For methods that are reversible and long-acting, upswing continues

Access is increasing and barriers are being reduced when it comes to provision of long-acting reversible contraceptive (LARC) methods. About 40% of participants in the 2014 Contraceptive Technology Update Contraception Survey say they have seen “dramatically more” women choosing intrauterine (IUD) and implant contraception.

Almost one-quarter (23.5%) of survey participants said they inserted more than 25 IUDs in the past year. About 24% indicated 11-25 IUD insertions in the same time period. About one-third (32.3%) said they had inserted more than 25 implants, and about 9% indicated they inserted 11 to 25 of those devices.

Women in the United States are beginning to emulate their European counterparts, says Andrew Kaunitz, MD, University of Florida Research Foundation professor and associate chairman of the Department of Obstetrics and Gynecology at the University of Florida College of Medicine — Jacksonville. Data gathered during the mid-to-late 2000s indicate that the IUD and implant are used by 15% of contraceptors worldwide, including 11% of British users, 23% of French users, 27% of Norwegian users, and 41% of Chinese users.¹

CTU Contraception Survey results

This issue includes the results of the 2014 Contraceptive Technology Update Contraception Survey. Gain perspective from this overview of current clinician practice, and obtain updated information on how to use such long-acting reversible contraceptives as intrauterine devices and the contraceptive implant. Review the latest information on oral contraceptives and the contraceptive patch. We hope you enjoy this special edition of CTU.

¹ Data from the Contraceptive Technology Update Contraception Survey.
“European women are more likely to use effective methods of contraception and have fewer unintended pregnancies and induced abortions than U.S. women,” notes Kaunitz. “Closing that gap is a good thing.”

Clinicians at Virginia League for Planned Parenthood in Virginia Beach are putting IUDs in on the day of a surgical abortion procedure, and that change has helped move the method forward, says Karen Albright, WHNP-BC, lead clinician. Use of the implant has “really increased,” she notes. “I have seen some extra magazine advertising, and I think word of mouth has made it more popular,” Albright states.

In September 2014, the Elk Grove Village, IL-based American Academy of Pediatrics issued a policy statement recommending long-acting reversible contraceptive methods as first-line contraceptive choices for adolescents.2 (CTU reported on the statement. See the column, “Use motivational interviewing with teens,” December 2014, p. 142.) The move echoes similar recommendations from the American College of Obstetricians and Gynecologists.3

Clinicians are getting the message: 91% of respondents to the 2014 CTU Contraception Survey said they would recommend an IUD to adolescents ages 14-17.

Albright says her facility now offers Skyla, the smaller of the two levonorgestrel intrauterine devices marketed by Bayer HealthCare Pharmaceuticals of Wayne, NJ. Skyla’s small, flexible plastic T-shaped device measures 28 mm by 30 mm, compared to Mirena’s 32 mm by 32 mm dimensions. “I think once the word gets out about this IUD, we will see more insertions,” says Albright.

In a retrospective cohort study that compared the insertion and postinsertion experiences between nulliparous and parous teens, data suggest adolescents experience minimal complications with IUD use, with similar rates of successful insertion as adults.4 Rates of IUD discontinuation rates were not significantly different between nulliparous and parous teens, findings indicate.4

Researchers who performed a multicenter retrospective chart review of adolescents and women ages
13-35 who had an IUD inserted for contraception found that similar to adults, IUD use in adolescents and nulliparous women is effective and associated with low rates of serious complications.5

Despite an upsurge of interest in LARC methods, there is no standardized LARC training in pediatric residency programs or adolescent medicine fellowships, states a recent commentary.6 This lack of standardized training might be a barrier to young women trying to access these methods. Findings from one study found that 25% of adolescent medicine clinicians were trained to insert intrauterine devices or implants.7

The commentary calls for the development of a curriculum spearheaded by experts in family planning and adolescent medicine to provide didactic and hands-on training in LARC provision that can be disseminated across adolescent medicine fellowship programs.6

Efforts are being made to increase provider training for LARC methods. CAI, a New York City-based training and capacity building organization, has teamed up with the Contraceptive CHOICE Project at Washington University in St. Louis to create the Contraceptive Action Plan, with funding support from the Centers for Disease Control and Prevention. The program is an evidence-informed intervention that draws on key findings from the Contraceptive CHOICE Project and CAI’s experience in working with healthcare providers across the nation to enhance access to contraception. Participating organizations will have access to free professional development and training for all staff levels including continuing medical and nursing education. Enrollment for the program was held in late 2014, with the program scheduled to kick off in 2015.

