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How Family Planning Providers Can Handle Challenges of COVID-19 Vaccine Rollout

Issues with logistics, staff hesitancy

The COVID-19 vaccine received mixed reviews in its early rollout. Public health officials and healthcare providers praised the research leading to the safe, effective vaccines, while antivaccine groups expressed skepticism and disdain.

From a reproductive health provider perspective, the big question is how to handle the rollout and overcome challenges on both the supply and demand sides.

The vaccine supply questions continued into 2021. In late December 2020, the United States government reached agreements with Pfizer/BioNTech and

Moderna to obtain 400 million doses of their COVID-19 vaccines by July 31.

This would provide vaccination to 200 million Americans, as both vaccines require two doses.¹

**FROM A
REPRODUCTIVE
HEALTH
PROVIDER
PERSPECTIVE, THE
BIG QUESTION IS
HOW TO HANDLE
THE ROLLOUT
AND OVERCOME
CHALLENGES ON
BOTH THE SUPPLY
AND DEMAND
SIDES.**

But there were early obstacles to a smooth vaccine rollout, including the requirement to transport and store the Pfizer/BioNTech vaccine at temperatures between -76° F and -112° F. Some health systems have freezers capable of storing the vaccine, but ambulatory sites likely do not.

Also, Pfizer planned to ship coolers to keep the vaccine cold for about a week,

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says **Robert Salata**, MD, professor of medicine, chair of the department of medicine, and a physician-in-chief of University Hospitals Cleveland Medical Center. Salata participated in Phase II and Phase III of the Pfizer vaccine trial.

"Once the vaccine is taken out of a container, it takes 30 minutes to thaw. After that, it's like any other vaccine," Salata explains. "These are multidose vials with five doses in each vial. After administering the vaccine, we kept people around for 30 to 60 minutes to make sure there were no immediate side effects."

In the first two weeks of the Pfizer and Moderna vaccine rollouts, severe allergic reactions were reported among eight people out of more than 270,000 who first received the vaccine. Typically, anaphylactic reactions occur in one out 1 million doses of any vaccine.²

Another logistical challenge is tracking those who received the first dose of vaccine and when they need to receive the second dose (21 days for Pfizer, 28 days for Moderna), Salata notes.

The first doses went to hospitals and nursing homes, but ambulatory healthcare settings and pharmacies also are preparing for the vaccine. "Places like CVS are getting geared up to have the vaccine available,

but I don't know how fast that is coming," Salata says.

"Pfizer cannot ship [hundreds of] millions of doses immediately," says **Tinglong Dai**, PhD, associate professor of operations management and business analytics at Johns Hopkins University Carey Business School in Baltimore. Dai also is core faculty at Hopkins Business of Health Initiative.

"By February, we should see 100 million doses, and by March, we should have more vaccines available — maybe have 100 million people vaccinated," Dai says.

Weather also is a supply obstacle. Heavy storms could impede vaccine transportation and pause vaccination efforts.

Even with the logistical issues, it is likely that demand obstacles will be as big of a problem as supply obstacles. "The issue is that by the time vaccines have arrived, there is no guarantee that all staff members will be taking them," Dai says.

To Mandate or Not to Mandate

As frontline healthcare workers began receiving the vaccine in mid-December 2020, it appeared that many hospitals were not requiring

EXECUTIVE SUMMARY

The coronavirus vaccine rollout faces challenges from logistical supply issues and vaccine hesitancy among healthcare staff and the general public.

- Barriers to effective rollout to all healthcare staff included the requirements to transport and store the Pfizer/BioNTech vaccine at temperatures between -76°F and -112°F.
- Hospitals and other providers appeared hesitant to mandate vaccination, even if they already had flu shot mandates.
- Reproductive health providers also need their employees to continue wearing masks and practicing social distancing.

staff to take the vaccine, even if they mandate flu shots for all employees. This raised the question about what ambulatory healthcare sites should do.

"The reason hospitals are not mandating the vaccine is because around 40% of individuals in the United States don't want to be primarily vaccinated," says **David F. Archer**, MD, professor of OB/GYN at the Jones Institute for Reproductive Medicine at Eastern Virginia Medical School in Norfolk. Archer also is an editorial advisory board member for *Contraceptive Technology Update*. "Some of that is related to the type of information we've seen in the media about how rapidly it has moved forward."

Many people are unsure whether they can trust the vaccine, and forcing every employee to become vaccinated further erodes trust. It is better to allow staff to have a say in the decision, Archer says.

