Contraceptive Updates and Recommendations

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MCH Public Health Webinar
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Learning Objectives

- Review updates to the U.S. Medical Eligibility Criteria (MEC)
- Describe CDC’s new U.S. Selected Practice Recommendations for Contraceptive Use (SPR)
- Identify recommendations for contraceptive use for women with contraceptive management issues
Disclosures

- Merck Pharmaceuticals
- Teva Women’s Health

- Some recommendations may be inconsistent with prescribing information
U.S. Medical Eligibility Criteria
A Success Story!
Quick Question

Are you currently using the U.S. Medical Eligibility Criteria for Contraceptive Use (MEC) in clinical practice?

Yes

No
U.S. Selected Practice Recommendations for Contraceptive Use, 2013
Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd Edition

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/index.htm

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

U.S. Selected Practice Recommendations
Just Released!!
Quick Question

Have you heard of the Selected Practice Recommendations for Contraceptive Use (SPR)?

Yes

No
How to find CDC’s contraception guidance

Search

CDC - Contraception - Reproductive Health
www.cdc.gov/reproductivehealth/.../contraception.htm
In the United States, almost half of all pregnancies are unintended. Yet, several safe and highly effective methods of contraception (birth control) are available ...
Reversible Methods of Birth Control:

CDC - United States Medical Eligibility Criteria (USMEC) for Contraceptive Use
www.cdc.gov/reproductivehealth/unintendedpregnancy/usmek.htm
Jun 21, 2012 - In 1996, the World Health Organization (WHO) published the first edition of the Medical Eligibility Criteria for Contraceptive Use, which gave ...

Update to CDC’s U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (USMEC), providing evidence-based guidance for the ...

FASTSTATS - Contraceptive Use
www.cdc.gov/nchs/fastats/contraceptive.htm
Jul 18, 2012 - Leading contraceptive method among women aged 15-29: Pill ...
Source: Use of Contraception in the United States: 1982-2008 (data for ...

CDC: Nearly 40 percent of US Births Are Unintended - ABC News
abcnews.go.com + Health
Jul 24, 2012 - Previous studies have found that about half of unintended births come from ineffective use of contraception -- not wearing a condom or ...

CDC: No link seen between contraceptives and higher HIV risk | Fox News
www.foxnews.com/.../cdc-no-link-seen-between-contraceptives-and-health...
Jun 22, 2012 - There is no clear link between the use of contraceptives such as the
CDC Contraceptive Guidance for Health Care Providers

Unintended pregnancy rates remain high in the United States. About 50% of all pregnancies are unintended, with higher proportions among adolescent and young women, women who are racial/ethnic minorities, and women with lower levels of education and income. Unintended pregnancies increase the risk for poor maternal and infant outcomes and in 2002, resulted in $5 billion in direct medical costs in the United States.

About half of unintended pregnancies are among women who were not using contraception at the time they became pregnant. The other half are among women who became pregnant despite reported use of contraception. Strategies to prevent unintended pregnancies include removing unnecessary medical barriers to contraceptive use, and helping women and men at risk for unintended pregnancy choose appropriate contraceptive methods and use them correctly and consistently to prevent pregnancy.

In 2010, CDC adapted global guidance from the World Health Organization (WHO) to help health care providers counsel women, men, and couples about contraceptive method choice. The U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (US MEC), focuses on who can safely use specific methods of contraception, and provides recommendations for the safety of contraceptive methods for women with various medical conditions (such as hypertension and diabetes) and characteristics (such as age, parity, and smoking status).

The U.S. Selected Practice Recommendations for Contraceptive Use, 2013 (US SPR) provides guidance on how contraceptive methods can be used and how to remove unnecessary barriers for patients in accessing and successfully using contraceptive methods. The US SPR includes recommendations on when women can start contraceptive methods, what exams and tests are needed before starting a method, what follow-up is appropriate, and how to address side effects and other problems with contraceptive method use.

How to Use the US MEC and US SPR
Health care providers can use these documents when counseling patients about contraceptive choice, how to use contraceptive methods, and how to manage problems with contraceptive use. CDC has...
Provider tools
U.S. Medical Eligibility Criteria
US Medical Eligibility Criteria for Contraceptive Use

More to come –
# How to use the US MEC

<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>Sexually transmitted infections</td>
<td></td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>a) Current purulent cervicitis or chlamydial infection or gonorrhea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Other STIs (excluding HIV and hepatitis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Increased risk of STIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(I) = Initiation
(C) = Continuation
### US Medical Eligibility Criteria: 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 medical 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 – or that there are no other methods that are available or acceptable to the women with that medical condition</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that medical condition</td>
</tr>
</tbody>
</table>

Available at: [http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf)
Quick Question

Are you aware that the CDC produces interim contraceptive guidance when new evidence becomes available and a change in recommendations is warranted?

Yes

No
What’s happened since the US MEC was released?