Women or LARC first?

When discussing LARC methods with patients, enthusiasm is important, but remember to focus on the patient, says Lisa Haddad, MD, MS, MPH, assistant professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta. Haddad spoke on LARC methods at the recent Contraceptive Technology conference in Atlanta.8

Long-acting reversible contraceptive use must be driven by women’s preferences, states a recent viewpoint on the topic. While enthusiasm about LARC methods has increased among U.S. reproductive health professionals in recent years due to their potential to help decrease the national rate of unintended pregnancy, failure to temper such verve could lead to programs and contraceptive counseling that promote their use among those identified as high risk for pregnancy populations — young, black, Latino, and poor women — in ways that restrict the contraceptive options for these women.9

Use of LARC methods should be driven by women’s desires and not by programmatic efforts to reduce population-level unintended pregnancy, the authors state. Programs designed to promote LARC use should prioritize the needs and preferences of individuals. Features beyond effectiveness, such as the ease of partners or parents detecting a contraceptive method, influence method selection, they note.9

REFERENCES

The reproductive health research community is paying tribute to Michael Rosenberg, MD, MPH, founder and chief executive officer of the Durham, NC-based clinical research organization, Health Decisions. Rosenberg was killed in a Dec. 8 plane crash in Maryland.

He was an adjunct professor of epidemiology and of maternal and child health at the Gillings School of Global Public Health, University of North Carolina, Chapel Hill.

Rosenberg, a member of the Contraceptive Technology Update Editorial Advisory Board since 1992, had been involved with design and execution of pharmaceutical development programs for more than 25 years. Rosenberg and Health Decisions under his leadership garnered numerous awards for innovation and growth, including the Association of Clinical Research Professionals’ 2014 Award for Innovation in Clinical Research and the Triangle Business Journal 2014 Life Sciences CEO of the Year Award.

Rosenberg was an “innovative individual” who early recognized the need to organize clinical trials and their results to capture information in such a manner that would be compatible with a Food and Drug Administration New Drug Application, recalls David Archer, MD, fellow CTU Editorial Advisory Board member and professor of obstetrics and gynecology and director of the Clinical Research Center at the Eastern Virginia Medical Center in Norfolk. This information would be stored appropriately from the beginning and would use advanced technologies to reduce the need for paper and duplication in moving the data from the clinical site to the central data storage facility, Archer explains.

“He was well-liked and had an outgoing personality,” said Archer. “He was committed to his company, Health Decisions, and moved it forward to its current role as a significant player in the field of clinical research organizations.”

Anita Nelson, MD, professor in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles and CTU board member, says Rosenberg will be “seriously missed.” “I worked mostly with Michael as the CEO of Health Decisions, where he so very competently oversaw the conduct of many of the most important contraceptive trials of our time,” says Nelson. “His advice was sage; his experience invaluable; his dedication to getting quality data inspired his people and gave credibility to the results.”

A graduate of University of California, Davis and Harvard University, Rosenberg also was an award-winning author. His book, The Agile Approach to Adaptive Research: Optimizing Efficiency in Clinical Research (Wiley 2010) received the Journal for Clinical Studies’ JCS Library Award and was selected for the First Clinical Research Bookshelf by The Journal of Clinical Research Best Practices.

In a statement from the company, Patrick Phillips, DPhil, Health Decisions’ vice president of clinical affairs, said, “We can best honor Michael by carrying on and realizing his vision of a more efficient approach to clinical development. We are committed to that goal.”

Ortho Evra patch discontinued — What next?

Rewind to 2002: The first transdermal contraceptive, the Ortho Evra patch, hit U.S. pharmacy shelves. Fast forward to the present: The manufacturer has production of the device “due to a business decision,” according to information on the Food and Drug Administration (FDA) website.

William Foster, spokesperson for Janssen Pharmaceuticals, confirmed the move in the following statement: “Janssen Pharmaceuticals has decided to discontinue its birth control patch Ortho Evra (norelgestromin/ethinyl estradiol transdermal system) in the United States. A generic version of the contraceptive patch is now available, and if women have questions about transitioning to this generic alternative, or to other forms of birth control, they should speak with a health care provider.”