"Most individuals on the frontline, if they have faith in the FDA, and believe in clinical trials, they'll be vaccinated," he adds.

The issue family planning providers and other healthcare facilities are seeing is a fundamental dilemma in the face of a global pandemic of a very transmissible and dangerous virus, coupled with the arrival of new vaccines that work in ways unfamiliar to the general public.

But should directors require or merely request that staff be vaccinated? What should they do if some employees refuse or ask to wait a few months? "I will certainly recommend to my staff that they become vaccinated," Archer says.

"The first reaction is to mandate it and not give anyone a choice. That gets us closer to 70% to 80% immunity for the entire population," says **Ken Resnicow**, PhD, Irwin M.

Rosenstock collegiate professor of health behavior and health education at the University of Michigan.

But if COVID-19 vaccination is mandated, it could backfire by making people who are vaccine hesitant feel they are being controlled. "We have about 30% who are hesitant, and about half of them are a hard 'no,' a refusal to be vaccinated at this point," Resnicow says.

The good news is that surveys show a decline in vaccine hesitancy, from 37% in September 2020 to about 29% in December 2020, he adds.

"We still have to do something about that 30%, or we'll have a hard time with the goal of vaccinating 80% of people," Resnicow says. (*See story in this issue on obtaining vaccination buy-in.*)

From a health facility director's perspective, it is desirable to vaccinate every staff member. For instance, family planning centers generally serve younger, healthier populations that are at less risk from serious illness due to COVID-19. If a clinic's entire staff received all necessary doses of a vaccine, it could be easier for the clinic to reopen to an optimal level of in-person visits. Some staff could return to the building instead of continuing their work remotely.

Until the pandemic ends, meaning zero cases over many weeks or months, facilities need to continue requiring masks and extra attention to hand hygiene, surface disinfection, and some level of keeping patients and their guests masked and separated. They might continue to screen patients by phone, and take other measures to prevent outbreaks.

"We should continue to urge people to mask and maintain social distancing," Archer says.

Preventing pandemic fatigue will be a big challenge in 2021. Family

planning providers can emphasize the point that no one knows when the COVID-19 pandemic will end.

"We didn't even know about this disease until late 2019. It's a novel disease, and we have a novel vaccine," Dai says.

Data on Immunity Needed

While the vaccine is effective at preventing COVID-19 symptoms, there is less information about whether the vaccine stops the SARS-CoV-2 virus from replicating and spreading.

"In the clinical trials, researchers looked at people who developed the symptoms and then got tested for COVID-19," Dai explains. "What we don't know is whether there are any clinical trial participants who developed COVID-19, but didn't show symptoms and weren't tested."

Also, there are no data on how long vaccine immunity lasts. "From [data on the] people who were given the vaccine in Phase I, their protection seems to be lasting at least three months," Salata explains. "We'll be studying these people for 26 months and making sure we're measuring several things, including capturing COVID cases, looking at antibody persistence, and assessing other responses in immunity."

Until researchers obtain longer-term vaccine results, healthcare providers will need to ask staff and patients to continue following infection prevention practices.

"No one can claim the vaccine will last for one year or more than one year because we don't have the data," Dai says. "I believe it will be long-lasting enough to end the pandemic. If we could vaccinate 75% of the population by May or June, then our

lives will be back to normal by the fall.”

But this is an unknown. Healthcare providers and leaders should not make this promise, as several obstacles could slow down the pandemic’s end, including the logistics of the federal government distributing the vaccine to everyone by summer.

Even people who have had COVID-19 will be asked to take the

vaccine, says **Eli Rosenberg**, PhD, associate professor in the department of epidemiology and biostatistics at the University at Albany School of Public Health, SUNY – The State University of New York.

“There’s no data out yet on how prior infection and vaccine will interact,” Rosenberg says. “Most current thinking is that all people with prior infection should be vaccinated, even those who had severe illness.” ■

Providers Can Reduce Vaccine Hesitancy Among Staff

Some people are “anti-first,” not anti-vax

New COVID-19 vaccines offer great hope for healthcare facilities in 2021. But, the next challenge is obtaining employees’ and patients’ buy-in to become vaccinated.

According to early reports, many healthcare workers refused the first doses of the vaccine. A survey revealed that half of hospital and public officials on the frontlines of the pandemic were refusing the vaccine. The governor of Ohio said that 60% of nursing home staff turned down the shot.¹

Every family planning and healthcare leader should know that vaccine hesitancy or reluctance varies.

“We know there are four to five reasons why individuals are reluctant,” says **Ken Resnicow**, PhD, Irwin M. Rosenstock collegiate professor of health behavior and health education at the University of Michigan School of Public Health.

