Expanding Access to Contraception for Teens

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Our Mission
Improve Adolescents' Access and Utilization of Comprehensive Sexual and Reproductive Healthcare Services by Enhancing Knowledge, Expanding Training and Growing Advocacy Capacity of Current and Future Clinical Partners

David & Lucile Packard Foundation
Population & Reproductive Health #2015-62389

http://www.medschool.lsuhsc.edu/pediatrics/real.aspx
• Mission: to integrate and enhance family planning training for obstetrics and gynecology residents in U.S. and Canada

• Provides resources and expertise to establish a formal, opt-out rotation in family planning
Objectives

- Summarize the various forms of contraception
- Discuss the importance of diverse contraceptive options for adolescents
- Plan to assist patients in choosing contraception to best meet their needs and wishes
Who needs it?

• 2012: 67 million U.S. women of reproductive age.
• > ½ (38 million) in need of contraceptive services
• Typical American woman
  – wants 2 children
  – 3 years: pregnant, postpartum, or trying to become pregnant
  – 30 years: trying to avoid pregnancy.
Using Contraception: No small task

• From age 18 to 49, assuming she wants to have two children:
  – 360 monthly ovulations
  – Must prevent pregnancy for 306 months

• She must spend 85% of her reproductive life using contraception effectively
Unintended pregnancy

Frost. Contraceptive Needs and Services
Teen Pregnancy

• 42% adolescents aged 15-19 have had sexual intercourse

• 82% adolescent pregnancies unplanned, accounting for 1/5 of all unintended pregnancies.
Teen Pregnancy

U.S. teen pregnancy, birth and abortion rates reached historic lows in 2011
Rates per 1,000 women aged 15-19

Pregnancy Rate
Birthrate
Abortion Rate

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U.S. Teen Pregnancy Rates in 2011

The highest teen pregnancy rates are found in the South and Southwest

SOURCE: GUTTMACHER INSTITUTE ©2016
Abortion Incidence and Service Availability in the U.S., 2014

The U.S. abortion rate reached a historic low in 2014

Abortions per 1,000 women aged 15–44

GUTTMACHER INSTITUTE

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Contraception works

**Contraception Works**

The two-thirds of U.S. women at risk of unintended pregnancy who practice contraception consistently and correctly account for only 5% of unintended pregnancies.

**WOMEN AT RISK (43 MILLION)**

- 16% Consistent use
- 65% Inconsistent use
- 19% Nonuse

**UNINTENDED PREGNANCIES (3.1 MILLION)**

- 52% Consistent use during month of conception
- 43% Inconsistent use during month of conception
- 5% Nonuse during month of conception

Frost. Contraceptive Needs and Services
CHOICE Project

• 75% choose LARC

• LARC or DMPA had lowest unintended pregnancy rates

• Rate of teenage birth:
  – 6.3 per 1,000
  – U.S. rate of 34.3 per 1,000.

• In absence of financial, knowledge, health care provider, or logistical barriers, the rate of initiation of LARC was higher than any other contraceptive method.

Peipert. No-Cost Contraception and Unintended Pregnancies
Colorado Family Planning Initiative

- LARC use 15-24 yo 5% to 19%
- 1 in 15 young, low-income women received LARC (previously 1 in 170)
- High-risk births decreased 24%
- Abortion rates fell 34% among 15-19 yo and 18% by 20-24 yo
- Fertility rates 15-19 yo declined 26%

Ricketts. Game Change in Colorado.
Barriers to use by adolescents

- Lack of familiarity, misperceptions about the methods
- High cost
- Lack of access
- Health care providers’ concerns about safety in adolescents

ACOG Adolescents and Long-Acting Reversible Contraception
Health Care Provider

• Provider misinformation

• Insufficient continuing education on advances and changes in contraceptive methods

• High upfront costs (buy and bill)

• Clinician practice patterns
Ob/Gyn knowledge and attitudes

- Survey to 250 Ob/Gyn providers in St. Louis
- 29% believed IUC causes increased risk of PID
- 19% willing to offer to unmarried, nullip 17 yo
- Recent residency graduates or higher volume of contraceptive patients more likely to insert IUC

Madden. Intrauterine contraception in St. Louis
Case 1

- 15 yo with sickle cell disease admitted for sickle crisis.
Case 2

• 16 yo with history of seizure disorder, previously well controlled on lamotrigine, started on COCs three months ago. Presents to ER with seizure activity.
Case 3

- 17 yo with SLE, flare within past 6 months, positive antiphospholipid antibodies, presenting for continuation of methotrexate.
Cases

• 15 yo with sickle crisis*.
• 16 yo with history of seizure* disorder on lamotrigine*.
• 17 yo with SLE* on methotrexate*.