Under Section 506C of the Federal Food, Drug, and Cosmetic Act, companies are required to notify the FDA of a permanent discontinuance of certain drug products six months in advance, or as soon as practicable. Projections indicate that product inventory of the Ortho Evra patch was set to deplete at distribution centers at the end of October 2014.

As of Contraceptive Technology Update press time, no information about the discontinuation had been posted on the Janssen Pharmaceuticals’ website; the
Executive Summary

The manufacturer of the Ortho Evra patch has discontinued production of the device “due to a business decision,” according to information on the Food and Drug Administration (FDA) website.

- Mylan in April 2014 received FDA approval to market a generic version of the Ortho Evra patch. The patch, trademarked as Xulane, delivers a daily dose of 150 mcg of norelgestromin and 35 mcg of ethinyl estradiol through its transdermal system. This hormonal formulation is exactly the same one as in the Ortho Evra product.
- Patch use has dropped. According to results of past CTU Contraception Surveys, 93% of respondents in 2005 said their facility provided the method as a contraceptive option; by 2013, 70% said they provided the patch.

News of the Ortho Evra patch discontinuation might not prove to be a problem for some providers. Patch use has dropped. According to results of past CTU Contraception Surveys, 93% of respondents in 2005 said their facility provided the method as a contraceptive option; by 2013, 70% said they provided the patch. National prescription numbers for Ortho Evra reflect the decline. Prescriptions decreased from five million in 2006 to about 1.3 million in 2010.²

Patch use might have fallen off with concerns about its use and risk of venous thromboembolism (VTE). Since Ortho Evra was approved in 2001, its labeling has been edited to address issues relating to VTE risk and exposure to contraceptive hormones seen with Ortho Evra as compared to certain combined oral contraceptives. In March 2011, the boxed warning label was edited to include information about the potential risk of VTE and the pharmacokinetics profile of ethinyl estradiol associated with the use of Ortho Evra, which made it more prominent to healthcare providers.

References

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Contraceptive Survey Profile

The 2014 Contraceptive Technology Update (CTU) Contraception Survey monitors contraceptive trends and family planning issues among readers. Results were tallied and analyzed by AHC Media in Atlanta, publisher of CTU and dozens of other medical newsletters and provider of books and webinars. The survey was mailed in November 2014 to 752 subscribers and also was distributed to attendees at the 2014 Contraceptive Technology conference.

About 82% of respondents identified themselves as care providers, with 9% involved in administration and about 9% identifying themselves as faculty/teacher/student.

About 50% said they worked in public health facilities, with about 18% listing in student health centers. About 12% reported working in hospitals, with 9% in private practice. The remaining percentage listed other healthcare settings.

When it comes to location, about half (44%) said they worked in a rural area location. About 21% said they were employed in a suburban area, with about 32% listing an urban setting.

Mylan is familiar with transdermal delivery of medicines. It was the first company to receive approval for generic nitroglycerin, estradiol, and fentanyl transdermal systems. It also produces transdermal clonidine and aided in the development of EMSAM (selegiline transdermal system), which it now manufactures.

A check of the web site, www.goodrx.com, shows that estimated cash prices for one package (three patches) of Xulane at area Atlanta drug stores range from $106 to $125, while estimated cash prices for one package of Ortho Evra (three patches) range from $126 to $158. Be sure to check local pharmacies to see if Xulane is stocked.

Family planners do have an option for transdermal contraception. Mylan of Pittsburgh announced in April 2014 it had received FDA approval to market a generic version of the Ortho Evra patch. The patch, trademarked as Xulane, delivers a daily dose of 150 mcg of norelgestromin and 35 mcg of ethinyl estradiol through its transdermal system, the same formulation as in the Ortho Evra product.