For some groups, there might be a sense of not wanting to be the first people vaccinated, Resnicow says.

“The thought might be, ‘We want to wait and let other people go first,’” he explains. “It’s not that this group is anti-vax; they’re just anti-first.”

Another group might hold hardcore feelings against vaccines, related to their distrust of the

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pharmaceutical industry and distrust of all vaccines. “That group might be more difficult,” he adds.

For people who have received other vaccines and do not necessarily subscribe to the anti-vaccine movement’s philosophy that all vaccines pose health threats, a good tactic to ease them over to vaccine acceptance is to affirm their concerns.

For example, when someone points out that the vaccine was developed quickly and has not completed Phase III clinical trials, the leader could say, “Yes, the first two coronavirus vaccines were developed in record time, mostly because of work scientists started more than a decade ago when earlier coronaviruses and similar viruses caused outbreaks and epidemics in some parts of the world.”

The key is not to argue or offer a counterargument to everything the vaccine skeptic says, Resnicow says. “Instead, agree as much as you can. If they say it was done fast, then say, ‘You’re right.’”

Use motivational interviewing, in which the leader rolls with resistance.

EXECUTIVE SUMMARY

As the COVID-19 vaccine was rolled out in the United States, many healthcare workers refused vaccination. Reproductive healthcare centers will need to obtain staff buy-in as they begin a vaccination program.

- Some people may not want to be vaccinated until more people receive it.
- Other people hold strong antivaccination feelings and distrust.
- One method to gain vaccine acceptance is to present it as something healthcare workers should do to protect patients and their older family members.

"Just agree, don't argue, and that will soften the resistance," he adds. "Agree that years of abuse on studies happened to Black Americans. Some agreeing can be helpful in interpersonal communications."

Another tactic is to offer staff a parameterized choice, similar to what parents will offer their children. For instance, instead of telling staff that they must receive the vaccine on a specific day or week, the leader can offer them the choice of taking the vaccine on a specific week or scheduling their shot for a month later.

"We do this with kids: 'You can have fast food once a week; you can go to McDonald's or to Burger King, but you can't go to both,'" Resnicow explains. "With the vaccine, it might be powerful to say, 'If you choose not to go first, we'll hold your place for you,' although that could be difficult."

Leaders also can repeat the person's concern, offering affirmation without fully agreeing with everything the person says, Resnicow says. For instance, the leader could say, "You're worried about getting COVID-19 from the vaccine. We hear that a lot."

Resnicow and the University of Michigan's work with Yale School of Public Health and the University of Southern California Norman Lear Center uncovered findings about COVID-19 deniers, as well as people who could be moved into the vaccine acceptance bucket. Their work

focused on obtaining compliance with mask-wearing and vaccination.

"Our team believes the way to handle this is to make the motive outside of self," Resnicow says. "It's not about protecting yourself — it's about protecting the vulnerable in your life."

What sticks with people who are hesitant and resistant is the message that they should do this for their grandma. "You can say, 'You're right; you're invulnerable, and the pharma company is blah, blah, blah, but do it for grandma,'" he explains.

The message to staff also can be this: "We need healthcare workers to get vaccinated because they cannot help people if they get sick."

But providers and leaders should be prepared for some small number of staff that will refuse the vaccine.

"There is a percentage we can't move, but we want to make that percentage as small as possible, which is something we do in smoking cessation research," Resnicow explains. "There are some people we won't persuade, but some others can be brought along by early adopters, social norms, and pressure."

There also is value in giving staff a forum where they can ask questions. This could be a virtual town hall, he suggests.

"Have a person skilled in communication field the questions and describe the rationale for the vaccine schedule," Resnicow says.

"Giving people a forum to hear your reasons, and then time to question them, can do more good than harm."

Another tactic is to market vaccination as a bundle that includes vaccination, mask-wearing, hand hygiene, and social distancing. "In Australia, they had a very successful skin cancer campaign, called Slip-Slop-Slap, which people saw as a bundle," he says. People knew the words were a shortcut for slipping on long-sleeved clothing, slopping on sunscreen, and slapping on a hat.

Since there is a realistic fear that people will stop wearing masks once they become vaccinated, the bundled marketing message could reinforce the importance for staff and patients to continue to wear masks and stay distant, even after they receive the vaccine.

