

CONTRACEPTIVE TECHNOLOGY

U P D A T E[®]

The Trusted Source for Contraceptive and STI News and Research for More Than Three Decades

April 2014: Vol. 35, No. 4
Pages 37-48

IN THIS ISSUE

- Long-acting methods: Implant makes inroads . . . cover
- LARC methods: How to increase use 40
- Quick Start, extended regimens: Clinicians share strategies 41
- Power of the Pill: Readers speak out 43
- Combined hormonal methods: Science eyes ring option 44
- Intimate partner violence: Get up to speed on screening guidance. 45

Financial Disclosure: Consulting Editor **Robert A. Hatcher**, MD, MPH, Author **Rebecca Bowers**, and Executive Editor **Joy Dickinson** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Melanie Deal**, nurse reviewer, discloses that she is on the speakers bureau for Actavis and Merck & Co. and the advisory board for Actavis, Teva, and Hologic.



Contraceptive implant makes inroads as birth control option

Use of long-acting reversible methods continues, clinicians say

Whether it's the intrauterine device (IUD) or the contraceptive implant, women are choosing long-acting reversible contraceptive (LARC) methods, say respondents to the 2013 *Contraceptive Technology Update* Contraception Survey. About 60% of survey respondents said they placed more than 10 intrauterine devices last year, while 73% said their facility is offering/plans to offer the contraceptive implant, a 10% jump from 2012.

Southern Nevada Health District Family Planning Clinic — East Las Vegas and Henderson has IUDs and implants readily available, says clinician **Susan Kilburn**, RN, APRN-BC. The clinic operates on a sliding pay scale basis, and most patients are donation-only status, she explains. Clinicians favor the LARC methods for women who are appropriate candidates, Kilburn notes.

Karen Albright, WHNP-BC, lead clinician at Planned Parenthood Southeastern Virginia in Virginia Beach, says, "We are using more and more LARCs because we have a grant for long-term contraception; without the grant, our self-pay clients would never be able to afford it. We are also putting IUDs in at the in-clinic abortion visit."

When **Caroline Strzeszynski**, WHNP-BC, a clinician at Wood County Community Health & Wellness Center in Bowling Green, OH, came to her facility, LARC was not available, and few patients were following up when referred for LARC elsewhere. Since mid-2013, LARC is offered and, as a result, women are requesting that option, she reports.

This month: Results of CTU Contraception Survey

This issue includes the results of the 2013 *Contraceptive Technology Update* Contraception Survey. Gain perspective from this overview of current clinician practice, and obtain information on how to use long-acting reversible contraceptives, as well as oral contraceptives, the contraceptive vaginal ring, and the contraceptive patch. We hope you enjoy this special edition of CTU. ■

NOW AVAILABLE ONLINE! Go to www.ahcmedia.com.
Call (800) 688-2421 for details.

Family Planning Association of Northeast Ohio in Painesville is better supplied with LARC methods due to an increase in Medicaid patients, says **Dianne Rafferty**, CNP, director of nursing. Since Ohio has expanded Medicaid, the extra Medicaid reimbursement has allowed the organization to offer LARCs to more clients who don't have insurance.

Contraceptive Technology Update® (ISSN 0274-726X), including STI Quarterly™, is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Rd, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Contraceptive Technology Update®, P.O. Box 550669, Atlanta, GA 30355.

Opinions expressed are not necessarily those of this publication.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST. Subscription rates: U.S.A., **Print:** 1 year (12 issues) with free *AMA Category 1 Credits*™ or Nursing Contact Hours, \$479. Add \$19.99 for shipping & handling. **Online only, single user:** 1 year with free *AMA Category 1 Credits*™ or Nursing Contact Hours, \$429. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreuzer at 404-262-5482. Back issues, when available, are \$75 each. (GST registration number R128870672.) Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media. Address: P.O. Box 550669, Atlanta, GA 30355. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcmedia.com>.

Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AHC Media, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

AHC Media, LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media, LLC designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

This activity is intended for OB/GYNs, nurses, nurse practitioners, and other family planners. It is in effect for 24 months from the date of publication.

Editor: **Rebecca Bowers**.

Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410 (joy.dickinson@ahcmedia.com).

Production Editor: **Kristen Ramsey**.

Director of Continuing Education and Editorial: **Lee Landenberger**.

Copyright © 2014 by AHC Media, LLC. Contraceptive Technology Update® and STI Quarterly™ are trademarks of AHC Media, LLC. The trademarks Contraceptive Technology Update® and STI Quarterly™ are used herein under license. All rights reserved.



Editorial Questions

Questions or comments?
Call Joy Daughtery Dickinson
(404) 262-5410.

How about the implant?

