Contraception

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Objectives

To review:
- Basics of contraceptive methods
- Patient-centered contraceptive care
- Evidence-based guidelines
- Importance of offering post-abortion contraception
Proportion of women with unmet need for family planning is as high as 50% by country
Contraceptive Prevalence & Maternal Deaths

Figure 1: Contraceptive prevalence rate in relation to log of the proportion of maternal deaths in deaths of women aged 15–49 years (log PMDF)
Effect of Unmet Need for Contraception

U.S. Need for Contraception

Pregnancies in the United States

- Intended: 52%
- Unintended, despite method used: 25%
- Unintended, no method used: 23%

6.4 million unintended pregnancies

Jones PSRH 2008; Mosher Vital Health Stat 2010
Public Health Goals: Contraception

• Meet unmet need for contraception
  – Increase availability of modern methods
  – Decrease financial cost and other barriers to access
• Facilitate effective use
• Make contraception available at all points of care
• Help individual women use best method for them
Contraceptive Methods
Contraception Methods

- **Least Effective**
  - Episodic
  - Daily
  - Weekly
  - Monthly
  - 3 mos
  - 3-5 yrs

- **Most Effective**
  - Permanent
  - >99%
  - 10 yrs
  - 3-5 yrs

**Barrier Methods**
- Condom
- NFP
- EC

**Ovulation Control**
- OCPs
- Patch
- Ring (Inj.)

**Injections**
- Progestin
- Progestin Implant
- LNG-IUD
- Copper IUD

**Surgical**
- BTL
- Hysteroscopic Vasectomy

**Combined Hormonal**

**Progestin Only**

**IUD**

**Sterilization**
How effective is the combined oral contraceptive?

Perfect = <1%

Typical = 9%
## Natural Family Planning

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perfect Use</td>
</tr>
<tr>
<td>No Method</td>
<td>85%</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>4%</td>
</tr>
<tr>
<td>Periodic Abstinence</td>
<td></td>
</tr>
<tr>
<td>Standard Days Method®*</td>
<td>5%</td>
</tr>
<tr>
<td>Symptothermal</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Two-Day Method®</td>
<td>4%</td>
</tr>
<tr>
<td>Lactational Amenorrhea</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

* Including Cycle Beads
## Barrier Methods

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perfect Use</td>
</tr>
<tr>
<td>Condoms</td>
<td>2%</td>
</tr>
<tr>
<td>Cervical Cap (parous/nulliparous)</td>
<td>26%/9%</td>
</tr>
<tr>
<td>Sponge (parous/nulliparous)</td>
<td>20%/9%</td>
</tr>
<tr>
<td>Female Condoms</td>
<td>5%</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6%</td>
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</table>

National Center Health Statistics; Contraceptive Technology
## Hormonal Methods

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perfect Use</td>
<td>Typical Use</td>
</tr>
<tr>
<td>Progestin Pills</td>
<td>&lt;1%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Combined Pill/Patch/Ring</td>
<td>&lt;1%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Combined 1-month injection</td>
<td>&lt;1%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>3-Month Injection</td>
<td>&lt;1%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>Copper IUD/LNG IUD</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td></td>
</tr>
</tbody>
</table>
Long-acting Reversible or Highly-effective Contraceptives
Every 10 Years: Copper T IUD

- No hormones
- Effective for 12 years
  - Can be used as emergency contraceptive
- Efficacy 99.2% in one year
- Placed and removed by clinician
- Side effects
  - Heavier, regular bleeding
  - Immediate return to fertility
- Insertion-associated risk of PID then no increase
Every 3 or 5 Years: Levonorgestrel IUD

- Levonorgestrel
  - 5-year: 14-20 mcg/day
  - 3-year: 5-13 mcg/day – smaller device
- Efficacy 99.8% in one year
- Placed and removed by clinician
- Side effects
  - Initial spotting x 6 mos. then decreased blood loss
  - 5-year with more effect on blood loss
  - Immediate return to fertility
- Insertion-associated risk of PID then decreased
Every 3 Years: Single Implant

- Etonogestrel 25-60mcg/day
- Efficacy > 99.9%
- Implant placed and removed by clinician – 3 years
- Side effects
  - Decreased blood loss but common unpredictable spotting
  - Immediate return to fertility
- Also levonorgestrel, 2-implant method – 5 years
Short-acting or Less-effective Contraceptives
Every 3 Months: Progestin Injection

- Medroxyprogesterone acetate 150 mg IM or 104 mg SQ (also bimonthly injection)
- Efficacy 99.8% (perfect) / 94% (typical)
- Injection every 12 (13) weeks
- Side effects
  - Decreased blood loss – 50% with amenorrhea
  - Decreased bone mineral density
  - Delayed return to fertility
Monthly: Combined Hormonal Injection