If a facility decides to mandate COVID-19 vaccination because of the risks to staff, there is another message the family planning director can impart to staff. "If you want to be here in the trenches, your being vaccinated and having immunity to the virus is going to make you a better healthcare provider, and it will allow you to keep working," Resnicow says. ■

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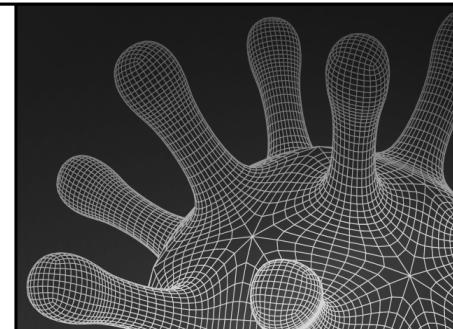
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Should Family Planning Clinics Volunteer to Vaccinate Patients?

They can reach underserved populations

One of the biggest challenges this spring will be to find enough trained medical staff and ambulatory sites to vaccinate hundreds of millions of people within a six- to seven-month time frame.

States will prioritize sites to receive the COVID-19 vaccine. They also will prioritize which populations will be vaccinated first, since there likely will not be enough vaccine available to cover the entire United States population until summer.

Family planning centers might be lower on the priority list for vaccination because they serve a younger population, says **David F. Archer**, MD, professor of OB/GYN at the Jones Institute for Reproductive Medicine at Eastern Virginia Medical School.

“Family planning clinics are providing family care for some people who do not seek out other primary care,” Archer says. “I would say it is a worthwhile thing for them to offer up the manpower to give the vaccine and to elevate them as a priority to get the vaccine for staff.”

Vaccine Programs Possible

It is possible some reproductive health clinics, such as health centers that serve low income populations, will set up public vaccination programs because they employ skilled medical staff in areas with little infrastructure needed to offer vaccination programs.

For instance, in December 2020, Planned Parenthood of Northern

New England offered free flu vaccines at all 12 of its Vermont health centers. (*More information is available at: <http://bit.ly/2WWGQz3>.*)

“One of the long-term challenges is finding spaces where people can go to get vaccinated and making sure people have access to those sites,” says **Samantha Penta**, PhD, assistant professor, in the College of Emergency Preparedness, Homeland Security and Cybersecurity at the University at Albany (NY).

As of early January, it was unclear how the federal government and states would distribute vaccine to rural areas and to marginalized populations. Vaccination sites need staff and personal protective equipment to handle the vaccination process.

“This is going to be hugely important,” Penta says. “Those kinds of support supplies or processes are really important to consider in the delivery of a vaccine, because it’s not just putting it in someone’s arm.”

Consider Logistical Challenges

Providers should consider their strategy for delivering vaccination to their patient population. “You need to think about those populations as you design it,” Penta says. “It’s possible that the approach you take for organizing how staff and personnel get the vaccine will not work for patients.”

Thinking about these logistical challenges in advance will improve the eventual vaccination process. “The more you anticipate these things

now, the smoother the process will be down the road,” Penta says.

Pros and Cons

There are many pros and cons, from the family planning center’s or OB/GYN office’s perspective, to these sites becoming vaccination places for their patients and possibly other members of their communities:

- **Pro 1:** Family planning centers serve populations that need vaccination access. “We don’t have a vaccine for everyone until we have a vaccine for pregnant women,” said **Kathleen M. Neuzil**, MD, MPH, FIDSA, Infectious Diseases Society of America (IDSA) fellow, director of the Center for Vaccine Development and Global Health, and Myron M. Levine professor in vaccinology at the University of Maryland School of Medicine. Neuzil also is co-director of the COVID-19 Prevention Network. She spoke at IDSA’s virtual COVID-19 vaccine briefing on Dec. 3, 2020.

“We know our children are suffering, and we’re seeing more impact of the pandemic on minority children,” Neuzil noted.

Pfizer and Moderna began studying the vaccines in adolescents in late 2020, she added.

“Pregnant women could make a decision to receive the vaccine, even though it’s not approved for this category,” Neuzil said.

The Centers for Disease Control and Prevention (CDC) listed pregnant and breastfeeding healthcare professionals on its priority list for

vaccination. The CDC cited evidence that pregnant women were potentially at increased risk for severe COVID-19 illness and death.¹

Although reproductive-age women are at less risk of severe COVID-19 symptoms, the women seen at family planning centers often work high-risk jobs, and this makes their vaccination a priority. For example, women who work in schools, the service and entertainment industries, or in factories might be at higher risk of becoming infected.

Women from multigenerational households and who are Native American, Latina, or Black American also are at greater risk of infection and morbidity from the disease.