The contraceptive implant (Nexplanon, Merck & Co., Whitehouse Station, NJ) is highly effective, not motivation dependent, and can be used during lactation. It is discreet, virtually invisible, and is rapidly reversible. As a subdermal implant, its features include:

- a long duration of action (labeled for up to three years);
- not subject to patient error or imperfect use;
- continuous steady state steroid levels;
- avoidance of 'first-pass' peak effect via the hepatic portal system, which is associated with oral contraceptives; and
- higher bioavailability, which yields lower doses with parallel decreases in adverse effects.¹

One of the downsides of implant use is irregular bleeding. 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 completely. (*Download a free patient sheet on the implant, available in English and Spanish, at <http://bit.ly/1eSubxO>.*)

Donna Gray, CNM, WHNP, a clinician at the Wyoming County Health Department's Men's and Women's Reproductive Health Services in Silver Springs, NY, has performed more Nexplanon insertions in the last six months than the first year the device was on the market.

"Some do complain of the increased bleeding episodes, but we usually work with them trying [a non-steroidal anti-inflammatory drug], estrogen, or oral contraceptives to cut back on episodes of bleeding, instead of removing it," says Gray.

With a LARC grant, clinicians at Planned Parenthood Southeastern Virginia are putting in more implants, but unfortunately they also are seeing a lot of removals for bleeding, says Albright. Even with

EXECUTIVE SUMMARY

Women continue to choose long-acting reversible contraceptive (LARC) methods, say respondents to the 2013 *Contraceptive Technology Update Contraception Survey*.

- About 60% of survey respondents said they placed more than 10 intrauterine devices last year.
- About 75% said their facility is offering/plans to offer the implant, a 10% jump from 2012's numbers.
- Irregular bleeding is linked to implant use. Counsel women that they might have heavy and/or longer periods, or periods that are lighter and occur less often. Some women become amenorrheic.

increased counseling and offering medication to help with bleeding, the client tends to opt for removal, she notes.

Handle call backs

With contraceptive use comes patient call backs. At the LARC First web site, www.larcfirst.com, developed by the St. Louis-based Washington University School of Medicine's Contraceptive CHOICE project, answers can be found for commonly asked questions about the implant and IUD.

The project has developed a clinician callback system to provide an efficient way to manage patient concerns, which might lead to higher continuation and satisfaction rates for contraceptive methods. Staff members, from receptionists to clinicians, participate in training in appropriate responses. Questions marked in green represent those that can be answered by receptionists, with yellow indicating questions for counselors and staff nurses, and red denoting attention from advanced practitioners.

If a patient calls to ask "Why I am having all this irregular bleeding with the implant?" the suggested CHOICE Project response for a receptionist would be: "It can be normal to experience irregular bleeding with the implant. This method releases a small amount of the hormone progesterone that keeps the lining of the uterus thin. Although it may be somewhat annoying, it is not harmful. If the bleeding persists for a long time and is bothersome, discuss this with your clinician. There are some medications that may help."

If a patient with an IUD calls in asking about irregular bleeding, the CHOICE Project suggests the following response for a receptionist: "It can be normal to experience irregular bleeding with the IUDs, especially for the first few months. This usually subsides with the copper IUD. The hormonal IUD is releasing a small amount of the hormone progesterone that is thinning out the lining of your uterus. This is why it is perfectly normal to have irregular bleeding, and eventually lighter periods or no period at all."

How about patients who say after four months they are still having periods that last 15 days with implant or intrauterine contraception? The suggested response from a staff nurse would include the following: "When the bleeding starts, try taking 600 mg of ibuprofen three times a day with food for the next five to seven days. This can help cut down how long the bleeding lasts. It may take three days before you notice a decrease in bleeding."

For women who still experience irregular bleeding with the implant or intrauterine contraception and have tried approaches mentioned above, clinicians

Survey Profile

The 2013 *Contraceptive Technology Update* (CTU) *Contraception Survey* monitors contraceptive trends and family planning issues among readers. Results were tallied and analyzed by AHC Media, LLC in Atlanta, publisher of CTU and dozens of medical newsletters and sourcebooks. The survey was mailed in December 2013 to 835 subscribers with 61 responses, for a response rate of 7.3%.

Fifty-two percent of responses came from nurse practitioners, with physicians representing about 40% of respondents. About 82% of respondents identified themselves as care providers, with 10% involved in administration and about 3% identifying themselves as faculty/teacher/student.

About 49% work in public health facilities, with about 28% listing private practice. About 12% listed employment in other settings; about 7% work in hospitals

When it comes to location of their employment, 43% said they work in a rural area location. About 27% said they are employed in a suburban area, with about 25% listing an urban setting. ■

may look at the following prescription options:

- naproxen, 500 mg tablet, one by mouth twice a day for 5-7 days;
- estrogen supplementation options: Conjugated estrogen, 1.25 mg tablet, one by mouth daily for 7-14 days; or micronized estradiol, 2 mg tablet, one by mouth daily for 7-14 days, or transdermal estrogen patch: 0.1 mg patch for 7-14 days;
- mefenamic acid, 500 mg tablet, twice a day for 5-7 days;
- tranexamic acid, 500 mg tablet, twice a day for 5-7 days;
- doxycycline, 100 mg tablet, one by mouth twice a day for 7 days.²

In prescribing such options, explain to women that while such methods will help stop the bleeding, there is no proven method to keep the bleeding from returning. The bleeding might stay away permanently, stay away several months, or return at the completion of the medication.²

REFERENCES

1. Association of Reproductive Health Professionals. New developments in contraception: the single-rod implant. Accessed at core.arhp.org.