- Estrogen and progestin – types and doses vary
- Efficacy 99.7% (perfect) / 91% (typical)
- Monthly IM injection
- Side effects – same as other combined methods
  - Decreased blood loss – may have spotting
  - Short-term nausea, vomiting, breast tenderness
  - Decreased acne
  - Increased risk venous thromboembolism (< preg.)
  - Immediate return to fertility
Monthly: Contraceptive Vaginal Ring

- Ethinyl estradiol and etonogestrel
  - 15 mcg EE & 120 mcg desogestrel
- Efficacy 99.7% (perfect) / 91% (typical)
- Use: One ring each month
  - can be used continuously
  - should not be out >3 hrs.
- Side effects
  - Same as other combined hormonal methods
  - Sometimes can feel ring
Weekly: Patch

• Norelgestromin (150 mcg) and Ethinyl Estradiol (20 mcg)
  – Higher estrogen exposure than a 35 mcg EE pill
• Efficacy 99.7% (perfect) / 91% (typical)
• Use: 1 patch per wk for 3 wks then 1 wk off
• Side effects
  – Same as other combined methods
  – Application site problems
Daily: Combined Oral Contraceptives

- Variety of estrogens + progestins / formulations
- Efficacy 99.7% (perfect) / 91% (typical)
- Use:
  - Traditional prescription flawed (3 wks / 1 wk)
  - Extended cycle or shortened placebo week may ↑efficacy
- Side effects
  - Same as other combined hormonal methods
Daily: Progestin Pills

- Progestin – norethindrone 0.35 mg
- Efficacy 99.7% (perfect) / 91% (typical)
- Take one pill per day – at same time
- Side effects
  - Decreased blood loss; may have spotting
  - Immediate return to fertility
Permanent Methods of Contraception
Permanent:
Tubal Sterilization and Vasectomy

Efficacy 99.9% at one year and >97% at 10 years
Emergency Contraception
Post-exposure: Emergency Contraception

Levonorgestrel – 2% failure
• 150 mg x 1, up to 5 days
• Delays LH peak

Ulipristal Acetate – 1% failure
• 30 mg, up to 5 days
• Selective progesterone receptor modulator
• Delays LH peak and follicular rupture
Post-exposure: Emergency Contraception

• Copper IUD - <0.1% failure
  – VERY effective as EC
  – SPR recs up to 5 days
  – Can place beyond 5 days if not more than 5 days after ovulation
  – More effective than LNG EC

• Mifepristone (10, 25 or 50 mg)

• Yuzpe regimen
  – More side effects and less effective
Contraception Methods

Least Effective

Episodic 91%

Barrier NFP EC

Least Effective

OCPs

Patch

Ring (Inj.)

Progestin Injection

Progestin Implant

LNG-IUD

Copper IUD

Least Effective

Combined Hormonal

Progestin Only

Least Effective

IUD

Sterilization

Permanent

Most Effective

10 yrs

BTL Hysteroscopic Vasectomy

Most Effective

Permanent

Permanent

Least Effective

94%

3 mos

Permanent

Most Effective

>99%

3-5 yrs

Permanent

Most Effective

<90%

3-5 yrs

Permanent

Most Effective

>99%

10 yrs

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Perm
Providing Patient-centered and Evidence-based Contraceptive Care
Contraceptive Counseling

- Preference-sensitive decision
- Patient-centered care
- Respect diverse priorities, concerns, experiences
  - Efficacy
  - Convenience
  - Concern about, experience with or desire for side effects
  - Future pregnancy plans
  - Personal and friends’/family members’ experiences
  - Safety concerns
Contraceptive Counseling

• Preference-sensitive decision
• Patient-centered care
• Questions to pose patients
  – Which method did you come today wanting to use?
  – Are you interested in one of the most effective?
  – When – if ever – do you want a (another) child?
  – What method(s) have you used in the past?
  – What are you doing to protect yourself from STIs?
  – What side effects are you willing to accept or desire?
Many women do not understand efficacy and/or have other priorities.
Medical Eligibility Criteria (MEC)

• Evidence-based guidelines for safety of methods with co-existing conditions
• Modified by many countries – U.S.
# Medical Eligibility Criteria