* Conditions which expose a woman to increased risk as a result of unintended pregnancy.
Medical Eligibility Criteria: The Who

- Category 1: no restriction
- Category 2: advantages generally outweigh risks
- Category 3: risks generally outweigh advantages
- Category 4: unacceptable risk
<table>
<thead>
<tr>
<th>Category</th>
<th>Restriction</th>
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<tbody>
<tr>
<td>1</td>
<td>No restriction</td>
</tr>
<tr>
<td>2</td>
<td>Advantages generally outweigh theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks usually outweigh advantages</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk</td>
</tr>
</tbody>
</table>
Cases

• 15 yo with sickle crisis [2].

• 16 yo with history of seizure [1] disorder on lamotrigine [3].

• 17 yo with SLE, positive antiphospholipid antibodies [4] on methotrexate.
US Selected Practice Recommendations for Contraceptive Use: The When (and then what..)

- **Class A**: tests and examinations essential and mandatory in all circumstances for safe and effective use of the contraceptive method.
- **Class B**: Contribute substantially to safe and effective use, but may be considered in context.
- **Class C**: Do not contribute substantially.
Young Women’s Health

http://youngwomenshealth.org/
Long-Acting Reversible Contraception
Advantages of LARC Methods

- Effectiveness independent from coitus, user motivation, adherence
- Highest effectiveness, continuation rates, and user satisfaction
- No need for frequent visits for resupply
- No requirement for additional funding
- Highly cost-effective
- Reversible, rapid return to fertility
- Few contraindications
Copper IUD

• Approved for use up to 10 years

• Mechanisms of action:
  ▪ Inhibits sperm migration and viability
  ▪ Changes ovum transport speed
  ▪ Damage/destroys ovum
  ▪ All before implantation
LNG IUS

- FDA approved for 5 years
- May be effective up to 7 years
- Mechanisms of action:
  - Similar to copper IUD
  - Also- endometrial suppression, changes in cervical mucus
  - All before implantation
LNG IUS Types

• Mirena
  - 52 mg LNG
  - FDA approved 5 years
  - Evidence suggests 7 years
  - Sound 6-10 cm
  - Outer diameter 4.4 mm

• Liletta
  - 52 mg LNG
  - FDA approved 3 years
  - Ongoing studies to 7 years
  - Outer diameter 3.8 mm

• Skyla
  - 13.5 mg LNG
  - FDA approved 3 years
  - Outer diameter 3.8 mm

• Kyleena
  - 19.5 mg LNG
  - FDA approved 5 years
  - Outer diameter 3.8 mm
Complications are Rare

- Perforation: 1 per 1,000 insertions or fewer
- Risk decreases with increasing insertion experience
IUDs ≠ PID

• Few studies exclusively on adolescents
• PID increased only in first 20 days, then returns to baseline
• LNG-IUD may in fact lower risk of PID by thickening cervical mucus, thinning endometrium
Adolescents should be screened for STIs at insertion

• Women 15-19 have 2nd highest rates of CT, highest rates of GC

• Reasonable to screen and place same day

• Administer treatment if test results positive

• May treat without removing IUD

• Abx prophylaxis not recommended
IUDs ≠ infertility

• Large case-control study- presence of CT antibodies, not previous IUD use, associated with infertility

• Baseline fecundity returns rapidly after IUD removal
May be inserted without technical difficulty in most adolescents

• Anticipatory guidance regarding pain and provision of analgesia should be individualized
  – Supportive care, NSAIDs, Narcotics, Anxiolytics, Paracervical blocks

• Most effective method not established

• Misoprostol does not reduce insertion pain, adverse effects common
Expulsion uncommon in adolescents

- Expulsion rates 3% to 5% for all IUD users
- 5% to 22% in adolescents
- Young age, previous IUD expulsion, nulliparity may slightly increase risk (research limited)
Ectopic Pregnancy

- IUDs may be offered to women with a history of ectopic pregnancy
- IUD use does not appear to increase absolute risk
Etonorgestrel implant: Nexplanon

- 68 mg etonorgestrel
- 4 cm long
- 3 years
- Initial “burst” effect
  - Max concentration at week 1, slow decline after that
- Most common side effect: irregular bleeding
Options for LARC availability

• WHC Support Center “Buy & Bill”
  – Purchase directly and bill the patient’s insurer for the product

• Specialty Pharmacy Program (SPP)
  – Order for each patient from CVS Caremark
  – CVS Caremark supplies and bills the medical insurer directly.
  – Pharmacy verifies coverage and collects any out-of-pocket expense.
  – No inventory-related expenses for the medical practice.
Same-day LARC

• Should be initiated the day a patient decides, as long as reasonably certain she is not pregnant.
• She may not return.
• She may get pregnant.
• ACOG: Adopt same-day insertion protocols.
• Screening for chlamydia, gonorrhea, and cervical cancer should not be required before implant or IUD insertion.
• May be obtained on the day of insertion, if indicated.