Get practice up to speed on LARC methods

How can your clinic increase use of long-acting reversible contraceptive (LARC) methods? Take notes from the LARC First web site, www.larcfirst.com. Developed by the St. Louis-based Washington University School of Medicine's Contraceptive CHOICE project, the site offers a compilation of materials that will help your facility become a "LARC First" practice.

The online resource center is divided into six modules:

- The opening module provides a starting point for exploring what makes a practice LARC friendly.
- The second module gives information to support organizational adoption of the CHOICE model of contraceptive care.
- The third module provides tools to help clinics successfully put CHOICE contraceptive counseling into practice.
- The fourth module lists evidence-based resources and provision guidelines for advanced practitioners who work in primary care, pediatric, or gynecological practice settings.
- The fifth module provides tips on cross-training, managing patient concerns, and providing reassurance and resources for sexually transmitted infection testing and follow-up.
- The final module details the materials and best practices used by the Contraceptive CHOICE Project to hire staff, set organizational goals, and create a mission-focused environment.

It is essential that all staff members within a LARC First practice, from receptionist to administrator, are on board with the mission to ensure quality patient care and experience, say Contraceptive CHOICE staffers. (*See how positive LARC messages can be used by all clinic staff, p. 41.*)

Requests are increasing

Respondents to the 2013 *Contraceptive Technology Update* Contraception Survey say word of mouth from satisfied users is bringing in more women requesting LARC options.

The copper-T 380A intrauterine device (ParaGard IUD, Teva North America, North Wales, PA), the levonorgestrel IUDs (Mirena and Skyla, Bayer

HealthCare Pharmaceuticals, Wayne, NJ), and the contraceptive implant (Nexplanon, Merck & Co, Whitehouse Station, NJ) are becoming more popular due to their convenience, say survey respondents. LARC methods require no pharmacy visits and no need to do something about contraception on a daily basis, says Donna Gray, CNM, WHNP, a clinician at the Wyoming County Health Department's Men's and Women's Reproductive Health Services in Silver Springs, NY. Many patients are switching to LARC methods based on their friends' positive experiences with such options, Gray reports.

Use of LARC methods has definitely grown since the 2000 introduction of the Mirena IUD. Just 3% of respondents to the 2001 CTU survey reported 25 or more IUD insertions; in 2013, that number jumped to 32%.

Check clinic LARC IQ

While you might be up to date on the latest evidence-based medicine when it comes to LARC methods, how about the rest of your clinic staff?

Results of a survey conducted at 40 Planned Parenthood clinics in 2011-2012 indicate differences between health educators' and clinicians' practices regarding LARC options. According to survey results, educators considered a smaller proportion of their clients eligible to use LARC methods than did clinicians (57% versus 77%). Educators were less likely to consider offering IUDs to teenagers (79% versus 96%), to women who had never had children (82% versus 98%) and to unmarried women (90% versus 99%).¹ (*To review research backing safety of IUD use in teens and nulliparous women, see the CTU articles, "Old myth debunked: Data show IUD is safe birth control option for teens," July 2013, p. 73,² and "LARC methods: 7 things you need to know, January 2014, p. 4.³*)

EXECUTIVE SUMMARY

Clinics looking to increase use of long-acting reversible contraceptive (LARC) methods have tools and evidence to support their actions.

- Visit www.larcfirst.com to access a compilation of materials from the Washington University School of Medicine's Contraceptive CHOICE Project. Materials are designed to make your clinic a "LARC First" facility.
- Check that all employees have equal understanding of LARC eligibility. Results of a recent survey indicate differences between health educators' and clinicians' practices. Educators considered a smaller proportion of their clients eligible to use LARC methods than did clinicians.

Based on the survey results, 64% of educators and 40% of clinicians desired additional LARC training.¹ “Even in clinics that specialize in reproductive health care, health educators are less likely than clinicians to apply current evidence-based criteria in counseling about LARC,” the researchers note. “To provide evidence-based contraceptive counseling, health educators need training on LARC eligibility and indications.”

Even clinicians might not be clear on potential LARC candidates. To assess such knowledge, researchers conducted a survey regarding LARC beliefs and practices among medical directors from 1,000 sites in the Family Planning Access Care and Treatment program (California’s family planning Medicaid program) provider database. Most respondents (448/587) were physicians.⁴

Respondents were most likely to consider women with a history of pelvic inflammatory disease (PID) unsuitable for hormonal (27%, n=161) and copper (26%, n=154) intrauterine devices. According to the U.S. Medical Eligibility Guidelines for Contraceptive Use, the copper T380A IUD and the levonorgestrel IUD are rated “1” (no restrictions on use) for women with a past history of PID and a subsequent pregnancy, and a “2” (advantages generally outweigh theoretical/proven risks) for women with past PID history and no subsequent pregnancy.³ Nearly three-fourths of respondents routinely discussed IUDs (413/561) and nearly half (271/558) discussed implants with their contraceptive patients.