Company still lists the Ortho Evra patch under its current list of products. There also is no indication of the discontinuation of the product on its dedicated web site, www.orthoevra.com.
With unsurpassed efficacy and rapid reversibility, contraceptive implant can be put into practice

While use of long-acting reversible contraceptive (LARC) methods is growing, the contraceptive implant (Nexplanon, Merck & Co., Whitehouse Station, NJ) is still underused, say family planning experts. Look at the most recent national figures: In 2009, 8.5% of women using contraceptives relied on LARC methods, rising from 5.5% in 2007 and 2.4% in 2002. However, most of these women (nearly 8%) use intrauterine devices (IUDs), compared to less than 1% who use the implant.¹

About one-third of participants (32.3%) in the 2014 Contraceptive Technology Update Contraception Survey reported more than 25 implant insertions in the past year. In 2013, about 75% of survey respondents said their facility offered or planned to offer the implant, which is a 10% jump from 2012.

“Imagine how underutilized the implants are by primary care providers.”

What will increase usage?

What will it take to change what Nelson terms “this tragic picture of underutilization”? One move might be to increase clinician education and training on implant insertion and usage of the method.

According to a survey of fellows in the American College of Obstetricians and Gynecologists, most providers generally offer IUDs, but fewer offer the contraceptive implant.² Almost all (92%) reported residency training on IUDs, while about 51% reported residency training on implants.²

A total of 59.6% of providers surveyed said they had received continuing education on at least one LARC method in the past two years. Recent continuing education was most strongly associated with implant insertion, and 31.7% of those responding to the survey listed lack of insertion training as a barrier.²

Nelson, who presented information on the implant at the 2014 Contraceptive Technology conference in Atlanta, points to the leading benefits of the device:

* unsurpassed contraceptive efficacy;
* rare medical contraindications;
* rapid reversibility.³

In international trials of the device, zero pregnancies were recorded in 58,900 cycles, Nelson notes.⁴ The device is labeled for three years of effective use; however data indicate its effectiveness might be longer than that.⁵

Numbers may improve

Nexplanon usage at El Paso County Department of Health and Environment in Colorado Springs was implemented with private donor funding to Title X, says Ingrid Silva, ANP, clinical manager at the facility. The funding is part of the Colorado Family Planning Initiative. Made by a confidential private donor, it is distributed through the Colorado Department of Public Health and Environment’s Title X Family Planning Program. The Initiative has addressed barriers to LARC methods by training providers, financing method provision at Title X-funded clinics, and increasing patient caseload. Research indicates the Initiative has been successful. In two years, caseloads increased by 23%, and LARC use among 15- to 24-year-olds grew from 5% to 19%.

EXECUTIVE SUMMARY

While use of long-acting reversible contraceptive (LARC) methods is growing, the Nexplanon contraceptive implant is still underutilized, say reproductive health advocates.

- In 2009, 8.5% of women using contraceptives relied on LARC methods, rising from 5.5% in 2007 and 2.4% in 2002. However, most of these women (nearly 8%) use intrauterine devices (IUDs), compared to the less than 1% that use the implant. A Colorado project aimed at improving LARC usage is set to change those numbers: in two years, it reports LARC use grew among 15- to 24-year-olds from 5% to 19%.
- The implant offers unsurpassed contraceptive efficacy, rare medical contraindications, and rapid reversibility. In international trials of the device, zero pregnancies were recorded in 58,900 cycles.
Cumulatively, one in 15 young, low-income women had received a LARC method, up from one in 170 in 2008. Compared with expected fertility rates in 2011, observed rates were 29% lower among low-income 15- to 19-year-olds and 14% lower among similar 20- to 24-year-olds, data suggests.6

Silva credits the popularity of implant in the younger woman who does not want a cycle; young peers getting the implant, who in turn influence other teens to get the device; and teens who like the idea of the device being implanted in the arm versus anything placed in the vagina or uterus.

“Some other clinics learn we have the grant for LARC methods and send their patients to us for the IUD or implant,” notes Silva.

Counsel on bleeding

One of the downsides of implant use is irregular bleeding. Patients at El Paso County Department of Health and Environment either love the implant or want it out because they don’t like their bleeding profile, reports Silva.

According to a fact sheet issued by the Association of Reproductive Health Professionals, some women might have heavy and/or longer periods, while other women have periods that are lighter and occur less often. Some women stop getting their period all together. (Download a free patient sheet on the implant, in English and Spanish, at http://bit.ly/1eSUbxO.)

Counsel women on what to expect with implant bleeding patterns, says Nelson. “Irregular bleeding improves with time for the majority of women,” she notes.

REFERENCES


Oral contraceptives — Should they be OTC?

