Contraceptive Care During COVID-19: Overcoming Challenges + Optimizing Opportunities

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shaping the future of sexual + reproductive health care™

Disclosure

- Speakers and planners have no financial conflicts to disclose.

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THE LANCET

"There is now a great deal of talk about the urgent need to devise a post-pandemic economic plan. But what is also needed is a post-COVID-19 health recovery programme—let's call it CoHERE, signifying the need to unify not only the global response to the pandemic, but also a global commitment to mitigate its damaging aftermath."

Centring sexual and reproductive health and justice in the global COVID-19 response

Global responses to the coronavirus disease 2019 (COVID-19) pandemic are converging with pervasive, existing sexual and reproductive health and justice inequities to disproportionately impact the health, wellbeing, and economic stability of women, girls, and vulnerable populations. People whose human rights are least protected are likely to experience unique difficulties from COVID-19.[1] Women, girls, and marginalised

www.thelancet.com Vol 395 April 11, 2020

COVID-19: the gendered impacts of the outbreak

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Policies and public health efforts have not addressed the gendered impacts of disease outbreaks.[3] The response to coronavirus disease 2019 (COVID-19) appears no different. We are not aware of any gender analysis of the outbreak by global health institutions or governments in affected countries or in preparedness phases. Recognising the extent to which disease outbreaks affect women and men differently is a fundamental step to understanding the primary and secondary effects of a health emergency on different individuals and communities, and for creating effective, equitable policies and interventions.

Although sex-disaggregated data for COVID-19 show equal numbers of cases between men and women so far, there seem to be sex differences in mortality and vulnerability to the disease.[2] Emerging evidence suggests that more men than women are dying, potentially due to sex-based immunological[3] or gendered differences, such as patterns and prevalence of smoking.[4] However, current sex-disaggregated data are incomplete, cautioning against early assumptions. Simultaneously, data from the State Council Information Office in China suggest that more than 90% of health-care workers in Hubei province are women, emphasising the gendered nature of the health workforce and the risk that predominantly female health workers incur.[5]

The closure of schools to control COVID-19 transmission in China, Hong Kong, Italy, South Korea, and beyond might have a differential effect on women, who provide most of the informal care within families, with the consequence of limiting their work

World Health Organization

human reproduction programme hrp research for impact

COVID-19 and violence against women

What the health sector/system can do

7 April 2020

ACOG
The American College of Obstetricians and Gynecologists

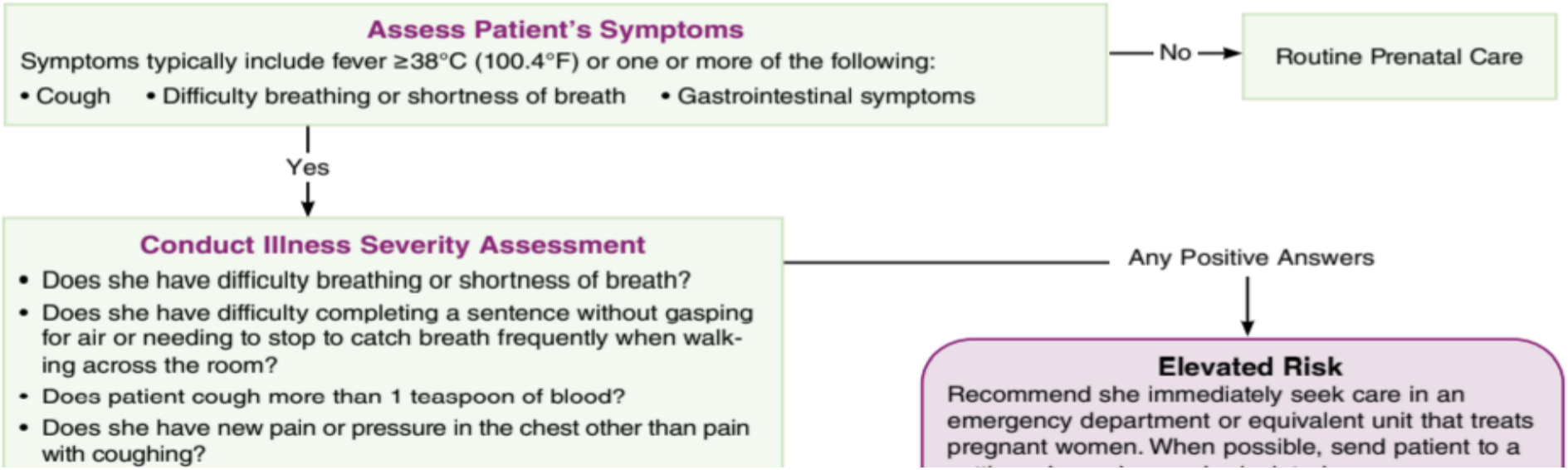
Society for Maternal-Fetal Medicine
High-risk pregnancy experts

Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)

Unlike influenza and other respiratory illnesses, based on a limited number of confirmed COVID-19 cases, pregnant women do not appear to be at increased risk for severe disease. However, given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted.

This algorithm is designed to aid practitioners in promptly evaluating and treating pregnant persons with known exposure and/or those with symptoms consistent with COVID-19 (persons under investigation [PUI]). If influenza viruses are still circulating, influenza may be a cause of respiratory symptoms and practitioners are encouraged to use the ACOG/SMFM influenza algorithm to assess need for influenza treatment or prophylaxis.

Please be advised that COVID-19 is a rapidly evolving situation and this guidance may become out-of-date as new information on COVID-19 in pregnant women becomes available from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/coronavirus/2019-nCoV/index.html



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WHO

"Contraception and family planning information and services are life-saving and important at all times."

"Sexual activity does not cease with the COVID-19 pandemic, it is therefore crucial to ensure that people are able to access rights-based services and information to initiate and / or continue use of contraception. "

- Increase use of telehealth for counselling and sharing of messages related to safe and effective use of contraception and for selection and initiation of contraceptives.
- Ensure adequate inventory to avoid potential stock outs at all levels of the health system.
- Prepare advisories for users on how they can access contraceptive information, services and supplies.
- Monitor contraceptive consumption in your area to identify any potential pitfall and shortage.
- Increase availability and access to the contraceptives which can be used by the client without service provider support.

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Remote Contraception

Initiation and Continuation

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Case

31 y/o G2P2 has telephone visit scheduled for contraception initiation consultation.

She had a normal vaginal delivery 4 months ago.

She is not breastfeeding and has a history of thyroid disease.

She has used the implant and pills in the past.

She is interested in using the contraceptive ring.

Contraception – Virtual Initiation

- First ask:
- Do you think you might be pregnant?
- Have you had a baby in the past 3 weeks?
- Have you had an abortion in the last week?
- Have you had unprotected sex in the last 5 days?
  - If yes, offer emergency contraception in addition to birth control method.
- When was your last period?
- Have you had unprotected intercourse since your last period?
- Are you currently breastfeeding and your baby is less than 6 months old?

- ***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 <u>one</u> 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*

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Contraception – Virtual Initiation

Quick Start

- If a woman does NOT meet these criteria, the provider should plan to start the desired hormonal contraception
- The woman should also be instructed to take a home pregnancy test in 2-3 weeks.
- If the test is positive, she should discontinue the method and be seen as soon as possible in person.
- There is no evidence that any hormonal method of contraception is teratogenic if taken during an ongoing pregnancy.

Contraception – Virtual Initiation

Screening for contraindications to estrogen-containing methods

- Smoker & Age >35
- History of MI, Stroke, Heart Disease Diabetes
- Migraines with Aura (any age)
- History of DVT/PE

- Hypertension
  - Should have BP prior to prescribing estrogen-containing methods
  - Can be any time in last 3-12* months

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Contraception – Virtual Initiation

Evaluation other medical disorders

- Liver Disease
- Gallbladder Disease
- Breast Cancer
- Elevated Cholesterol
- Medications for seizure disorders, TB or HIV