“Although there has been significant progress in expanding access and understanding about LARC, many clinicians from sites offering family planning services held beliefs limiting the provision of intrauterine devices and were unfamiliar with the implant, suggesting the need for targeted trainings aimed at informing clinicians of recent developments in LARC recommendations,” researchers state.

REFERENCES

1. Thompson KMJ, Stern L, Gelt M, et al. Counseling for IUDs and implants: are health educators and clinicians on the same page? *Perspect Sex Reprod Health* 2013; 45(4):191-195.
2. Centers for Disease Control and Prevention. U.S. Medical Eligibility Criteria for Contraceptive Use. *MMWR* 2010; 59(RR04):1-6.
3. Berenson AB, Tan A, Hirth JM, et al. Complications and continuation of intrauterine device use among commercially insured teenagers. *Obstet Gynecol* 2013; 121(5):951-958.
4. Biggs MA, Harper CC, Malvin J, et al. Factors influencing the provision of long-acting reversible contraception in California. *Obstet Gynecol* 2014; doi: 10.1097/AOG.000000000000137. ■

Extended OC use, Quick Start has arrived

As a family planning provider, your focus is to remove barriers to contraceptive use. Responses to the 2013 *Contraceptive Technology Update* Contraception Survey indicate that many clinicians have moved to remove one hurdle by adopting the Quick Start method of method initiation. More than 75% of respondents say they use Quick Start to start patients on combined hormonal contraceptives.

“I have been using Quick Start for 10 years at least,” says **Caroline Strzeszynski**, WHNP-BC, a clinician at Wood County Community Health & Wellness Center in Bowling Green, OH. “It is an excellent option for pregnancy prevention; otherwise, women get pregnant waiting for a menstrual period to start their birth control method.”

Such practice is upheld by the U.S. Selected Practice Recommendations for Contraceptive Use, 2013 (U.S. SPR).¹ The U.S. SPR clarifies that all methods may be initiated at any time in the menstrual cycle if the provider is reasonably certain that the woman is not pregnant.²

According to the U.S. SPR, a provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any of the following criteria:

- has not had intercourse since last normal menses;
- or has been correctly and consistently using a reliable method of contraception;
- or is within seven days after normal menses;
- or is within four weeks postpartum (non-lactating);
- or is within the first seven days postabortion or miscarriage;
- or is fully or nearly fully breastfeeding, amenorrheic, and less than six months postpartum.¹

Quick Start is preferred

When it comes to combined pills, Quick Start is preferred because other combined oral contraceptive initial protocols generally have a time gap between the time of prescription and the time the patient begins taking it. Research indicates as many as 25% of women who use other protocols fail to take the pills as instructed because they conceive in the interim, fail to fill the prescription, or worry about taking the Pill.^{3,4} (*The New York City-based Reproductive Health Access Project, a reproductive health advocacy organization, has developed a Quick Start algorithm for different methods. Download a version of the tool at <http://bit.ly/1fWSNH2>.*)

What’s your practice when it comes to prescribing

extended or continuous regimen pills? About 35% of 2013 survey respondents reported an uptick in use. About 55% of 2012 survey respondents saw increase in such regimens.

A new option in extended regimen pills came in April 2013 when the Food and Drug Administration approved Quartette (Teva Pharmaceuticals, North Wales, PA). Quartette incorporates an ascending-dose approach, with 20, 25 and 30 mcg of ethinyl estradiol, combined with 150 mcg of levonorgestrel over 84 days, followed by seven days of 10 mcg of ethinyl estradiol alone.

Current extended regimen pills include four brands of 30 mcg ethinyl estradiol/150 mcg levonorgestrel pills, packaged as 84 active pills and seven placebo pills: Seasonale and Jolessa (Teva Pharmaceuticals), Quasense (Actavis, Parsippany, NJ) and Introvale (Sandoz, Princeton, NJ). There are three brands of 30 mcg ethinyl estradiol/150 mcg levonorgestrel and 10 mcg ethinyl estradiol pills, packaged as 84 active pills and seven low-dose estrogen pills: Seasonique and Camrese (Teva Pharmaceuticals) and Amethia (Actavis). There are three brands of 20 mcg ethinyl estradiol/100 mcg levonorgestrel pills and 10 mcg pills, packaged as 84 active pills and seven low-dose estrogen pills: LoSeasonique and CamreseLo (Teva Pharmaceuticals) and Amethia Lo (Actavis).

There are two continuous regimen pills, containing 20 mcg ethinyl estradiol/90 mcg levonorgestrel, packed as 28-day packs with no hormone-free interval: Lybrel (Wyeth Pharmaceuticals, Philadelphia) and Amethyst (Actavis).⁵

Check pregnancy rates

While newer pill regimens potentially might improve efficacy and alter bleeding profiles compared to the standard 21/7 dosing strategy, few data on comparative pregnancy rates with these regimens are available, reports a new paper on the subject.⁶ In a retrospective analysis, real-world pregnancy rates were lower with

EXECUTIVE SUMMARY

Responses to the 2013 *Contraceptive Technology Update Contraception Survey* indicate that many clinicians have moved to remove one hurdle to contraception by adopting the Quick Start method of method initiation.