"I would recommend people who work in bars and restaurants to be inoculated," Archer says.

• **Con 1:** There are potential costs to facilities. The federal government has paid for the initial COVID-19 doses through Operation Warp Speed, and providers can receive these at no cost. But they cannot charge out-of-pocket costs for administration of the vaccine. Private insurance, Medicare, and Medicaid must cover the vaccine in states that receive public health emergency federal funding. But centers that serve uninsured populations, which participate in the CDC COVID-19 Vaccination Program, will have to bill the Provider Relief Fund for reimbursement of vaccine administrative costs.²

Healthcare facilities likely will have to cover the costs of any equipment they purchase for their vaccination program. "Providers may have to buy an arctic freezer, and they have to invest in that," says **Tinglong Dai**, PhD, associate professor of operations management and business analytics at Johns

Hopkins University Carey Business School. Dai also is core faculty at Hopkins Business of Health Initiative.

Another option is for centers to use a Pfizer portable cooler, but the vaccines only last for about a week.

• **Pro 2:** Family planning providers employ nurses and providers capable of administering the vaccine.

One major obstacle to a fast and efficient vaccine rollout is the lack of trained staff in many rural and underserved regions. For example, rural areas have about one-third fewer RNs than metro areas. Nonmetro areas also have 12.7 physicians per 10,000 people, compared with 33.3 physicians per 10,000 people in metro areas.³

Since the vaccine is new, it is important for healthcare providers to monitor the patients who receive the vaccine. This is why it is helpful to set up vaccine sites in locations where people already seek medical care, such as reproductive health centers.

"Vaccination can be done where you would seek your care if you had a problem with that vaccine," Neuzil says.

• **Con 2:** Reproductive health clinics already are stretched thin. The COVID-19 pandemic burdened all healthcare providers in 2020 as patients overcrowded hospital emergency departments and intensive care units.

The pandemic may cause overcrowding in family planning centers, as an estimated 7.7 million workers lost their jobs by mid-2020. They also lost their employer-sponsored health insurance. Including family members, more than 14 million people will have to shift to an Affordable Care Act plan — or grapple with being uninsured or underinsured. This could cause long waits for appointments at free

medical clinics and federally funded reproductive health clinics.⁴

Any healthcare facility that signs up to provide vaccines to the public should be prepared for this to take up to half a year to complete. "It will take four to six months before we have vaccinated enough people to reduce the rate of transmission," Archer says. "The pool of potential infected people is huge, and the number of vaccinations will take too long."

Another consideration is that reproductive health centers serve a younger population that likely will be low on the vaccine priority list. "Hospitals are trying to protect people at greatest risk," Archer says. "In the ambulatory care situation, these are not people at the highest risk. If you ask the right questions, and they have not traveled or are being exposed, I think they're probably at low risk of infection." ■

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New Contraceptive Patch Is a Weekly Option

Twirla, a new low-dose contraceptive patch, is effective at preventing pregnancy among American women, according to researchers.

Phase III clinical trial results were favorable for efficacy, safety, and tolerability of a levonorgestrel/ethinyl estradiol transdermal delivery system. The new patch uses a progestin and contains less estrogen than prior patches. It is believed to be associated with a lower risk of blood clot formation.¹

"Women used one patch a week for three weeks, then wore no patches for one week to have scheduled bleeding," says **Anita L. Nelson, MD**, study author and professor and chair of obstetrics and gynecology at Western University of Health Sciences in Pomona, CA. "The trial design explicitly sought to test this new product in women who were more representative of real potential users in the U.S. For example, there was no limit placed on weight. As a result, 35.3% of subjects had a body mass index [BMI] over 30 kg/m² — [classified as] obese."

Also, women were enrolled from a diverse sample of races and ethnicities. "The overall pregnancy rate for all participants was 5.8%," she says. "But, it is clear that the patch works better for non-obese women."

For women with a BMI of 30, the pregnancy rate at one year was 4.3%. For women with lower BMI, the failure rate was 3.5%.¹

"Bleeding patterns were well tolerated by users," Nelson adds. "There were four women who experienced blood clots, and all of them had BMIs equal to or greater than 30."

One in 10 women reported some degree of itching or skin irritation. Overall, the patch adhered reasonably well, Nelson says.

"Eleven percent of women discontinued due to treatment-related complications," she adds. "Because of the lower efficacy and the observed blood clots seen in women with BMI greater than or equal to 30, the product carries the same FDA labeling as the other available patch, Xulane. Each is indicated only for women with BMI less than 30."