These disorders are NOT always contraindicated

You MUST check with CDC Medical Eligibility Criteria

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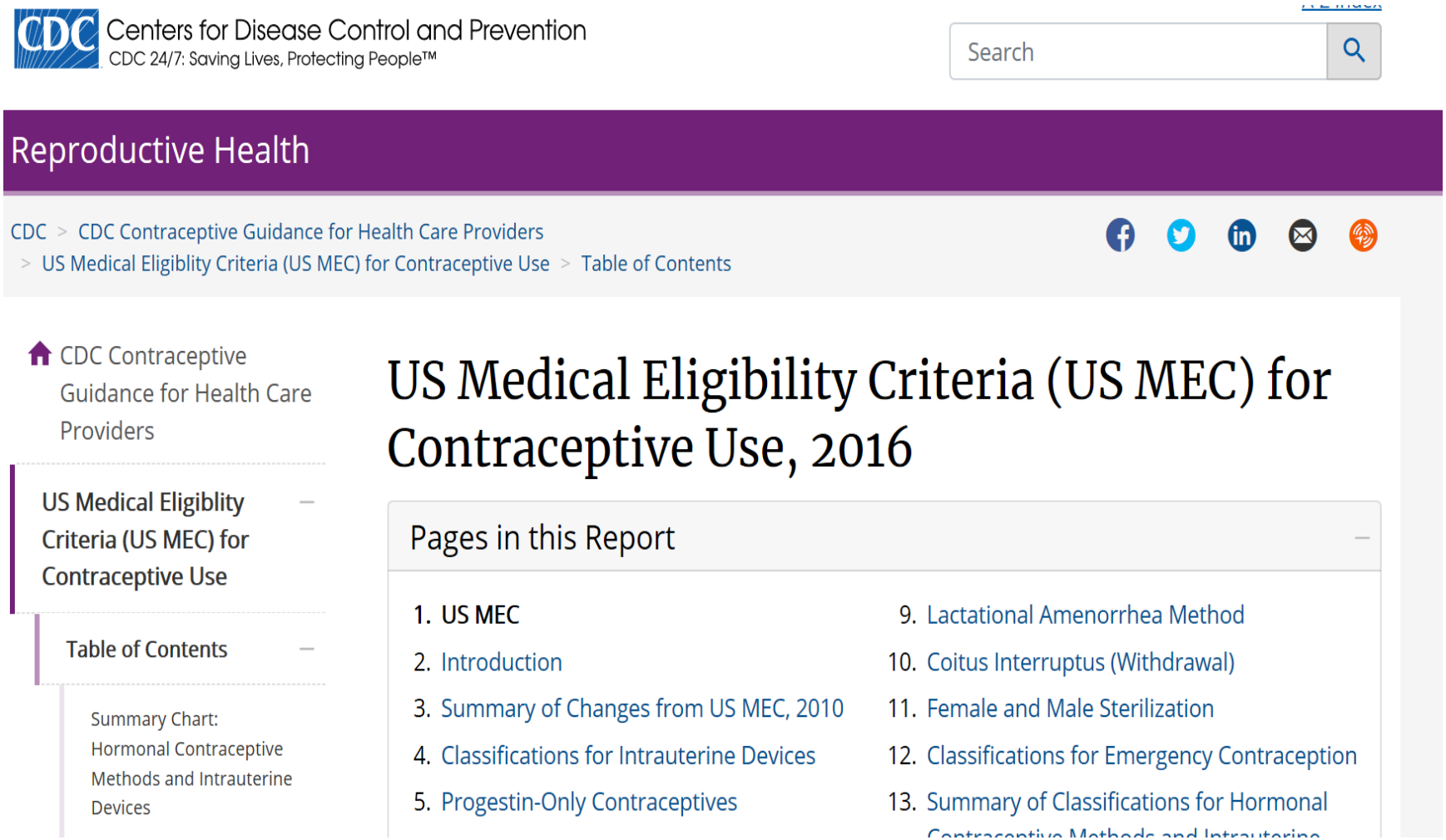
Contraception – Virtual Initiation