- More than 75% of respondents say they use Quick Start to start patients on combined hormonal contraceptives.
- When it comes to prescribing extended or continuous regimen pills, about 57% of 2013 survey respondents say their numbers have stayed the same in the last year, with 35% reporting an increase in use. About 55% of 2012 survey respondents saw increase in such regimens.

84/7 regimens versus 21/7 and 24/4 regimens.⁶ One-year pregnancy rates were significantly lower with 84/7 regimens than with 21/7 regimens (4.4% versus 7.3%; *p* less than .0001) and 24/4 (4.4% versus 6.9%, *p* less than .0001) regimens.

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, is “intrigued but not surprised” by the retrospective analysis’s findings. “In one study of 1.7 million women filling their first pill prescription, we found that women using the three-month products were more likely to refill their prescriptions on time for a year than were women given monthly cycles of pills,” says Nelson. “The convenience of getting supplies may add to the biological ovarian suppression to reduce pregnancy rates.”⁷

Use counseling tips

What are some important talking points to use when discussing extended or continuous methods? According to information presented by Lee Shulman, MD, chief of the Division of Obstetrics and Gynecology-Clinical Genetics and Anna Lapham Professor of Obstetrics and Gynecology at the Northwestern University Feinberg School of Medicine in Chicago, such regimens offer the following advantages and benefits:

- Alleviate menstruation-related conditions.
- May reduce some side effects.
- Offer convenience.
- Require less need for hygiene products.
- Unscheduled breakthrough bleeding might occur, but should lessen over time.⁸

Counsel women to contact you if they experience any of the following, advised Shulman:

- heavy bleeding;
- nausea with vomiting;
- bloating;
- severe headaches;
- mood changes;
- suspect pregnancy.⁸

REFERENCES

1. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC). U.S. Selected Practice Recommendations for Contraceptive Use, 2013: adapted from the World Health Organization selected practice recommendations for contraceptive use, second edition. *MMWR* 2013; 62(RR-05):1-60.
2. ACOG Committee Opinion No. 577: Understanding and using the U.S. Selected Practice Recommendations for Contraceptive Use, 2013. *Obstet Gynecol* 2013; 122(5):1132-1133.

3. Westhoff C, Kerns J, Morroni C, et al. Quick start: novel oral contraceptive initiation method. *Contraception* 2002; 66(3):141-145.
4. Nelson AL. Combined oral contraceptives: update 2012. Presented at the Contraceptive Technology: Quest for Excellence conference. Atlanta; November 2012.
5. Jacobson JC, Likis FE, Murphy PA. Extended and continuous combined contraceptive regimens for menstrual suppression. *J Midwifery Womens Health* 2012; 57(6):585-592.
6. Howard B, Trussell J, Grubb E, et al. Comparison of pregnancy rates in users of extended and cyclic combined oral contraceptive (COC) regimens in the United States: a brief report. *Contraception* 2014; 89(1):25-27.
7. Nelson AL, Westhoff C, Schnare SM. Real-world patterns of prescription refills for branded hormonal contraceptives: a reflection of contraceptive discontinuation. *Obstet Gynecol* 2008; 112(4):782-787.
8. Shulman LP. Extended- and continuous-cycle oral contraception: finding the right choice for the right patient. Presented at the Association of Reproductive Health Professionals Reproductive Health 2013 conference. Denver; September 2013. ■

Pills are still popular with many women

When selecting from the cafeteria of current contraception options, what do women choose? According to results from the 2013 *Contraceptive Technology Update* Contraception Survey, while many women continue to pick combined oral contraceptives (OCs), other options are making inroads on the popular choice. In 2013, about 27% of survey respondents said more than 50% of their patients left using pills, down from 40% in 2012. In contrast, in 2013 about 85% of respondents said use of intrauterine devices and the contraceptive implant had increased.

“I actually do think the number of pill users has gone down,” says **Susan Kilburn**, RN, APRN-BC, a clinician at Southern Nevada Health District Family Planning Clinic — East Las Vegas and Henderson. “Most are moving toward Depo-Provera (Pfizer, New York City) or the intrauterine device for more convenience.”

However, the Pill continues to be a popular choice for many patients. Many younger women still want to try oral contraceptives, even with counseling about long-acting reversible contraceptive methods, says **Karen Albright**, WHNP-BC, lead clinician at Planned Parenthood Southeastern Virginia in Virginia Beach. These women look to setting an alarm on their cell phones to take their pill on time, she says. (*The Bedsider web site, www.bedsider.org, operated by The National Campaign to Prevent Teen and Unplanned Pregnancy, offers a text reminder to help women suc-*

cessfully use their chosen methods. Visit <http://bit.ly/1h8TO42> to set up reminders for the vaginal ring, patch, Pill, or shot.)

The Pill is still the most requested method at Wood County Community Health & Wellness Center in Bowling Green, OH, says clinician **Caroline Strzesynski**, WHNP-BC. The method is considered affordable to patients, because some generics are \$9 at Wal-Mart, Rite-Aid or Kroger. At 100% on the center’s sliding-fee scale, a pack of pills is \$15, making the method generally affordable for women, whether insurance covers it or not, she notes.