- Keeping guidance up to date:
  - UPDATE: Combined methods for postpartum women
  - UPDATE: Hormonal contraception and HIV
Update: Combined methods for postpartum women (pills, patch, ring)

CDC, MMWR, 2011; 60(878-883)
A 30 y.o. female is s/p c-section, ready to be discharged from hospital and desires contraception with combined hormonal pills. She does not wish to breastfeed. When is the soonest time it would be safe to initiate her birth control pills?

A. Immediately postpartum
B. 21 days (3 weeks) postpartum
C. 42 days (6 weeks) postpartum
Systematic review

- 3 studies directly compared postpartum risk of venous thromboembolism (VTE) to non-pregnant women
  - Risk (probability) is 22 to 84 times as high in postpartum women than non-pregnant women
- Rate ratio comparing postpartum risk of venous thromboembolism (VTE) to non-pregnant women calculated for 3 studies
  - Rate Ratio: 2.5 to 21.5 in postpartum women

Jackson, Obstet Gynecol, 2011;117:691.
VTE by week postpartum

Jackson, Obstet Gynecol, 2011;117:691.
Previous US MEC guidance for CHCs in the postpartum period

<table>
<thead>
<tr>
<th>Postpartum (non-breastfeeding)</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>3</td>
</tr>
<tr>
<td>&gt;21 days</td>
<td>1</td>
</tr>
</tbody>
</table>

**Update:**
**Combined methods for postpartum women**

<table>
<thead>
<tr>
<th>Postpartum (non-breastfeeding)</th>
<th>Category</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>21-42 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With other risk factors</td>
<td>3</td>
<td>Other risk factors might increase classification to “4”</td>
</tr>
<tr>
<td>Without other risk factors</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>&gt;42 days</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Other risk factors: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, age ≥ 35 years, smoking, preeclampsia, postcesarean delivery, postpartum hemorrhage
Update: Combined methods for postpartum women

<table>
<thead>
<tr>
<th>Postpartum (breastfeeding)</th>
<th>MEC Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>4</td>
</tr>
<tr>
<td>21-&lt;30 days</td>
<td>3</td>
</tr>
<tr>
<td>With other risk factors for VTE (such as age ≥ 35, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, post cesarean delivery, preeclampsia, or smoking)</td>
<td>3</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>3</td>
</tr>
<tr>
<td>30-42 days</td>
<td>3</td>
</tr>
<tr>
<td>With other risk factors for VTE (such as age ≥ 35, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, post cesarean delivery, preeclampsia, or smoking)</td>
<td>3</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 42 days</td>
<td>2</td>
</tr>
</tbody>
</table>
Update:
Hormonal contraception and HIV

Update to CDC’s U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Hormonal Contraception Among Women at High Risk for HIV Infection or Infected with HIV

CDC, MMWR, 2012; 64(449-452)
Update:
Hormonal contraception and HIV

<table>
<thead>
<tr>
<th>Condition</th>
<th>CHC</th>
<th>POP</th>
<th>DMPA</th>
<th>Implants</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk for HIV</td>
<td>1</td>
<td>1</td>
<td>1†</td>
<td>1</td>
</tr>
<tr>
<td>HIV infection</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td>AIDS</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
</tbody>
</table>

* Clarification: Drug interactions might exist between hormonal contraceptives and antiretroviral drugs; refer to the section on drug interactions.

† Clarification: See next slide.
Clarification for progestin-only injectables among women at high risk of HIV

Some studies suggest that women using progestin-only injectable contraception might be at increased risk for HIV acquisition; other studies do not show this association. CDC reviewed all available evidence and agreed that the data were not sufficiently conclusive to change current guidance. However, because of the inconclusive nature of the body of evidence on possible increased risk for HIV acquisition, women using progestin-only injectable contraception should be strongly advised to also always use condoms (male or female) and take other HIV preventive measures. Expansion of contraceptive method mix and further research on the relationship between hormonal contraception and HIV infection are essential. These recommendations will be continually reviewed in light of new evidence.
United States (U.S.) Adaptation of World Health Organization (WHO) Selected Practice Recommendations for Contraceptive Use (SPR)
World Health Organization
Family Planning Guidance

Guidance for guides

Guidance for providers
U.S. Adaptation of WHO SPR

- **2010:**
  - Talked to key family planning providers in US
  - Identified WHO recs to consider adapting, new clinical questions to consider adding

- **2010-2011:**
  - Conducted systematic reviews of evidence

- **2011:**
  - Expert meeting
  - Presented evidence, discussed and drafted US recs

- **2012-2013:**
  - Finalize US SPR
U.S. Adaptation of WHO SPR

- Much of the guidance is same or very similar to WHO SPR
  - Addresses issues related to use of contraceptives
    - Examinations and tests recommended prior to contraceptive method use
    - Timing of initiation of the contraceptive method
    - Follow up
    - Addressing problems that come up during use
      - Missed pills
      - Side effects, such as unscheduled bleeding during contraceptive method use
  - Does not address guidance on every aspect of provision and management of contraceptive method use