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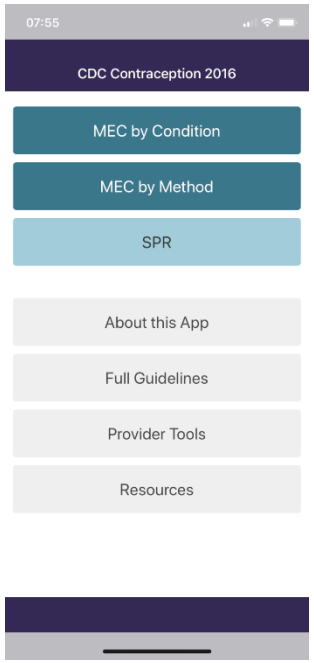
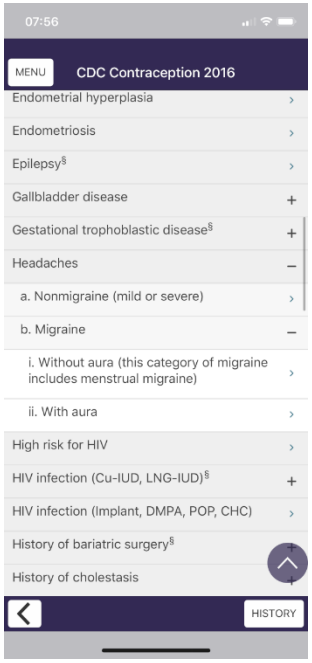
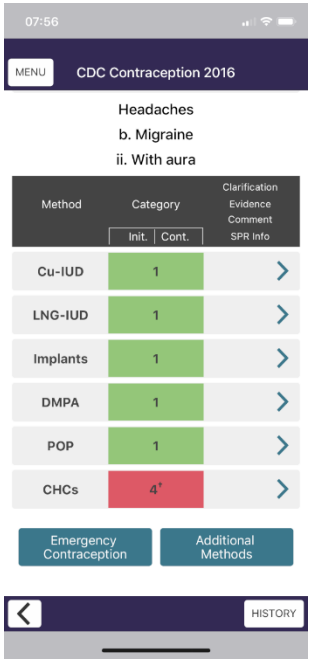
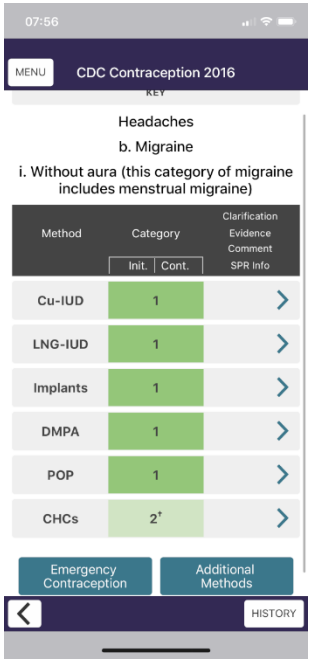
Contraception – Virtual Initiation

Free App – CDC Contraception MEC









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Non-Hormonal Methods

- Male or female condoms
- Cervical cap
- Spermicidal agents
  (foam, film, sponge)

Can be initiated at any time and
do not require any physical exam

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Back to our case…

- She is not breastfeeding and her LMP is 10 days ago. She has not had sex since her last menstrual period.
- She denies any history of HTN, cardiac disease, migraines or smoking.
- Upon review of her chart, her BPs were normal during her pregnancy.

Contraception – Continuation

- Ask her if there have been any changes to her medical history since her last visit
  - If Yes, refer to CDC Medical Eligibility Criteria for guidance
- Confirm with patient that she has been using her method consistently
- Determine if she needs Rx for emergency contraception
- Send Rx
- Encourage regular preventive care (when convenient or after COVID, whichever comes first!)

Case

35yo G2P1 just took her pills for medication abortion calls you with a question about when she can start her pill….

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Contraception – post abortion

a. Any contraceptive method can be initiated at the time of aspiration abortion.
b. At the time of medication abortion, see the below recommendations:
    i. Combined hormonal contraceptive: Can be started same day as misoprostol.
    ii. Implant: Can be started same day as mifepristone.
    iii. Depo-provera: Can be started same as mifepristone.
    iv. IUD: Can be started once patient is no longer pregnant.
    v. Progestin-only pill: Can be started same day as misoprostol.
    vi. Emergency contraception: Advanced provision of EC pills is appropriate at the time of abortion.