The impact of generic oral contraceptives is making an impact on the choices named by clinicians in the annual survey. For the first time in survey history, “other” was named by more respondents than any branded pill for the top pill for young women, whether or not formulary dictates prescribing practice. About 22% named generic choices such as Sprintec, a 35 mcg pill, as well as Apri and Portia, two 30 mcg pill, all from Teva Pharmaceuticals, North Wales, PA, for formulary and non-formulary options.

Loestrin from Teva Pharmaceuticals edged Ortho Tri-Cyclen Lo (Ortho-McNeil Pharmaceutical; Raritan, NJ) as the leading branded pill when it comes to the top non-formulary pill for young women. It also takes the first spot in branded pills when formulary rules dictate which OC to use for this age category.

When it comes to the pill of choice for older women, Alesse (Wyeth, Philadelphia) was named by 29% of readers, dropping its 45% share in 2012. Loestrin 24 FE (Actavis, Parsippany, NJ) was named as second choice; this pill has been replaced by Actavis with Minastrin 24 Fe, a bioequivalent.

Alesse also dominates as the leading option for women who have experienced nausea when using pre-

EXECUTIVE SUMMARY

According to results from the 2013 *Contraceptive Technology Update* Contraception Survey, while many women continue to pick combined oral contraceptives (OCs), other options are making inroads on the popular choice.

- In 2013, about 27% of survey respondents said more than 50% of their patients left using pills, down from 40% in 2012. In contrast, in 2013, about 85% of respondents said use of intrauterine devices and the contraceptive implant had increased.
- The impact of generic oral contraceptives is making an impact on the choices named by clinicians in the survey. For the first time in survey history, “other” was named by more respondents than any branded pill for the top pill for young women, whether or not formulary dictates prescribing practice.

vious pills. About 44% named it as top pill, compared to 55% in 2012.

When it comes to oral contraceptives, budget constraints are leading many clinics to stock more generic pills instead of branded OCs. About 58% say their facilities are using more generic drugs, compared to 2012's 62% reading.

Clinicians continue to hold the line when it comes to prescribing combined pills to older women (40 and above) who smoke 10 cigarettes a day. About 97% said they would withhold OCs from such patients, which is comparable to 2012's 95% statistic. Readers are less emphatic when it comes to women smokers ages 35-39. About 78% said they would not prescribe combined pills to those who smoke 10 cigarettes a day, similar to 2012's 77% figure.

According to the *U.S. Medical Eligibility Guidelines for Contraceptive Use*, use of combined hormonal contraceptives for smokers under age 35 as a "2," which is a condition for which the advantages of using the method generally outweigh the theoretical or proven risks. When it comes to combined OC use for women age 35 or older who smoke less than 15 cigarettes per day, the guidelines list it as a "3," which is a condition for which the theoretical or proven risks usually outweigh the advantages of using the method. For women in the same age range who smoke 15 cigarettes or more per day, the guidelines give a "4" ranking, because the condition represents an unacceptable health risk if the method is used.¹

REFERENCE

1. Centers for Disease Control and Prevention. U.S. Medical Eligibility Criteria for Contraceptive Use. *MMWR* 2010; 59(RR04):1-6. ■

Contraception focus: Combined hormones

The contraceptive vaginal ring (NuvaRing, Merck & Co., Whitehouse Station, NJ) and the contraceptive patch (Evra, Ortho Women's Health & Urology, Raritan, NJ) offer two options for women who choose combined hormonal methods. Results of the 2013 *Contraceptive Technology Update Contraception Survey* indicate that use of both methods is consistent with 2012's figures, with 95% of respondents indicating prescription of rings at their facilities and 70% noting patch use.

"NuvaRing is stocked and available, but we only distribute two rings at a time to those who do not

have insurance and cannot get it with a prescription," states **Dianne Rafferty**, CNP, director of nursing at the Family Planning Association of Northeast Ohio in Painesville. "The response is good but would probably be better if we could distribute more at a time, but cost prohibits."

Clinicians at Planned Parenthood Southeastern Virginia in Virginia Beach don't actually dispense Evra and NuvaRing, but do write prescriptions, reports **Karen Albright**, WHNP-BC, lead clinician. Many patients would love to use NuvaRing, but most insurance companies will cover only contraceptives that have a generic option, she notes. "NuvaRing at a pharmacy is at least \$80 or more per month, and my patients can't afford that," Albright states.

Interest in the contraceptive patch has waned, says **Donna Gray**, CNM, WHNP, a clinician at the Wyoming County Health Department's Men's and Women's Reproductive Health Services in Silver Springs, NY. "Evra was very popular about eight years ago. I use to have cases of it; now only a few women want it," Gray observes. "I think mostly [it is] because it can be seen and it leaves a mark when removed."