Twirla is like a 30 mcg contraceptive pill, while Xulane is closer to a 50 mcg pill, she notes.

"The levonorgestrel in Twirla has been associated with the lowest blood clot risk in oral contraceptives, whereas the Xulane patch progestin is like other formulations with higher rates," she adds. "We did not compare the other methods, but only one in 10 women discontinued using the

patch during the one-year study because of adverse events they thought came from the patch."

From a reproductive health provider's perspective, the new, once-a-week patch is an attractive option to women with BMIs below 30 kg/m², particularly if they have difficulty taking a daily pill and do not want to use vaginal devices.

"It would also be a good option for women who are not able to absorb hormones from pills due to stomach or intestinal problems," Nelson says. "The visibility can be very reassuring — she has it on her, and she doesn't need to wait until she gets home to see if she took today's pill."

Patches are highly portable, making them convenient for travel. "This patch offers non-obese women a non-daily transdermal contraceptive option they control, and that reduces estrogen exposure with favorable effectiveness, safety, and tolerability," she adds. ■

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Pregnancy Risk Increases When Young Women Travel

Although most international trips, including students' study abroad programs, were put on hold in 2020, these might resume this year after the COVID-19 vaccine reaches student populations. Reproductive health providers can help young women

prepare for the contraceptive needs and uncertainties of travel.

A new study revealed that young female travelers overwhelmingly say they will be abstinent during their travels, but their actual experience is the opposite.¹

"Women who returned from travel told me they left with no intention of having a new sex partner, but that was not how it turned out," says **Summer Martins, PhD, MPH**, postdoctoral associate in the department of obstetrics, gynecology, and women's

health at University of Minnesota Medical School. “Women in the pre-travel group thought they would not be sexually active, so that expectation lowers their level of alertness.”

For instance, a women might think, “I might be a month late with my contraceptive shot, but I’ll just get it when I come back,” she explains.

From a clinician’s viewpoint, it would be worthwhile to say, “Maybe you’ll be abstinent, but just in case, let’s renew your shot right now before you go, and then we won’t have to worry about it,” she adds. “Some of those risks can be mitigated. It’s a clinician’s job to help patients anticipate where those potential risks are.”

In 2016 and 2017, Martins and co-investigators recruited female students who had either completed an international trip in the previous three months or who had plans for international travel in the next three months.

“It was important in this study to gather data in both the pre-travel period to know what are the risks they’re preparing for, and also after they travel, to see what their experiences are when they traveled,” Martins says.

While travel is not universally risky from a reproductive health perspective, some women in the study found themselves in situations that posed risk. “In the pre-travel period, when I asked women if they had ever used emergency contraception, they were very experienced with it, but very few of them were planning on bringing it with them,” Martins says.

The reality is that international travel is a situation in which someone might not have access to emergency contraception when its needed. “You need that backup, Plan B, and they were not bringing it with them,” she says.

Researchers found that 17% of women who had recently traveled

internationally formed new sexual partnerships with men during their travel period. Overall, 29% experienced a contraceptive lapse. Contraceptive lapse was highest (50%) among pill users. The pill was the most commonly reported contraceptive method.^{2,3}

Researchers were motivated to identify potentially vulnerable points in women’s travel and reproductive health and safety. Knowing that women might underestimate their potential for sexual experiences abroad, providers and counselors can make suggestions and educate them on those risks.

“Someone could say, ‘You’re traveling internationally, and you’ll face risks, and here’s a dose to bring with you. You might not need it, but here it is, just in case,’” Martins says. “Providers and counselors can raise awareness of the different types of risks women may face when they’re traveling.”

Providers also can help women access emergency contraception in areas where it might be difficult to find over the counter. Providers can write a prescription before the woman travels.

Doctors give travelers prescriptions of antibiotics to take in the event of foodborne illnesses, and they vaccinate travelers to prevent infectious diseases. Giving travelers an emergency contraceptive to take with them is similar, Martins notes.

“If we do it for diarrhea, we can do it for unplanned pregnancy,” she adds.

Another issue that young women travelers might experience is running out of contraception during their overseas stay. During in-depth interviews with study participants, researchers found that women often were unable to get enough contraception to cover their entire travel period.

“Either there were insurance rules that limited the number of pill packs dispensed at one time so they couldn’t get an entire semester of pills, or there were other logistics,” Martins explains.

For instance, some women did not expect to have sex while they traveled, so contraceptives were a low priority. They expected to let their patch or injection lapse. “Some, at the last minute, got their pills refilled, but the timing was wrong, and they ended up traveling to another country without a continuation of their preferred method,” Martins explains.