Polling question

Have you developed protocols for virtual initiation of contraception?

Does your health system allow personnel such as nurses or pharmacists to deliver protocol based contraceptive services?

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Long-Acting Reversible Contraception (LARC)

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Case

25yo G3P3 calls for an appointment to remove and replace IUD “because it has been 5 years”….

Table 1. Long-Acting Reversible Contraceptive Methods ⇦

Extended LARC Use

SHOULD BE TREATED THE SAME

Brand Name	Medication and Device Type (Dose)	Initial Rate of Release (micrograms/ day)	FDA-approved Duration of Use	Potential Efficacy Beyond FDA-approved Duration	Identifying Character-istics	Size of Device (Horizontal x Vertical, mm)	Inserter Tube Diameter (mm)	Percentage of Women Experiencing an Unintended Pregnancy in the First Year of Use (Typical Use)*
Kyleena	LNG-IUD (19.5 mg)	17.5	5 years	N/A	Blue strings; silver ring	28 x 30	3.8	0.20[†]
Liletta	LNG-IUD (52 mg)	19.5	4 years	+1 year[‡]	Blue strings	32 x 32	4.4	0.20[†]
Mirena	LNG-IUD (52 mg)	20	5 years	+2 years[§,‖]	Gray strings	32 x 32	4.4	0.20[†]
Skyla	LNG-IUD (13.5 mg)	14	3 years	N/A	Gray strings; silver ring	28 x 30	3.8	0.20[†]
Paragard	Copper T380A IUD (380 mm^2)	NA	10 years	+2 years[¶]	White strings	32 x 36	4.01	0.80
Nexplanon/ Implanon	Etonogestrel single-rod contraceptive implant (68 mg)	60–70	3 years	+1-2 years[‖,#]	N/A	40 x 2	N/A	0.05

Abbreviations: FDA=U.S. Food and Drug Administration, IUD=intrauterine device, LNG=levonorgestrel.

*Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404.

[†]For all LNG-IUDs

[‡]Creinin MD, Jansen R, Starr RM, Gobburu J, Gopalakrishnan M, Olariu A. Levonorgestrel release rates over 5 years with the Liletta® 52-mg intrauterine system. Contraception 2016;94:353–6.

[§]Rowe P, Farley T, Peregoudov A, Piaggio G, Boccard S, Landoulsi S, et al. Safety and efficacy in parous women of a 52-mg levonorgestrel-medicated intrauterine device: a 7-year randomized comparative study with the TCu380A. IUD Research Group of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Contraception 2016;93:498–506.

[‖]McNicholas C, Swor E, Wan L, Peipert JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. Am J Obstet Gynecol 2017;216: 586.e1–6.

[¶]Wu JP, Pickle S. Extended use of the intrauterine device: a literature review and recommendations for clinical practice. Contraception 2014;89:495–503.

[#]Ali M, Akin A, Bahamondes L, Brache V, Habib N, Landoulsi S, et al. Extended use up to 5 years of the etonogestrel-releasing subdermal contraceptive implant: comparison to levonorgestrel-releasing subdermal implant. WHO study group on subdermal contraceptive implants for women. Hum Reprod 2016;31:2491–8.

IUD self-care

https://vimeo.com/211761364

With one foot raised, bear down, which will bring your cervix a little closer to your hand. Use your index and middle finger to hold the strings. Wrap them around your fingers and pull. It will be easier to get a grip onto the device if the strings are longer. Once the IUD is out, look at it to make sure the T is intact. Some light spotting and/or cramping is normal, but if you experience severe pain, cramping, or bleeding, get to a provider as soon as you can.