When it comes to moving oral contraceptives over the counter (OTC), almost 50% of participants in the Contraceptive Technology Update Contraception Survey say they support such a move. Support for OTC access is growing; 62% of American women support the pill being available without a prescription.3

Moving the Pill to OTC status was spotlighted in 2014 when some opponents of the Affordable Care Act’s (ACA) contraceptive coverage guarantee promoted the idea that oral contraceptive pills should be available to adult women without a prescription. In July 2014, Sens. Kelly Ayotte (R-NH) and Mitch McConnell (R-KY) introduced the Preserving Religious Freedom and a Woman’s Access to Contraception Act, a bill calling for the Food and Drug Administration (FDA) to study such a move. With a new Congress set to convene, it is unclear whether Congressional conservatives will further address the over-the-counter issue. (To read more about the 2015 EXECUTIVE SUMMARY

When it comes to moving oral contraceptives over the counter (OTC), almost 50% of participants in the Contraceptive Technology Update Contraception Survey say they support such a move. Support for OTC access is growing; 62% of American women support the pill being available without a prescription.

• Progestin-only pills have fewer contraindications and thus might have a better safety profile than combined oral contraceptives, which makes them a potential first candidate for OTC access.
• In 2014, the American Academy of Family Physicians adopted a resolution supporting over-the-counter access to oral contraception without a prescription.
legislative forecast, see the CTU article “Family planning issues might be in this Congress’ crosshairs,” January 2015, p. 10.)

“Making birth control pills available over the counter, if done right, would meaningfully improve access for some groups of women,” states a recent journal of health policy thought and research.2 “However, such a change is no substitute for public and private insurance coverage of contraceptives, let alone justification for rolling back coverage of all contraceptive methods and related services for the millions of women who currently have it.”

Insurance coverage

It is extremely important that insurance cover all forms of contraception, including all formulations of OCs and all over-the-counter methods, including a future OTC pill, says Daniel Grossman, MD, vice president for research at Ibis Reproductive Health in Oakland, CA. “It is important to note that one formulation of OCs will move over the counter at a time, and a progestin-only pill (POP) is the most likely first candidate for a future OTC OC product,” notes Grossman. “This means that the vast majority of other pill formulations would remain available by prescription only.”

Ibis Reproductive Health coordinates the Oral Contraceptives (OCs) Over-the-Counter (OTC) Working Group, an informal coalition of reproductive health and rights organizations, nonprofit research and advocacy groups, university-based researchers, and clinicians who are looking at the risks and benefits of demedicalizing contraceptive care, with an eye toward improving access to OCs and potentially other hormonal contraceptive methods by making them available without a prescription.

Progestin-only pills have fewer contraindications and thus might have a better safety profile than combined oral contraceptives, which makes them a potential first candidate for OTC access. Because progestin-only pills do not contain estrogen, they carry a lower risk of estrogen-related complications, such as stroke, heart attack, or blood clots.

Anita Nelson, MD, professor in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles, supports bringing progestin-only pills over the counter. Nelson says such a move is more than a decade overdue. About 32% of 2014 CTU survey respondents say that, in some situations, they would be in favor of an OTC progestin-only pill.

Would women begin using a progestin-only pill if it were available? Results of a recent survey indicate women would begin using such a pill if it were available. However, results suggest that few women would pay more than $30 per pack of pills.3

Physician support for expanding access has grown in the last year. In 2014, the American Academy of Family Physicians of Leawood, KS, adopted a resolution supporting over-the-counter access to oral contraception without a prescription. In its resolution, the group states its support of insurance coverage of oral contraceptives regardless of prescription status in all insurance plans. Groups such as the American College of Obstetricians and Gynecologists (ACOG) and Planned Parenthood Federation of America also have come out in support of expanded access. (CTU reported on the ACOG committee opinion. See “Should the Pill go OTC? ACOG says ‘yes’ to move,” February 2013, p. 15.)

If a birth control pill does reach over-the-counter status, affordability is an issue. Uninsured women on average pay $370 for a full year’s supply of the Pill.2 Cost continues to be a barrier to accessing emergency contraception over the counter, notes Grossman. To make a future over-the-counter birth control pill accessible, it must be available at an accessible price and covered by insurance, ideally without a prescription, he states.