According to *Contraceptive Technology*, the weekly contraceptive patch and the monthly vaginal contraceptive rings are effective in clinical trials. Of 1,000 women using the patch or ring, only 12 will become pregnant within a year.¹ Both methods fall in the second tier of contraceptive effectiveness, with higher failure rates than those of intrauterine devices and implants. Neither method requires daily use, which could facilitate consistent and correct use.¹

The New York City-based Population Council is preparing to submit a New Drug Application to the Food and Drug Administration for its investigational one-year vaginal contraceptive ring. The ring contains ethinyl estradiol and the progestin Nestorone. Soft and flexible, this investigational ring may be easily inserted

EXECUTIVE SUMMARY

Results of the 2013 *Contraceptive Technology Update Contraception Survey* indicate that use of the NuvaRing contraceptive vaginal ring and the Evra contraceptive patch is consistent with 2012's figures. More than 90% of respondents prescribe rings at their facilities, and 70% use patches.

- The Population Council is preparing to submit a New Drug Application to the Food and Drug Administration for its investigational one-year vaginal contraceptive ring. The ring contains ethinyl estradiol and the council's proprietary progestin, Nestorone.

- Soft and flexible, this investigational ring may be easily inserted and removed by the woman herself. Each ring is intended to be left in place for 21 days and removed for seven days, for up to 13 cycles (one year).

and removed by the user. Each ring is designed to be left in place for 21 days and removed for seven days, for up to 13 cycles (one year).

Results of one pivotal Phase 3 trial were presented at the October 2013 meeting of the American Society of Reproductive Medicine.² The multicenter, open-label trial involved more than 1,100 healthy, normally ovulating women ages 18-40 across 12 study sites in Australia, Europe, Latin America, and the United States.

Preliminary results suggest the ring is effective in preventing pregnancy when used as directed. Its safety profile is consistent with available combined hormonal contraceptives. Most women experienced regular (scheduled) bleeding during the seven-day period when they were not using the vaginal ring. Reports of unscheduled (irregular) bleeding were infrequent, researchers report. All women participating in the return to fertility study returned to menses within six months after study completion.²

The study also assessed women's acceptance of the ring. Results indicate that women were satisfied with the device, found it easy to use, and would recommend it to other women.²

If approved by regulatory authorities, this investigational ring would offer a unique contraceptive option to women who want to limit or delay pregnancy, says **Ruth Merkatz**, PhD, director of clinical development for the Population Council's Reproductive Health Program. This long-acting reversible contraceptive method is intended to not require refrigeration, and it does not require insertion or removal by a healthcare professional, she notes. It is designed to be under the woman's control, and therefore, could be well-suited for women in low-resource settings who want contraception but very often are unable to obtain it. "In these settings, women often lack convenient access to a healthcare facility or pharmacy, and live in areas where access to reliable electricity is a challenge," state Population Council researchers.

The Population Council also is studying the acceptability of a three-month progesterone vaginal ring in low-resource settings to understand what women and their providers think about the method. The ring, which uses natural progesterone, is approved for breastfeeding women in eight Latin American countries as a safe and effective method for spacing pregnancies. According to the World Health Organization, spacing pregnancies is an important strategy to promote the health of postpartum mothers and their children.³

"Our mission is to develop and help expand access to contraceptive technologies where high-quality, voluntary family planning services are scarce or non-existent," said **Peter Donaldson**, Population Council

president in a statement accompanying the study presentation. "The council's one-year contraceptive vaginal ring is a promising new technology; we look forward to furthering its development to meet the needs of underserved women."

REFERENCES

1. Nanda K. Contraceptive patch and vaginal contraceptive ring. In: Hatcher RA, Trussell J, Nelson AL, et al. *Contraceptive Technology*: 20th revised edition. New York: Ardent Media; 2011.
2. Merkatz R, Hoskin E, Sussman H, et al. Efficacy, safety and acceptability of a new contraceptive vaginal ring delivering Nestorone (150 mcg) and ethinyl estradiol (15 mcg) daily: results from a multi-center open label Phase 3 clinical trial. Presented at the 69th annual meeting of the American Society of Reproductive Medicine. Boston; October 2013.
3. World Health Organization. Programming strategies for postpartum family planning. Accessed at <http://bit.ly/MBPjBl>. ■

Add screening for violence by intimate partners

Intimate partner violence (IPV) and reproductive and sexual coercion disproportionately affect women.¹

According to the Family Violence Prevention Fund (now Futures Without Violence), intimate partner violence (IPV) "is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. [Such] types of behavior are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and is aimed at establishing control of one partner over the other."²

Check the following statistics:

- About one in four women has been physically and/or sexually assaulted by a current/former partner.³
- Nearly half (45.9%) of women experiencing physical abuse in a relationship also disclose forced sex by their intimate partner.⁴
- In one sample, one in four women reported lifetime coerced sex; among women reporting coerced sex, more than one-third were 15 years old or younger at the time of their first coerced sexual experience.⁵

The Affordable Care Act (ACA) offers coverage for screening and counseling for interpersonal and domestic violence without requiring a copayment, coinsurance, or deductible. The Department of Health and Human Services has adopted guidelines for women's preventive health services to help ensure that women can receive these services.

