Considerations for Contraception for Special Populations

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Disclaimer

- Nothing to disclose.

- The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Objectives

By the end of this session, participants will be able to:

- Describe the current evidence-based recommendations about the safety and effectiveness of contraceptive methods for:
  - Adolescents
  - Women at high risk for HIV
  - Postpartum women
  - Breastfeeding women
  - Perimenopausal women
BACKGROUND.
CDC’S CONTRACEPTIVE GUIDANCE
US Medical Eligibility Criteria for Contraceptive Use (US MEC)

- Safety of contraceptive methods among women with certain characteristics or medical conditions
- Includes recommendations for adolescents, women at high risk for HIV, postpartum and breastfeeding women

https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
# U.S. MEC: Categories

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction for the use of the contraceptive method for a woman with that condition</td>
</tr>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that condition</td>
</tr>
</tbody>
</table>
US Selected Practice Recommendations for Contraceptive Use (US SPR)

- Guidance for common contraceptive management topics, including:
  - How to be reasonably certain a woman is not pregnant
  - When to start contraception
  - When to stop contraception
  - Indicated exams and tests
  - Follow-up and management problems

https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html
PART I.
ADOLESCENTS
Pregnancy, birth and abortion rates for 15 -19 year olds

KostK et al., Guttmacher Institute, 2017.
Trends in adolescent pregnancy

- Majority of decline attributable to increased contraceptive use among adolescents
- 46% of teen pregnancies due to non-use of contraception
- 54% of teen pregnancies due to contraceptive failure related to:
  - Incorrect or inconsistent use of moderately or less effective methods

Scenario 1a:

- A19 y.o. G0 comes to the office desiring contraception. She has a history of chlamydia 6 months ago that was treated, and reports one new partner since then.

  - Q: Given her risk factors, what contraception can she use?
### Sexually transmitted diseases

<table>
<thead>
<tr>
<th>Condition</th>
<th>IUDs Init.</th>
<th>IUDs Cont.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current purulent cervicitis or chlamydial infection or gonococcal infection</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Vaginitis (including trichomonas and bacterial vaginosis)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other factors related to STDs</td>
<td>2*</td>
<td>2</td>
</tr>
</tbody>
</table>

*Clarification: If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC STD treatment guidelines, screening may be performed at the time of IUD insertion and insertion should not be delayed.*
# Age and parity

<table>
<thead>
<tr>
<th>Condition</th>
<th>IUDs</th>
<th>Implants</th>
<th>DMPA</th>
<th>POP</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>&lt;20 yrs: 2</td>
<td>All ages: 1</td>
<td>&lt;18 yrs: 2</td>
<td>&lt; 18 yrs: 1</td>
<td>&lt; 40 yrs: 1</td>
</tr>
<tr>
<td></td>
<td>≥20 yrs: 1</td>
<td></td>
<td>18-45 yrs: 1</td>
<td>18-45 yrs: 1</td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parous</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Scenario 1b:

- You’ve counseled her on her options, and she has decided she would like a levonorgestrel (LNG) IUD.

  - Q: Is it safe for her to get an IUD?
  - A: Yes, so long as she does not have purulent cervicitis or other contraindications. Perform screening for gonorrhea/chlamydia at the time of IUD insertion per CDC STD guidelines.
Scenario 1b:

- She has been counseled and consented. Now time to get ready for the procedure.

  Q: But wait, don’t you need to do more testing?
Exams and tests prior to initiation

- Unnecessary tests may create barriers to starting contraception
  - Women may not be comfortable with pelvic exam
  - Potential delays and additional visits to receive test results

- Recommendations address exams and tests needed prior to initiation
  - Class A = essential and mandatory
  - Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context
  - Class C = does not contribute substantially to safe and effective use of the contraceptive method
# US SPR

## Exams and tests prior to initiation

<table>
<thead>
<tr>
<th>Examination or test</th>
<th>LNG and Cu-IUD</th>
<th>Implant</th>
<th>Injectable</th>
<th>CHC</th>
<th>POP</th>
<th>Condom</th>
<th>Diaphragm or cervical cap</th>
<th>Spermicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A*</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>‒ †</td>
<td>‒ †</td>
<td>‒ †</td>
<td>‒ †</td>
<td>‒ †</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C</td>
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</tbody>
</table>

### Laboratory test

<table>
<thead>
<tr>
<th>Glucose</th>
<th>C</th>
<th>C</th>
<th>C</th>
<th>C</th>
<th>C</th>
<th>C</th>
<th>C</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipids</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Papanicolaou smear)</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td>‒ †</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>
How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum
Scenario 1c:

- She’s ready to get her LNG IUD, but has heard it might be painful. You remember that she is nulliparous as well.

