford another one. But if it happened I’d still be happy. I’d be really excited. We’d rise to the occasion... nothing would really change.”

“I already got a kid so you know I’m not opposed to having children. If it happens, it happens.... I’d prefer we don’t have children right now but if it happens, okay.”

But shouldn’t we get women to plan “for their own good”?  
- Is an unintended pregnancy a universally negative health outcome? 
- Little data to support this assumption  
  - Many studies show no association with social or health outcomes 
  - Some studies show associations with low birth weight and preterm birth 
  - However, generally not well-designed and well-controlled 
  - Most examine only retrospective intentions

Concerns with directive counseling approaches  
- Assuming women should want to use certain methods:  
  - Ignores variability in preferences, including around importance of avoiding unintended pregnancy  
  - Does not prioritize autonomy  
- Pressure to use specific methods can be counterproductive  
  - Perceived pressure increases risk of method discontinuation  
  - Perceiving provider as having a preference associated with lower satisfaction with method
Contraceptive decision making

Shared Decision Making in Family Planning

“I just think providers should be very informative about it and non-biased...maybe not try to persuade them to go one way or the other, but maybe try to find out about their background a little bit and what their relationships are like and maybe suggest what might work best for them but ultimately leave the decision up to the patient.”

Dehlendorf, Contraception, 2013

Shared decision-making in family planning

- “Investing in the beginning” and “Eliciting the patient perspective” both associated with contraceptive continuation (p<0.05)
- Patients who report sharing their decision with their provider had higher satisfaction with their family planning experience
  - Compared to both patient- and provider-driven decisions
  - May not be best for everyone, but provides starting point for counseling

Dehlendorf, Contraception, 2016

Dehlendorf, Contraception, 2017

Shared Decision Making and Disparities in Family Planning Care
History of reproductive injustices

- Nonconsensual sterilization of poor women and women of color throughout the 1900s
- Unethical testing of oral contraceptives in Puerto Rico
- 150 incarcerated women in California were illegally sterilized from 2006-2010

Race and trust in family planning services

- 35% of Black women reported “medical and public health institutions use poor and minority people as guinea pigs to try out new birth control methods.”
- Greater than 40% of Blacks and Latinas think government promotes birth control to limit minorities
- Black women more likely to prefer a method over which they have control

Provider bias in family planning

- Low-income women of color more likely to report being advised to limit their childbearing than middle-class white women
- Blacks were more likely than whites to report having been pressured by a clinician to use contraception
- 67% of black women reported race-based discrimination when receiving family planning care

Are women of color counseled differently?

- Family planning providers have lower levels of trust in their Black patients
- Providers are more likely to agree to sterilize women of color and poor women
- Are there also disparities in counseling about the IUD?
  - RCT using videos of standardized patients presenting for contraceptive advice
  - Shown to participants at national meetings of ACOG and AAFP

References:

- Jackson, Contraception, 2015
- Rocca, PSRH, 2012
- Turbin and Boyd, Women Health, 2005
Are providers more or less likely to recommend IUDs to Black and Latina women?

1. Providers are MORE likely to recommend IUDs to Black and Latina women than to White women.
2. Providers are LESS likely to recommend IUDs to Black and Latina women than to White women.
3. There are no differences by race/ethnicity in recommendations for IUDs.

Counseling and Family Planning Disparities

- Providers need to be aware of both historical context and documented disparities in counseling.
- Essential to ensure that providers focus on individual preferences when caring for women of color.
- Shared decision making provides explicit framework for doing this, without swinging too far to other side.

Percent of Providers Recommending IUC to Low SES Women, by Race/Ethnicity (n=173)

- Whites: 42%
- Blacks: 63%
- Latinas: 67%

The process of shared decision making

- Establish rapport
- Elicit informed preferences for method characteristics:
  - Effectiveness
  - Side effects
  - Frequency of using method
  - Different ways of taking methods
- Facilitate decision grounded in patient preferences.
Examples of facilitation

“I am hearing you say that avoiding pregnancy is the most important thing to you right now. In that case, you may want to consider either an IUD or implant. Can I tell you more about those methods?”

“You mentioned that it is really important to you to not have irregular bleeding. The pill, patch, ring and copper IUD are good options, if you want to hear more about those.”

Contraceptive Updates

Insertion tube of 4.4 mm
- 20 mcg/day (5 yr) - Mirena
- 19 mcg/day (3 yr) - Liletta
  - Current approval for 3 yrs
  - Lower cost
- Both have better bleeding profiles than smaller IUDs

Insertion tube of 3.8 mm
- 14 mcg/day (3 yr) - Skyla
- 17.5 mcg/day (5 yr) - Kyleena

What’s with all the new Levonorgestrel IUDs?

How long should we tell women a Mirena IUD is effective for?

a. 5 years
b. 6 years
c. 7 years
d. 12 years
The Latest on IUDs….