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2. Sonfield A, Barot S. Birth control pills should be available over the counter, but that’s no substitute for contraceptive coverage. Health Affairs Blog 2014; accessed at http://bit.ly/1t5dllP.

Despite new options, oral contraceptive pills are still in birth control mix, survey respondents say

How are oral contraceptives being used in today’s family planning practices? The Affordable Care Act (ACA) might be making a difference when it comes to use of the Pill. Between 2012 and 2013, the number of women who filled prescriptions for the Pill with no co-pay more than quadrupled from 1.2 million to 5.1 million, according to data from the IMS Institute for Healthcare Informatics in Parsippany, NJ, an information and technology service.1

According to IMS research, the total number of prescriptions for oral contraceptives with no co-pay jumped from 6.8 million in 2012 to 31.1 million in 2013 in part due to the Affordable Care Act’s zero-cost sharing provisions for certain preventive services.1

The increase in oral contraceptive prescriptions dispensed with no co-pay contributed to a $483.3 million reduction in out-of-pocket costs that would have been spent in 2013 had women bought the same mix of oral contraceptives as those purchased in 2012, according to IMS estimates.1

Karen Albright, WHNP-BC, lead clinician at Virginia League for Planned Parenthood in Virginia Beach, is seeing more patients use the discounted pills available at larger pharmacies such as Wal-Mart and Target. For young women with no insurance or high deductibles, access to such discounted pills has been very helpful, says Albright. (For a list of Wal-Mart $9 per month generic OCs, go to http://bit.ly/1stGeOz. For Target, which offers two generic OCs for $9 per month, go to http://bit.ly/1z2Glud.)

To help patients compare costs of branded pills versus generics, Albright has patients input www.goodrx.com into their cellphones while talking with them in the exam room. This website allows patients to compare costs at various local pharmacies, she notes.

How are pills being used in today’s practices? Results of the 2014 Contraceptive Technology Update Contraception Survey give insight on how providers are providing OCs.

Almost 97% of survey participants say their facilities use the Quick Start method of initiating same-day use of combined hormonal contraceptives. This statistic is a marked jump from 2013’s 75% number, and a significant climb from the 64.5% response in 2007 when the question first was asked.

With the official encouragement to do Quick Start/Same Day Start for every woman using combined pills from the Centers for Disease Control and Prevention’s U.S. Selected Practice Recommendations for Contraceptive Use, 2013 (SPR),2 Quick Start should be the new standard, says Anita Nelson, MD, professor in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles. Unfortunately, there are no outcome measures relating to family planning in the ACA regulations, she states.

If your facility allows direct dispensing, how many packages of pills do you provide to women who already have been on pills and are experiencing no problems at all? About 36% of survey participants say their program allows them to provide 12 or 13 packs at an annual visit, with an equal amount indicating they can issue three to five packs. Around 14% say they give out six to 11 packs. More packs dispensed might equal heightened compliance. A small body of evidence suggests that dispensing a greater number of oral contraceptive pill packs might increase continuation of use.3

About half of 2014 CTU survey participants say 1% to 10% of patients using combined pills leave offices with prescriptions for extended or continuous regimens. About 27% of respondents say 25% or more of patients use pills in such manner. Prescribing pills in this manner

EXECUTIVE SUMMARY

The Affordable Care Act might be making a difference when it comes to use of the Pill. According to data from the IMS Institute for Healthcare Informatics, between 2012 and 2013, the number of women who filled prescription for the Pill with no co-pay more than quadrupled from 1.2 million to 5.1 million.

• The increase in oral contraceptive prescriptions dispensed with no co-pay contributed to a $483.3 million reduction in out-of-pocket costs that would have been spent in 2013 had women bought the same mix of oral contraceptives as those purchased in 2012, according to IMS estimates.

• Almost all (97%) participants in the 2014 Contraceptive Technology Update Contraception Survey say their facilities use the Quick Start method of initiating same-day use of combined hormonal contraceptives. This statistics is a marked jump from 2013’s 75% number.
might aid in decreasing rates of unintended pregnancy. In a 2014 retrospective claims analysis, real-world pregnancy rates were lower with 84/7 regimens versus 21/7 and 24/4 regimens.4

After what period of time postpartum do 2014 survey participants say they usually recommend that a woman who is not breastfeeding start taking combined oral contraceptives? About 72% say they opt for four to six weeks postpartum.