  - Q: Should any medications be administered before IUD insertion?
Difficult IUD insertions

- Some providers may be concerned about difficult IUD insertions for adolescents and nulliparous women

- Rates of difficult IUD insertions may be higher among nulliparous women compared to parous women
  - No effect of age

- However, almost all IUD placements are successful in nulliparous women
  - 80% reported as easy, compared with 92% for prior vaginal delivery
  - 11% failed, compared with 2% for prior vaginal delivery

CDC SPR guidance

- **Misoprostol is not recommended for routine use before IUD insertion.**
  - A total of 10 randomized trials suggest that misoprostol does not improve ease of insertion, reduce the need for adjunctive insertion measures or improve insertion success
  - Misoprostol might increase patient pain and side effects

- **Paracervical block with lidocaine might reduce pain during IUD insertion.**

- **Limited evidence on NSAIDs and nitric oxide generally suggests no positive effect.**

Lopez et al. Cochrane Database Sys Rev 2015
Zapata et al. Contraception 2016
Additional considerations

- Use of cervical dilators may assist with resistance at the internal os
- Ultrasound guidance may decrease procedural pain

Less “medical” techniques:
- Visual distraction
- Ambient music
- Low abdominal heat

Carwile, J LowGenit Tract Dis, 2014.
Scenario 1d:

- You’ve successfully placed her IUD and she’s getting ready to go.

  - Q: What do you tell her about any additional contraception that she might need?
  - A: Discuss back up and dual protection.
## Recommendations for back up: U.S. SPR

### When to Start Using Specific Contraceptive Methods

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>When to start (if the provider is reasonably certain that the woman is not pregnant)</th>
<th>Additional contraception (i.e., back up) needed</th>
<th>Examinations or tests needed before initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper-containing IUD</td>
<td>Anytime</td>
<td>Not needed</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Levonorgestrel-releasing IUD</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Implant</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Injectable</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Combined hormonal contraceptive</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Blood pressure measurement</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 2 days.</td>
<td>None</td>
</tr>
</tbody>
</table>
“Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STDs, including HIV. Consistent and correct use of the male latex condom reduces the risk for HIV infection and other STDs, including chlamydial infection, gonococcal infection, and trichomoniasis.” — *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016*

“Condoms...should be used by all sexually active adolescents regardless of whether an additional method of contraception is used..... When initiating any hormonal contraceptive method, the need for consistent protection against STIs (either male or female condoms) should be reinforced.” — *American Academy of Pediatrics, Committee on Adolescence*

MMWR. Recommendations and Reports. 2016 Jul;65(3):1-104
Blythe, Pediatrics. 2007 Nov;120(5):1135-48
Scenario 1:

- Otherwise healthy adolescents and nulliparous women can generally use all contraceptive methods safely.
- Same-day STD screening and IUD placement is safe.
- SPR resources can help assess pregnancy status, necessary exams and tests, measures to ease IUD insertion, and the need for back up contraception.
- Dual protection is recommended for STD prevention.
PART II.
WOMEN AT HIGH RISK FOR HIV
Scenario 2:

- A 25 year old woman is returning to clinic for a repeat DMPA injection. She also is interested in discussing pre-exposure prophylaxis (PrEP) for HIV prevention. She recently learned about it, and thinks she might be a good candidate for it.

  Q: Should you recommend that she change her method of contraception?
US MEC Revised Recommendations, 2017

Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2016: Revised Recommendations for the Use of Hormonal Contraception Among Women at High Risk for HIV Infection

Naomi K. Tepper, MD; Jamie W. Krashin, MD; Kathryn M. Curtis, PhD; Rhonda Cox, MSPH; Maura K. Whiteman, PhD

CDC's U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC) (first published in 2010 and updated in 2016) provides evidence-based guidance for the safe use of contraceptive methods among U.S. women with certain characteristics or medical conditions (1), and is adapted from global guidance from the World Health Organization (WHO) and kept up to date based on continual review of published literature (2). CDC recently evaluated the evidence and the updated WHO guidance on the risk for human immunodeficiency virus (HIV) acquisition among women using hormonal contraception. After careful review, CDC adopted the updated WHO guidance for inclusion in the U.S. MEC guidance; this guidance states that the advantages of progestin-only injectable contraceptive use (including depot medroxyprogesterone acetate [DMPA]) by women at high risk

Background

Approximately half of pregnancies in the United States are unintended (3). Increasing access to and promoting correct and consistent use of contraception is a priority strategy to reduce unintended pregnancies. HIV infection continues to be a major public health issue in the United States. The vast majority of new infections among women are attributed to heterosexual contact. HIV infection is associated with adverse pregnancy outcomes for both the mother and child, including increased morbidity during pregnancy and perinatal HIV transmission (4). Therefore, prevention of both unintended pregnancy and HIV acquisition is critical among women at high risk for HIV infection.