ACOG CO #450
Postpartum and Postabortal initiation

- Adolescent mothers at high risk of rapid repeat pregnancy
- 20% give birth again within 2 years
- Immediate postpartum- highly motivated and within health care system
- Safe to place
- Possibly increased risk expulsion
Injectables

- Medroxyprogesterone acetate 150 mg IM every 12 weeks (+/- 2w)
- Effective for 3 months
- 0.3% failure rate
- 60% continuation at 1 year
- Reduction in frequency of epileptic seizures
- Reduction in sickle crises
- Reduction in symptoms of endometriosis
Combined Hormonal Contraception

- 3 methods:
  - Combined oral contraceptive (COC)
  - Transdermal (Xulane) patch
  - Vaginal ring (Nuvaring)

- Similar mechanisms of action

- May be differences in compliance, ease of use, preference
Contraceptive Vaginal Ring: Nuvaring

- Etonorgestrel and ethinyl estradiol
- 3 weeks in, one week off (labeling)
  - Effective in 24 hours
  - Continuous/extended use an option
- Can remove for up to 3 hrs
Contraceptive Transdermal Patch

• Norelgestromin and ethinyl estradiol
• Wear new patch each week for 3 weeks, then one week off
• Arm, buttocks, abdomen, back
• Side effects:
  – Detachment 2%
  – Site reaction 20%
  – Same as pill: breast tenderness, nausea
Combined Oral Contraceptives

- Most pills “low dose”:
- Ethinyl estradiol (20-35 mcg per pill)
- Progestin component varies
  - Norethindrone
  - Levonorgestrel
  - Desogestrel
  - Drospirenone
- Monophasic, biphasic, triphasic
COCs initiation

- Counseling is important!
- At any time if reasonably certain she’s not pregnant
- Needed prior to initiation
  - BP (maybe BMI)
  - A pelvic exam is not necessary
- Backup for 7d needed if >5d since LMP
Progestin-Only Oral Contraceptives ("Minipill") (POP)

- Levonorgestrel 0.03mg, NET 0.35mg
- May be less effective
  - Need for strict compliance
  - "27-hour rule" - hormone levels drop
- No "pill-free interval" - taken daily
- Few contraindications
Emergency Contraception

- Use after **unprotected** or **underprotected** intercourse

- **4 options:**
  - Progestin-only pills: (total 1.5mg levonorgestrel)
  - Yuzpe method
    - Combined OCPS (each dose: 100mcg EE + 0.5mg levonorgestrel)
  - Ulipristal
  - Copper IUD

ACOG PB 112, Reaffirmed 2014. Emergency Contraception
Access for Minors

• U.S. Supreme Court rulings extend constitutional right to privacy to a minor’s decision to obtain contraceptives.
• May provide medical care to a mature minor without parental consent (even when no policy or case law)
• Louisiana: Minor’s consent to contraceptive services: No policy in effect
• State law confers rights and responsibilities of adulthood to minors who are married.

Guttmacher Institute
Contraception and ACA

- Plans must cover women’s preventive services without cost-sharing (copay, coinsurance, or deductible).
- Women’s preventive services includes:
  - ALL FDA-approved contraceptive methods
  - Patient education and counseling
- OTC methods included IF prescribed.
- Plans must let women visit a specialist for Ob/Gyn care without referral or prior authorization.
Who is NOT covered

• Grandfathered plans (pre- March 23, 2010)
• Self-funded student health plans from religious universities
• Some religious institutions

For-profit companies? ....
Burwell v. Hobby Lobby

- Religious for-profits can opt out of paying for coverage, but their female employees can still receive the coverage, with either the insurers or the government paying for it.

- Considered a narrow decision.
  - Doesn’t mean an employer can automatically avoid paying for a particular coverage just because it has religious objections.
  - Example: vaccinations 2/2 need to prevent the spread of contagious diseases.
National Women’s Law Center

 COVER HER
 The health care you need. The coverage you deserve.
 NATIONAL WOMEN’S LAW CENTER
 CoverHer.org

http://action.nwlc.org/site/PageServer?
pagename=coverher

Call Us at 1-866-745-5487

Email Us at CoverHer@nwlc.org

Get Started on Your Own
Case 1

- 15 yo with sickle cell disease admitted for sickle crisis.
Case 2

• 16 yo with history of seizure disorder, previously well controlled on lamotrigine, started on COCs three months ago. Presents to ER with seizure activity.
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- 17 yo with SLE, flare within past 6 months, positive antiphospholipid antibodies, presenting for continuation of methotrexate.
Referrals

• LSU Complex Contraception Clinic at UMC
  – Patrice Bibbins RN lead 504-702-4139
  – Email me: vwil10@lsuhsc.edu

• CHNOLA Adolescent Clinic
  – Apt line 504-896-2888
9 MONTHS FROM NOW THE ONLY THING I'M EXPECTING IS TO BE MORE AWESOME.

Thanks, Birth Control
#THXBIRTHCONTROL

BEDSIDER.ORG