Even women who traveled with enough contraception faced problems. They found the time differences and new and hectic traveling schedule would throw off their timing in taking a daily birth control pill.

“They would have contraceptive lapse because they were traveling across time zones, and all of their routines were ended with a completely new country, different experiences, and a disruption in all those things that helped them keep on schedule with their daily pill,” Martins says.

Qualitative interviews of participants revealed that young women had an overall positive response to questions about intrauterine devices (IUDs) and whether these are appropriate for longer-term travelers. They acknowledged that IUDs were maintenance-free when compared with taking a pill every day, Martins says.

“But a lot of women expressed concern about adjusting to a new method like that,” she adds. “What if something went wrong and they needed to manage it in a clinician’s office? Would they have access to care if they had it inserted and then needed it removed?”

Clinicians could keep in mind the same guiding principles of patient autonomy when counseling women

travelers on contraceptive options and strategies. “Patients should choose the method that’s most well-suited for them,” Martins says.

Clinicians can guide patients in their choices by noting that not all methods will be available during their international travel, so they might want to plan ahead. Also, they could point out that it is difficult to maintain their pill schedule when traveling across time zones. “They need to have a plan, but not necessarily change their methods,” Martins says.

For example, some women interviewed by researchers said they anticipated that their contraceptive ring would need to be replaced while they were traveling. They replaced it right before their trip, which made it effective during a several-week travel schedule, she explains. Women also could get a contraceptive shot right before they leave.

“They could bring emergency contraception or condoms with them,” Martins says. “Clinicians can help them, saying, ‘I’ll give you this dose and six condoms, to make sure you’re set.’”

Women returning from trips often were resourceful and accessed contraception while abroad. One participant even obtained a medical abortion during her travels, she notes.

“Some of those travelers will have partners who have their own condoms, or they can find condoms in their destination,” Martins says.

But the important thing is for clinicians and counselors to help patients troubleshoot their potential obstacles and options before they leave the United States.

“If they’re going on a long trip, do they have enough supply of contraceptives? If not, help them get it,” Martins says.

Other issues that clinicians should discuss include the problems with language barriers and cultural miscommunication, which could affect contraception discussions with potential sexual partners. Also, there is potential for sexual assault and becoming infected with HIV or sexually transmitted infections (STIs). Women need consistent advice on STI/HIV prevention, and they should be offered condoms to take with them in case their sexual partners do not have condoms.

“Equip them to the best extent you can, literally with supplies,” Martins says.

Also, clinicians could ask women to return for a visit after their trip, to rescreen them for STIs in the event they had a new partner while traveling, she adds.

“Close physical and emotional relationships that lead to sexual intercourse and unintended pregnancies also expose women and men to COVID-19 infection,” explains **Robert A. Hatcher**, MD, MPH, chairman of the *Contraceptive Technology Update* editorial board. “Once exposed to the risk of becoming pregnant from unprotected sex, a woman may know she has the option of using an emergency contraceptive. There is no postcoital treatment that can lower a woman’s risk for COVID-19 infection.” ■

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Study: IUD Counseling Can Appear Coercive

The results of a recent study revealed that providers might think they are promoting their young patients’ decision-making, but their focus on intrauterine devices (IUDs) and other long-acting reversible contraceptives can come across as coercive.¹

Researchers interviewed 20 clinicians from 11 community health centers in the Bay Area of California.

“We were interested in their approaches to IUD counseling,” says **Antonia Biggs**, PhD, associate professor in the department of obstetrics, gynecology, and reproductive sciences at the University of California, San Francisco. “What we found was that the clinicians really talked about valuing patient-centered contraceptive counseling approaches, and they talked about how that was important.

But, when it came to IUD removals, we found they described dissuading patients from removing the IUD and downplayed side effects.”

There were inconsistencies between what the effects clinicians said they desired and their actual practices in engaging patients, particularly with IUD removal. “We found they wanted to provide comprehensive information to patients and inform them

about all kinds of methods, without prioritizing any particular method, and they wanted their patients to feel empowered,” Biggs explains. “But we also found that many reported how they would try to guide their patients toward higher-efficacy methods and guide them away from lower-efficacy ones, like withdrawal, and they discouraged IUD removal if it was within a year of placement.”

These actions could be described as coercive, and run counter to the principles of medical ethics and reproductive justice that say providers should respect a person’s bodily autonomy and decision-making, she says.