To date, recommendations for use of hormonal contraceptives among women at high risk for HIV infection have been

https://www.cdc.gov/mmwr/volumes/66/wr/mm6637a6.htm?s_cid=mm6637a6_w
US MEC Revised Recommendations, 2017

<table>
<thead>
<tr>
<th></th>
<th>Implants</th>
<th>DMPA</th>
<th>POP</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk for HIV</td>
<td>1</td>
<td>2*</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

* Clarification (DMPA): There continues to be evidence of a possible increased risk of acquiring HIV among progestin-only injectable users. Uncertainty exists about whether this is due to methodological issues with the evidence or a real biological effect. In many settings, unintended pregnancies and/or pregnancy-related morbidity and mortality are common, and progestin-only injectables are among the few types of methods widely available. Women should not be denied the use of progestin-only injectables because of concerns about the possible increased risk. Women considering progestin-only injectables should be advised about these concerns, about the uncertainty over whether there is a causal relationship, and about how to minimize their risk of acquiring HIV.
Updated review on DMPA and HIV acquisition

Limitations of evidence

- **Population**
  - Varying definitions of “high risk of HIV”
  - Behavioral differences between groups

- **Exposure**
  - Measurement of contraceptive use
  - Hormonal use in comparison group

- **Outcome**
  - Follow up not long enough

- **Methodology**
  - Objective of study generally not designed to assess HIV acquisition
  - Confounding (e.g. condom use)
  - Limited power to detect differences between groups

Polis, AIDS 2013;27:S3543.
Competing risks

- HIV infection
- HIV-related Morbidity & Mortality
- Unintended pregnancy
- Maternal Morbidity & Mortality

Hormonal contraception
Scenario 2:

- A 25 year old woman is returning to clinic for a repeat DMPA injection. She also is interested in discussing pre-exposure prophylaxis (PrEP) for HIV prevention. She recently learned about it, and thinks she might be a good candidate for it.

  - Q: Should you recommend that she change her method of contraception?
  - A: New evidence should help guide a conversation with the patient, however DMPA is still considered generally safe for women at high risk for HIV (MEC 2). Additionally, PrEP with tenofovir/emtricitabine is a way to prevent HIV infection for those at high risk for HIV.

PART III. POSTPARTUM CONTRACEPTION
Scenario 3a:

- 28 year old G1 is pregnant and being counseled for postpartum family planning. She is not planning on breastfeeding. What options are available to her postpartum?
Importance of postpartum contraception

- Prevention of unintended pregnancy
  - 45% of pregnancies in U.S. are unintended (includes mistimed and unwanted)
  - Unintended pregnancy is associated with later entry into prenatal care, decreased smoking cessation, increased low birth weight, decreased breastfeeding

- Prevention of short birth intervals
  - Short birth intervals are associated with low birth weight, preterm birth

- Immediate postpartum period is important time to consider initiation of contraception because women are in a health system and may not follow up for postpartum visit

Hormonal methods for non-breastfeeding postpartum women

<table>
<thead>
<tr>
<th>Postpartum (non-breastfeeding)</th>
<th>CHCs</th>
<th>Progestin-only methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>21-42 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With other risk factors for VTE</td>
<td>3*</td>
<td>1</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>&gt;42 days</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- VTE risk is increased during pregnancy and the postpartum period; most pronounced in the first 3 weeks after delivery, decreasing to near baseline levels by 42 days postpartum.

* Clarification: Other risk factors might increase classification to “4”
### Postpartum IUDs

<table>
<thead>
<tr>
<th></th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum (breastfeeding or non-breastfeeding, including post cesarean section)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10 min after delivery of placenta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-breastfeeding</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10 min to &lt;4 weeks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>&gt;4 weeks</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Postpartum sepsis</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

- Theoretical concern exists that postpartum insertion of an IUD in a woman with recent chorioamnionitis or current endometritis might be associated with increased complications
Scenario 3a:

- 28 year old G1 is pregnant and being counseled for postpartum family planning. She is not planning on breastfeeding. What options are available to her immediately postpartum?