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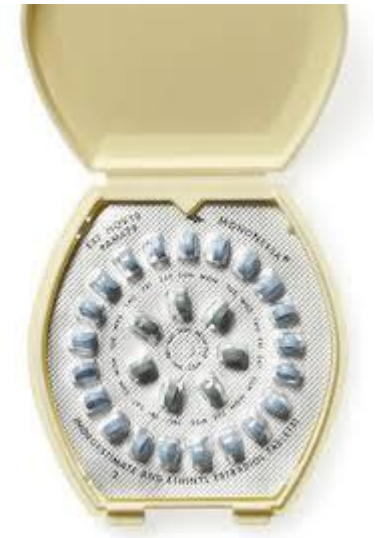
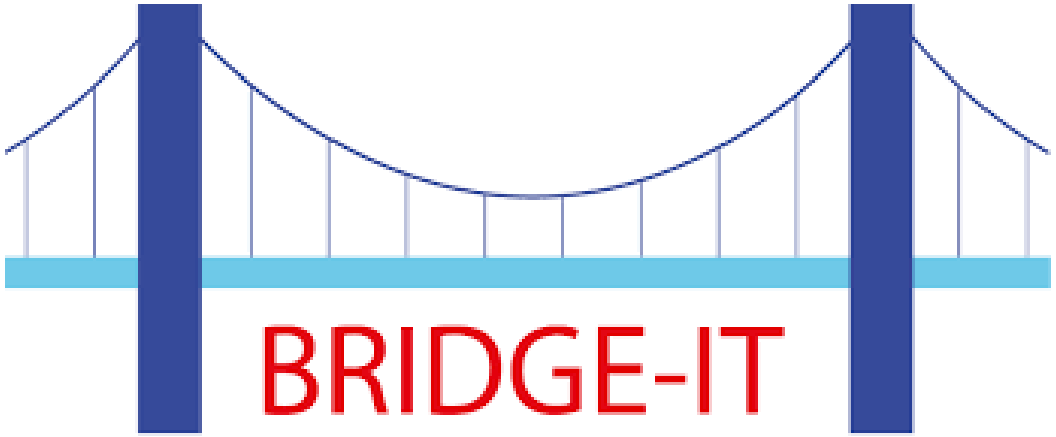
Case

19yo G1P0 calls because wants to have a long acting method but is concerned about coming to clinic because of COVID.

Bridging methods

- No time like the present to get protected
- Can delay the LARC method until after COVID





Polling question

Do you/your staff regularly counsel patients about IUD self care including string checks?

Does your practice counsel patients for extended use of long-acting reversible contraceptives?

Depo Medroxyprogesterone Acetate (DMPA) 104mg

Subcutaneous (“SubQ Depo”)

DMPA - SC

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Case

21yo G1P1 is due for DMPA but isn't excited about coming to visit the clinic in the time of COVID….

Background: Adherence

Randomized to clinic vs at home DMPA

- 1y: 69% self-administration group no gaps in use vs 54% clinic group
- Satisfaction with DMPA at 12 months was high and similar between the self-administration and clinic groups
- 97% reported self-administration was very or somewhat easy
- 87% would recommend to a friend
- 52% of clinic group would be interested in self-administration

Kohn JE, Simons HR, Della Badia L, Draper E, Morfesis J, Talmont E, Beasley A, McDonald M, Westhoff CL. Increased 1-year continuation of DMPA among women randomized to self-administration: results from a randomized controlled trial at Planned Parenthood. Contraception. 2018 Mar;97(3):198-204.

Background: Acceptability

Table 5
Reasons women in the abortion and family planning samples are or are not interested in self-administration of DMPA, $N=338$

	Family planning sample ($n=173$)	Abortion sample ($n=165$)	Total	
	%	%	n	%
Interest in a self-injectable formulation	18	26	339	21
Reasons for interest in a self-injectable formulation	100	100	339	100
I think I could give myself the injection.	55	43	165	49
I would not have to keep returning for injection.	58	48	180	53
It would save money not having to return for injection.	47	29	130	38
It would be less of a hassle.	56	40	164	49
I would feel more in control.	35	31	112	33
I could hide use from partner/parents.	10	3	22	7

SubQ Depo (DMPA – SC)