“Clinicians told researchers how they tried to talk with patients about IUDs like they were the best thing on earth, and they didn’t talk about the withdrawal method because they knew it doesn’t work,” Biggs explains. “I asked, ‘How do you talk to a patient about IUDs?’ and they would talk about a frustration they feel if their patients didn’t adopt an IUD.”

The providers saw the inability to successfully market the IUD as a failure. Instead, the focus should be on patient-centered counseling sessions. “We meet patients where they are and meet where their preferences are,” she says. “People have different preferences regarding contraceptives. We need to follow the patient’s lead, giving them the information they want and giving them objective information.”

For instance, explaining how withdrawal might not be as effective as an IUD is appropriate. But it also is important not to allow one’s biases to shade the way each contraceptive method is presented. “Some patients might not want an IUD because they’re not comfortable with that device’s placement in a private area,” Biggs explains. “Especially if they’re young, they might not be comfortable with that.”

But all patients want information delivered without bias and judgment. For example, tiered-effectiveness counseling can be a way to present information accurately and without bias.

“You talk about the most effective methods first, and then go down the list,” Biggs explains. “That type of counseling became popular in the early 2000s, but I don’t think it’s been studied to see how patients feel about it.”

Reduce Stigma

The key is to reduce stigma and build trust with patients. “From the research I’ve done, the sense I get is that patients don’t really like it when they feel their provider has a predetermined method in mind for them. That turns them off,” Biggs says.

For instance, the withdrawal method might be better than nothing. But if a provider shows a lot of judgment, then patients might feel less comfortable asking questions about how to do this and may choose not to access contraceptive counseling and care.

“When you think about young people who often do not plan to have sex, and they’re uncomfortable having a discussion with their partners about sex and contraception, they might not have a contraceptive, but they can have withdrawal,” Biggs says. “I tell my teens they should use withdrawal over nothing, and it has benefits that can be used in combination with condoms.”

Biggs has heard anecdotal experiences from young women who felt so much judgment from their contraception provider that they avoided visiting the provider for three years and ended up pregnant.

“The woman wanted to ask questions, but didn’t because she felt someone would judge her,” Biggs adds.

Maintain Patient Trust

Clinicians who strongly steer their patients away from an IUD removal within the year after insertion can lose patients’ trust.

“They described resisting that removal and trying to urge women to not remove the IUD. I didn’t hear a lot of listening to patients about reasons why they wanted it removed,” Biggs says. “One provider said, ‘Unless they have a really good reason, I’m not taking it out.’”

Biggs also heard providers talk about downplaying IUD side effects, which also erodes trust and can backfire.

“The issue with the IUD and implant is that they’re a provider-controlled method, so removal requires medical intervention,” Biggs says. “It’s different from other methods for that reason, and if the provider resists the removal, they’re stuck and have no choice, or have to go to another provider.”

Instead, providers should talk with patients and find out what is bothering them about the IUD. Then they could empower the patient and say that it is their decision and the clinician is there to do whatever the patient wants them to do, she adds. ■

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CME/CE QUESTIONS

- 1. What should reproductive health providers do if staff are hesitant to take the COVID-19 vaccine?**
 - a. Mandate staff vaccination.
 - b. Offer employees gift card incentives to take the vaccine.
 - c. Have all employees visit an ICU with COVID-19 patients, and then help them schedule their vaccine.
 - d. Allow staff to have a say in the decision, but do not erode trust through forcing staff vaccination.
- 2. What should family planning centers or reproductive health providers keep in mind if they decide to distribute the COVID-19 vaccine to the public?**
 - a. Although the federal government paid for the initial vaccine doses, providers have to cover the costs of any equipment they purchase, including freezers.
 - b. Pharmacies and hospitals might compete for the same people to receive the vaccine.
 - c. Providers are expected to pay for any vaccine costs not reimbursed by insurers.
 - d. Patients might be offended by a vaccination program sharing space with reproductive health counseling and visits.
- 3. Results of a new study revealed that young female travelers overwhelmingly say they will handle their reproductive health while traveling by:**
 - a. switching to long-acting reversible contraceptives.
 - b. abstaining from sex.
 - c. obtaining a several-month supply of birth control pills.
 - d. bringing a supply of condoms with them.
- 4. Research into providers' attitudes and actions toward patient-centered contraceptive counseling revealed that providers advocated those values, but also:**
 - a. dissuaded patients from removing IUDs within a year of insertion.
 - b. advocated for birth control pills over other methods.
 - c. admitted not believing patients when they said they could successfully use the withdrawal method.
 - d. asked patients which method they wanted to use and wrote prescriptions.