  - IUD (copper or levonorgestrel), progestin-only methods (pill, injectable, implant)
  - Combined hormonal methods (pill, patch, ring)
    - For estrogen-containing methods, wait until 21-42 days postpartum, depending on VTE risk factors
Scenario 3b:

- She decided to wait to start contraception until her postpartum visit. She returns to clinic for her 2 week postpartum visit after an uncomplicated delivery, and actually ended up breastfeeding.
  - **Does this change considerations for contraception?**
Concerns about hormonal contraceptives

- **Effect on breastfeeding performance?**
  - Progesterone plays a role in initiation and maintenance of lactation; exogenous progestins could therefore impact breastfeeding performance

- **Effect on the infant?**
  - Rodent studies show that progesterone receptors are common in the developing brain, higher in male brain
  - Some progestins transfer to breast milk and can be detected in infant serum
  - Theoretical effects of progesterone in reproductive, neuroendocrine and cognitive function; little information in humans
Breastfeeding and Postpartum

<table>
<thead>
<tr>
<th>POSTPARTUM (including cesarean delivery)</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;10 min after delivery of placenta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Breastfeeding</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ii. Nonbreastfeeding</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B. 10 min after delivery of placenta to &lt;4 weeks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>C. &gt;4 wks</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>D. Postpartum sepsis</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**BREASTFEEDING**

<table>
<thead>
<tr>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;21 days postpartum</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>B. 21 to &lt;30 days postpartum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. With other risk factors for VTE</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>C. &gt;42 days postpartum</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- Conflicting data on breastfeeding outcomes
- No differences in infant outcomes
**Breastfeeding and Postpartum**

**POSTPARTUM (including cesarean delivery)**

<table>
<thead>
<tr>
<th>PC of delivery</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;10 min after delivery of placenta</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>i. Breastfeeding</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>ii. Nonbreastfeeding</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>B. 10 min after delivery of placenta to &lt;4 weeks</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>C. &gt;4 wks</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>D. Postpartum sepsis</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BREASTFEEDING

- Most studies have found no differences in breastfeeding rates or infant outcomes among women using progestin-only methods compared to those not using hormonal contraception.
- Conflicting evidence with DMPA and POPs.
- Studies of COCs showed conflicting results in breastfeeding and infant outcomes.
- Conflicting evidence with DMPA and POPs.

**Braga, Contraception 2015.**

**Phillips, Contraception 2015.**

<table>
<thead>
<tr>
<th>PC of delivery</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. &lt;21 days postpartum</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>B. 21 to &lt;30 days postpartum</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. With other risk factors for VTE</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>C. 30-42 days postpartum</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>i. With other risk factors for VTE</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>ii. Without other risk factors for VTE</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>D. &gt;42 days postpartum</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Tepper, Contraception 2015.**
Scenario 3b:

- She returns to clinic after an uncomplicated delivery, and actually ended up breastfeeding.
  - Does this change considerations for contraception?
    - All methods without estrogen are safe.
    - MEC comment: certain women may be at risk for breastfeeding difficulties and should be counseled on risks, benefits, and alternatives for contraception.
Scenario 3:

- Postpartum contraception and breastfeeding are important priorities.
- Exercise caution with estrogen-containing methods when less than 42 days postpartum.
- Remaining methods are generally safe for both breastfeeding and non-breastfeeding women.
- Consider individual risks of breastfeeding difficulties when counseling on postpartum options.
PART IV.
PERIMENOPAUSAL WOMEN
Scenario 4:

- A 45 year old healthy woman who has been taking oral contraceptives for the past 10 years comes in to your office for an annual exam. She wants to know if she should go ahead and stop taking contraceptives, since she’s probably too old to get pregnant.

- Q: What do you advise?
When to stop contraception

- The American College of Obstetricians and Gynecologists and the North American Menopause Society recommend use until menopause or age 50 -55

- Median age of menopause is 51 years (range 40-60)

- No reliable test can definitively confirm loss of fertility

When to stop contraception

- Consider increased risk of pregnancies for women of advanced maternal age
- Consider increased risks associated with continuing contraception
- Development of chronic disease may influence what is still considered safe to use

Wu et al, Contraception, 2014.
Scenario 4:

A 45 year old healthy woman who has been taking oral contraceptives for the past 10 years comes in to your office for an annual exam. She wants to know if she should go ahead and stop taking contraceptives, since she’s probably too old to get pregnant.

Q: What do you advise?

A: Contraceptive protection is still needed for women aged > 44 years if the woman wants to avoid pregnancy. Consider balance of risks and benefits.
Objectives

By the end of this session, participants will be able to:

- Describe the current evidence-based recommendations about the safety and effectiveness of contraceptive methods for:
  - Adolescents
  - Women at high risk for HIV
  - Postpartum women
  - Breastfeeding women
  - Perimenopausal women
CDC contraceptive guidance documents:


- Online access: [https://www.cdc.gov/reproductivehealth/contraception/index.htm](https://www.cdc.gov/reproductivehealth/contraception/index.htm)
  - Find the iPhone and Android app, quick reference tables and charts, and more!