- MEC summary chart is included
U.S. Adaptation of WHO SPR

- New guidance in US SPR
  - Recommendations on patch and ring
  - How to start regular contraception after taking emergency contraceptive pills
  - Management of bleeding irregularities among women using extended or continuous CHCs
  - When a woman can rely on female sterilization for contraception
  - When a woman can stop contracepting
• Organized by contraceptive method
  – Methods presented in order of effectiveness (highest to lowest)
  – Each section provides
    • Recommendation
    • Comments and evidence
      – Comments about the recommendations
      – Brief summary of the scientific evidence on which recommendation is based
Systematic reviews behind the U.S. SPR recommendations

Contraception, Vol 87, May 2013
Clinical Scenario
Clinical scenario

Gina is a 19 y.o. G1P1 comes to your office for her 6-week postpartum visit desiring contraception and wants to have the levonorgestrel IUD (LNG-IUD)

Do you need to do any exams or tests before Gina has her IUD placed?

If so, which exams and which tests?
Evidence: STI screening

- **Women with and without IUD**
  - No difference in PID rates among women at low risk of STI

- **STI screening at time of insertion**
  - STI at time of Insertion: 0%-5% rate of PID
  - No STI at time of Insertion: 0%-2% rate of PID

Tepper et al. Contraception, 2013
# National STI Screening Guidelines

<table>
<thead>
<tr>
<th>When to Screen</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine care</td>
<td>Women ≤ 25 years annually; High-risk women &gt; 25 years</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Screen at the first prenatal visit; Retest in the 3\textsuperscript{rd} trimester if ≤25 years or &gt; 1 sex partner If positive, retest within 3-6 months-3\textsuperscript{rd} trimester</td>
</tr>
<tr>
<td>Postpartum care</td>
<td>If not screened during pregnancy, screen women ≤ 25 years or high risk women &gt; 25 years</td>
</tr>
</tbody>
</table>
# U.S. MEC Recommendation: STIs

<table>
<thead>
<tr>
<th>Condition</th>
<th>LNG-IUD</th>
<th>Copper IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Current purulent cervicitis or chlamydial infection or gonorrhea</td>
<td>4</td>
<td>2^</td>
</tr>
<tr>
<td>Increased risk of STIs</td>
<td>2/3*</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Clarification: If a woman has a very high individual likelihood of exposure to gonorrhea or chlamydia infection, the condition is a category 3*

(I) = Initiation  
(C) = Continuation
U.S. SPR
Exams and tests prior to initiation

- **Unnecessary tests may be barrier to starting**
  - Coming back for a second (or more) visit to receive test results
  - STI can be acquired between time test was done and results are known

- **Recommendations address exams and test 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
<table>
<thead>
<tr>
<th>Examination or test</th>
<th>Cu-IUD and LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examination</strong></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>C</td>
</tr>
<tr>
<td>Weight</td>
<td>+</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
</tr>
<tr>
<td><strong>Laboratory test</strong></td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>C</td>
</tr>
<tr>
<td>Lipids</td>
<td>C</td>
</tr>
<tr>
<td>Liver Enzymes</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Pap smear)</td>
<td>C</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td>*</td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
</tr>
</tbody>
</table>
Footnotes (Appendix C)

• * = Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC’s STD Treatment Guidelines. If screening according to guidelines has not been done, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (MEC 4). Women who have a very high individual likelihood of STD exposure (e.g. those with a currently infected partner) generally should not undergo IUD insertion (MEC 3). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

• + = Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (MEC 1) or generally can be used (MEC 2) among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.
Clinical scenario

Gina is 19 y.o. G1P1 comes to your office for her 6-week postpartum visit desiring contraception and wants to have the levonorgestrel IUD (LNG-IUD)

Do you need to do any exams or tests before Gina has her IUD placed?

Yes, she needs a pelvic exam prior to insertion and STD risk assessment to determine if currently infected

No, for STD screening if she has already obtained STD screening according to national guidelines during pregnancy.
Next steps

- **Work with partners on dissemination and implementation**
  - Office of Population Affairs/Title X Clinics
  - Medical Professional Organizations

- **Keeping guidance up to date**

- **Develop provider tools**

- **Address research gaps** (Folger et al., *Contraception*, May 2013)
Summary

• The CDC has produced two evidence-based guidelines related to contraceptive use
  – Medical Eligibility Criteria for Contraceptive Use (*Who* can use the method)
  – Selected Practice Recommendations for Contraceptive Use (*How* to use the method)
  – Both documents were adapted from the World Health Organization

• Recommendation updates will occur approximately every 4 years
  – Interim guidance will be released sooner if new evidence warrants a recommendation change
Resources

• CDC reproductive health:

• WHO reproductive health:
  – http://www.who.int/reproductive-health/family_planning/index.html

• Association of Reproductive Health Professionals (ARHP)
  – arhp.org

• Reproductive Health Access Project
  – http://www.reproductiveaccess.org/
THANK YOU!

Questions?
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