<table>
<thead>
<tr>
<th></th>
<th>Can use the method</th>
<th>No restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can use the method</td>
<td>Advantages generally outweigh theoretical or proven risks.</td>
</tr>
<tr>
<td>2</td>
<td>Should not use method unless no other method is appropriate</td>
<td>Theoretical or proven risks generally outweigh advantages</td>
</tr>
<tr>
<td>3</td>
<td>Should not use method</td>
<td>Unacceptable health risk</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Birth control methods

### WHO MEC

### Medical conditions

### MEC Category

### MEC = medical eligibility criteria
### Birth Control Methods

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Progestin-only pill</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Copper-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep venous thrombosis (DVT) /Pulmonary embolism (PE)</td>
<td>a) History of DVT/PE, not on anticoagulant therapy</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>i) higher risk for recurrent DVT/PE</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td></td>
<td>ii) lower risk for recurrent DVT/PE</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b) Acute DVT/PE</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td></td>
<td>c) DVT/PE and established on anticoagulant therapy for at least 3 months</td>
<td>4*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>i) higher risk for recurrent DVT/PE</td>
<td>4*</td>
<td>2</td>
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<td>2</td>
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<td>2</td>
</tr>
<tr>
<td></td>
<td>ii) lower risk for recurrent DVT/PE</td>
<td>3*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d) Family history (first-degree relatives)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e) Major surgery</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(i) with prolonged immobilization</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>(ii) without prolonged immobilization</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>f) Minor surgery without immobilization</td>
<td>1</td>
<td>1</td>
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Search: “WHO MEC”

About 52,600,000 results (0.46 seconds)

WHO | Medical eligibility criteria for contraceptive use
www.who.int/reproductivehealth/.../en/  World Health Organization
This document reviews the medical eligibility criteria for use of contraception, offering guidance on the safety of use of different methods for women and men with...

[PDF] CDC. US Medical eligibility criteria for contraceptive use...
www.cdc.gov/.../en/  United States Centers for Disease Control and Prevention
You've visited this page 2 times. Last visit: 12/12/13

CDC - United States Medical Eligibility Criteria (USMEC) for...
www.cdc.gov/.../us/  United States Centers for Disease Control and Prevention
Jan 20, 2014 - The United States Medical Eligibility Criteria for Contraceptive Use, 2010 (US MEC) is intended to assist health care providers when counseling...
US MEC Resources - Video Commentary - iPhone, iPad App

[PDF] CDC Summary Chart-US Medical Eligibility Criteria for...
Selected Practice Recommendations (SPR)

- Evidence-based guidelines for how to use methods
- Modified recently by US

World Health Organization

SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE
Second edition, 2004
For Each Method...

- When to start – “anytime if reasonably sure that she is not pregnant”
- How long to use backup
- Special considerations
- Missed or late doses
Post-abortion Contraception
Post-abortion Contraception

- Majority of women desire contraceptive counseling.
- Vast majority of US abortion clinics provide education and dispense contraception – 1/3 IUD
- Contraceptive counseling at time of abortion important
  - RCT in Brazil – group v. individual counseling
  - Individual counseling increased uptake, continuation, (98% v. 70% at 6 months,) adherence, satisfaction
- Effective contraception decreases subsequent abortion.

## WHO and US Medical Eligibility Criteria: Post-abortion

<table>
<thead>
<tr>
<th></th>
<th>CHC</th>
<th>POP</th>
<th>Progestin Inj.</th>
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<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; trimester</td>
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<td>2&lt;sup&gt;nd&lt;/sup&gt; trimester</td>
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<tr>
<td>Immediate post-septic abortion</td>
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### WHO and US Medical Eligibility Criteria: Post-abortion

<table>
<thead>
<tr>
<th></th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
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<tbody>
<tr>
<td><strong>1st trimester</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td><strong>2nd trimester</strong></td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>Immediate post-septic abortion</strong></td>
<td>1</td>
<td>4</td>
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</table>
Immediate Post-abortion IUD

- Cochrane Review
  - Immediate insertion safe and effective
  - Expulsion rates may be as high as 7%
  - Use at 6 months higher in immediate insertion group
- RCT: 69% did not return for interval insertion
- Prospective cohort study: Subsequent abortion risk 35/1000 IUD v. 92/1000 other methods
- Medication abortion – place one week after

Immediate Post-abortion IUD

- 2011 RCT in NEJM
  - 575 women randomized after abortion 5-12 wks.
  - 100% immediate and 70% interval placement
- Expulsion rate 5% v. 2.3%
- 92% (immediate) and 77% (delayed) women using IUD at 6 months

- Published success stories – changing practice

Conclusion

• Contraception saves women’s lives.
• There is a large unmet need for contraception.
• Patient-centered contraception care is critical.
• Women undergoing abortion should have access to contraceptive counseling and to all methods.