According to the U.S. Medical Eligibility Criteria for Contraceptive Use” (US MEC), no restriction (Category 1) applies for the use of combined hormonal contraceptives in women who are more than 42 days postpartum and are not breastfeeding. During 21-42 days postpartum, women without risk factors for venous thromboembolism generally can initiate combined hormonal contraceptives, but women with risk factors generally should not use these methods, the guidance notes. Combined hormonal contraception is classified as a Category 4 (unacceptable health risk) for all postpartum women, regardless of breastfeeding status, for the first 21 days postpartum.5

After what period of time postpartum do 2014 survey participants usually recommend that a woman who is breastfeeding start taking progestin-only oral contraceptives? About 40% say they provide such pills one to three weeks postpartum, while 31% report provision four to six weeks postpartum. Twenty-eight percent provide pills on hospital discharge.

Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants, are safe for postpartum women, including women who are breastfeeding, and they can be initiated immediately postpartum (Categories 1 and 2), according to the US MEC.5

REFERENCES

Where should teens access condoms?

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Latex condoms have been long proven to be critical tools in reducing the risk of pregnancy and sexually transmitted infections (STIs). However, condoms need to be used consistently and correctly to provide protection.

On the most recent Youth Risk Behavior Survey (YRBS), 40% of sexually active U.S. high school students reported that they did not use a condom at last intercourse. This percentage has significantly declined since 1991 when the survey began but has increased since a low of 37% in 2003.1 Additionally, in 2013 less than 10% of students reported dual use of condoms plus a hormonal method.1

Why don’t more teens consistently use condoms? One of the reasons teens cite most frequently is lack of availability of condoms.2 While adolescents legally can purchase...
condoms in many places, young people cite embarrassment as a major barrier. Cost also might be an issue. Health departments and community organizations might offer free condoms, but young people often don’t know about these programs or aren’t able to access them.

School-based condom availability programs have the potential to be the best venue for providing a large number of diverse young people with the protection they need. Unfortunately, while condom availability programs are in cities such as New York, they are sorely lacking in most schools across the country. The last major survey of condom availability programs in the country reported in 1996 that approximately 2% of U.S. schools have a program on site, which translates to about 50 school districts or 418 individual schools. Even schools with onsite health centers that offer STI screening and treatment often don’t offer condoms to students.

Schools without condom availability programs are missing a huge opportunity to reduce infections and unintended pregnancy among adolescents in their communities. Studies of existing condom availability programs show that they increase students’ likelihood of using condoms at last intercourse and can significantly improve sexual health outcomes.

For example, a 2011 study in Massachusetts showed gonorrhea and chlamydia rates declined significantly among male adolescents in schools that had a condom availability program, whereas rates increased among those in school without such a program. Critics of sexual health education and services such as condom availability argue that increased availability of condoms will lead to an increase in sexual activity among teens. In truth, no studies have shown such an increase to occur due to condom availability, and evidence indicates the opposite might be true. Condom availability programs, which usually are accompanied by an educational component, might be associated with decreases or delays in sexual activity.

**REFERENCES**


**COMING IN FUTURE MONTHS**

- Update on vaginal microbicides
- New multipurpose vaginal ring trial launched
- Teen pregnancy: How can LARC methods make an impact?
- New HPV vaccine approved
CNE/CME QUESTIONS

1. The Mirena IUD is 32 mm by 32 mm. What is the size of the Skyla IUD?
   A. 28 mm by 30 mm
   B. 30 mm by 30 mm
   C. 30 mm by 32 mm
   D. 28 mm by 32 mm

2. What is the name of the generic version of the Ortho Evra contraceptive patch?
   A. Xarelto
   B. Xulane
   C. EMSAM
   D. Twirla

3. The label for the Nexplanon implant says it provides effective contraception for what period of time?
   A. Five years

4. What is the “U.S. Medical Eligibility Criteria for Contraceptive Use” rating for use of combined hormonal contraceptives in women who are more than 42 days postpartum and are not breastfeeding?
   A. Category 4: Use represents unacceptable health risk
   B. Category 3: Theoretical or proven risks outweigh advantages
   C. Category 2: Advantages outweigh theoretical or proven risks
   D. Category 1: No restrictions

CNE/CME OBJECTIVES

After reading Contraceptive Technology Update, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.