• How many years can a woman leave an IUD in place?
  ▪ Data from the CHOICE study shows Mirena is effective at least for 7 years.
  ▪ Long standing data about the copper IUD indicates it is effective for at least 12 years
  ▪ (Contraceptive implant effective for at least 5 years)

• Do I need to get results of STI tests back before inserting an IUD?
  ▪ NO! Testing according to screening guidelines can be performed the day of the procedure as necessary

• Should we put barriers in place around IUD removal?
  ▪ NO!

Resistance to IUD Removals

I was telling the worse how I been on my period for like 3 weeks now, and I’m having bad cramps, and I’m even having them in my back, which I never had before. And she was saying, “Just give it another month or so and see how it goes.” . . . I was mad.

I told them that I wanted it out and they said that it’s really expensive and that the IUD’s the best option. I got some resistance there . . . I was a little emotional at the time and she [the provider] didn’t even care, it seemed.

Emergency Contraception

Emergency Contraception: Efficacy

• Effectiveness\(^1\)\(^,\)\(^2\)
  Ulipristal Acetate (UPA) more effective than LNG EC
  ▪ Taken at 120 hrs: OR = .55 (.32-.93)
  ▪ Taken at 24 hrs: OR = .35 (.11-.93)

• Obese women have lower EC efficacy
  ▪ LNG: No efficacy >70-75 kg (>154-165lb)
  ▪ Large drop in efficacy at BMI >26
  ▪ PK data: Doubling the LNG dose may increase efficacy\(^6\)
  ▪ UPA: Less efficacy in obese women but still effective
  ▪ May lose efficacy at weight of 90 kg (198 lb) or BMI >35

Quickstarting Contraception After UPA

<table>
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<tr>
<th></th>
<th>% cycles with ovulation within 5 days</th>
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<tbody>
<tr>
<td>UPA + placebo</td>
<td>3%</td>
</tr>
<tr>
<td>UPA + desogestrel OC</td>
<td>45%</td>
</tr>
</tbody>
</table>

Brache V et al. Hum Reprod 2015; 30:2785-93

Initiation of Contraception After UPA

- Start or resume HC no sooner than 5 days after UPA
- DMPA, implants, and IUDs at the time of UPA may be considered
  - The risk that the method might decrease the effectiveness of UPA must be weighed against risk of not starting a method
- Abstain or use a barrier for 7 days after starting or resuming HC, or until next menses, whichever comes first
- Any non-hormonal method can be started immediately
- Advise a pregnancy test if no withdrawal bleed within 3 weeks

Do you ask women of reproductive age about travel to areas with Zika?

a. Yes
b. No

What should I ask about Zika?

- Ask women about travel in past 8 weeks
- Ask men about travel in past six months
- Ask about planned travel
- Ask about pregnancy goals

Providing Family Planning Care for Non-Pregnant Women and Men of Reproductive Age in the Context of Zika
Contraceptive Performance Measures

• Measures for all women:
  1. The percentage of women at risk provided a most effective or moderately effective contraceptive method.
  2. The percentage of women at risk that is provided a long-acting reversible contraceptive (LARC) method.

• Measures for postpartum women:
  1. The percentage that is provided a most effective or moderately effective contraceptive method within 3 and 60 days of delivery.
  2. The percentage that is provided a LARC method within 3 and 60 days of delivery.

Public Comments During NQF Process

“The National Partnership for Women & Families strongly supports the committee’s recommendation to endorse this measure....It is extremely important to keep in mind that reproductive coercion has a troubling history, and remains an ongoing reality for many, including low-income women, women of color, young women, immigrant women, LGBT people, and incarcerated women. We hope this measure will be paired with a woman-reported “balancing measure” of experience of receiving contraceptive care. Such a measure can be expected to help identify and/or check inappropriate pressure from the health care system.”
Measure in Development at UCSF

Think about your visit with [provider] at [site] on [date of visit]. How do you think they did? Please rate them on each of the following by circling a number.

- **Respecting me as a person**
  - Poor
  - Fair
  - Good
  - Very good
  - Excellent
  - 1 2 3 4 5

- **Letting me say what mattered to me about my birth control method**
  - 1 2 3 4 5

- **Taking my preferences about my birth control seriously**
  - 1 2 3 4 5

- **Giving me enough information to make the best decision about my birth control method**
  - 1 2 3 4 5

https://Bedsider.org

Take home points

- Use of the CDC Medical Eligibility Criteria and SPR can help ensure safe and evidence-based prescribing
- Shared decision making is a valuable approach to providing patient-centered contraceptive care
- While IUDs and implants are good, highly effective methods, providers should not assume they are best for everyone
- Approaches to optimize women’s reproductive health care include using Bedsider.org, educating about Zika, and ensuring appropriate use of performance measures

References

- www.fpntc.org for the Zika toolkit