Depo SubQ: The do-it-yourself birth control shot

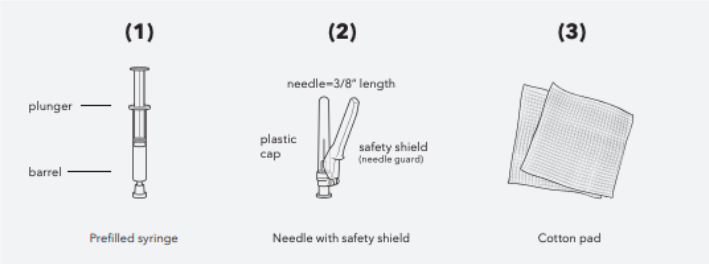
Three months of birth control in one shot, all in the privacy of your own home.

by Jessica Morse, MD, MPH
published 11/16/2015

How to use depo-subQ provera 104

Getting ready

- The medicine should be at room temperature, not too cold or too hot.
- Do not put it in the refrigerator or freezer.
- The medicine should be white in color, with no particles floating inside.
- You should have 3 things in front of you:



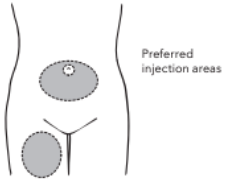
Step 1: Choose & prepare the injection area

Choose the injection area.

- Avoid bony areas and the navel (belly button).
- The upper thigh and abdomen (belly) are the best places to give the shot. See shaded areas in the picture.

Use an alcohol pad to wipe the skin in the injection area you chose.

- Let the skin dry.



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Polling question

Does your practice currently have “subQ Depo” (DMPA – SC) available for telehealth or home administration?

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Emergency Contraception

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Case

32yo G2P1011 calls clinic stating she had unprotected intercourse 2d ago and she is worried about becoming pregnant….

Patient is a smoker and has cHTN. LMP 1week ago. Weight 167lbs.

Only reported contraception is intermittent condom use…

EC: Choice of Method

ULIPRISTAL (UPA) 30mg: Anti-progestin. Taken as soon as possible but within 120 hours after unprotected intercourse. 85% effective. Less effective in people with weight greater than or equal to 195 lbs—consider IUD in those patients.

Levonogestrel (LNG) 1.5mg: Progestin. Taken as soon as possible (preferably within 72 hours) but within 120 hours after unprotected intercourse. 75-89% effective. Likely not effective in people with weight greater than or equal to 155 lbs--consider UPA or IUD in those patients.

Copper IUD: May be inserted up to five days after unprotected intercourse. 99% effective. May be used as continuing contraception.

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Initiation of Hormonal Contraception after EC use

- If using Copper IUD for EC and ongoing contraception, no backup method is necessary

- Patient is taking EC prior to starting progestin-containing method:

  - birth control method should not be resumed prior to 6 days after UPA.

  - If LNG given, birth control method may be started immediately (back-up method for 7d).

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Resources

- ACOG FAQ about COVID: https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics
- CDC MEC: https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
- IUD self-removal: https://vimeo.com/211761364
- Depo SQ: https://www.bedsider.org/features/789-depo-subq-the-do-it-yourself-birth-control-shot
- RN prescribing: https://www.guttmacher.org/state-policy/explore/nurses-authority-prescribe-or-dispense
- Pharmacist prescribing: https://www.bedsider.org/features/1192-can-pharmacists-really-prescribe-birth-control

QUESTIONS?

For continuing education credit, you must complete the post assessment evaluation and continuing education form. The survey will appear when you leave the webinar. An email with a link to the survey will also be sent to attendees the following day.

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Upcoming Events

Evolving Telemedicine Regulations Impacting Family Planning Services in CA
April 28, 2020 - 12:00 PM - 1:00 PM

Medication-Assisted Treatment for Substance Use Disorder in a Family Planning or Primary Care Setting
Free Webinar Series

Medication-Assisted Treatment (MAT) in the Primary Care Setting
May 18, 2020 - 12:00 PM - 1:00 PM

Operationalizing Addiction Screening + Treatment
May 29, 2020 - 12:00 PM - 1:00 PM

Problem Solving + Overcoming Challenges with Addiction Screening + Treatment
June 24, 2020 - 12:00 PM- 1:00 PM

Register at essentialaccesstraining.org for these and other Online Courses and On-Demand Webinars via our Learning Portal

Questions? Contact us at learningexchange@essentialaccess.org