More emphasis for IPV screening came in 2013, when the U.S. Preventive Services Task Force released a recommendation stating that “clinicians screen women of childbearing age for intimate partner violence (IPV) such as domestic violence and provide or refer women who screen positive to intervention services.”⁶

Jacquelyn Campbell, PhD, RN, FAAN, professor and Anna D. Wolf Chair in the Johns Hopkins University School of Nursing in Baltimore, is a national leader in research and advocacy in the intimate partner violence field. She says that those who have been working to improve the healthcare system response to women who are abused by partners are “extremely excited” that the Affordable Care Act provides for routine screening for IPV to be covered by insurance as part of the “well woman” visit.

“Without knowledge of current or recent IPV, providers cannot accurately diagnose and adequately treat health problems such as chronic pain, insomnia, or depression,” notes Campbell. “IPV is a risk factor that increases the chances of a women experiencing those health problems; by knowing about IPV and helping the woman figure out how to get safer and be put in touch with experts that can help with that, the provider can help prevent or lessen the severity of these health conditions and others like them that are associated with violence.”

The “well woman visit” is part of the new emphasis on preventive healthcare to help decrease the high costs of healthcare for severe, debilitating chronic conditions later, notes Campbell. With ACA coverage in place for IPV screening, there have been renewed calls to routinely screen for IPV in other health settings such as prenatal care, emergency departments, and urgent care, Campbell notes. *(To get up to speed on IPV screening, use the online Health Cares about IPV Screening Toolkit developed by Futures Without Violence. It offers tools to address domestic and sexual violence and strategies for forging partnerships with violence programs. Go to <http://bit.ly/1gzEpoQ>.)*

Family planning providers, who treat young women of reproductive age, need to familiarize themselves with intimate partner violence. College-age women (ages 18-25) are at high risk for dating violence, but they tend to seek services such as domestic violence advocacy programs at rates lower than older adults. It is estimated that one of five college females will experience some form of IPV during her college career.⁵

Young women are more likely than older women to look to their peers or to technology as a forum for accessing information about dating violence and safety resources, such as a dating violence hotline, says **Nancy Glass**, PhD, MPH, RN, FAAN, a professor in the Baltimore-based Johns Hopkins University School of

Nursing and associate director of the Johns Hopkins Center for Global Health. A smart phone application, One Love MyPlan, can be downloaded for free using iTunes or Google Android and is password protected. *(Go to the One Love Foundation website, <http://bit.ly/MOFz6E>, for links.)*

MyPlan is a safety decision aid for young women who are concerned about a partner’s controlling behavior and/or are experiencing physical/sexual violence or threats of violence in a dating or intimate relationship. It assists young women in assessing the danger in their abusive relationship, says Glass. It also helps set priorities for safety.

“Based on the young woman’s assessment and safety priorities, a safety plan is provided with suggested safety strategies personalized to her level of danger and highest priorities for safety,” states Glass. “These personalized strategies are then linked to national and state-level community advocacy, health, legal, and/or police resources depending on danger level and safety priorities.”

Once a young woman uses MyPlan, she can receive information by calling or chatting anonymously with a trained advocate. The safety plan also might provide suggestions for safely reaching out to friends, family, college administrators, or other trusted people for help and support, says Glass. The woman, using her secured password, can access MyPlan once downloaded to the smartphone, anytime. As dating relationships are dynamic, she might want to revise her danger assessment and safety priorities resulting in an updated personalized safety plan and/or learn about new strategies for safety, she explains.

Young women are likely to look to their peers for accessing safety resources, and peers report not having confidence in providing the support requested. Another feature of MyPlan is that friends — male or female — who are concerned about a friend’s safety in a dating relationship can download MyPlan app to their smartphone. The friend’s component of the MyPlan app will

EXECUTIVE SUMMARY

Intimate partner violence (IPV) and reproductive and sexual coercion disproportionately affect women. Such behavior is aimed at establishing control of one partner over the other.

- The Affordable Care Act offers coverage for IPV screening and counseling without requiring a copayment, coinsurance, or deductible.
- The U.S. Preventive Services Task Force released a 2013 recommendation calling for clinicians to screen women of childbearing age for IPV. Women who screen positive should be provided or referred to intervention services.

step the friend through a process to assess the danger in their friend's relationship and set priorities for safety, says Glass. The assessment and safety priorities will be used to develop a personalized plan with strategies to provide support and help to their friend.

"For example, the safety plan may provide examples of how to safely and respectfully bring up the concerns they have about the friend's partner and relationship," explains Glass. "The plan may include national and state advocacy resources that they can use to learn more about dating violence, [or] seek advice on how to support their friend and/or provide to their friend, such as dating violence hotline or campus support groups."

The MyPlan app can be accessed, once downloaded, at any time by the friends using their passwords, if they want to revise the assessment and safety priorities and receive an updated safety plan to use to support their friends, notes Glass.

"The MyPlan app is not a replacement for seeking resources and support through trained service providers, such as advocates, healthcare providers, college/university administrators," states Glass. "MyPlan is a resource that can help young women and their friends as they are struggling with understanding what is happening in the relationship and learn that there are resources and options for support/help to increase safety ... They are not alone."

REFERENCES

1. Chamberlain L, Levenson R. Addressing Intimate Partner Violence, Reproductive And Sexual Coercion: A Guide For Obstetric, Gynecologic And Reproductive Health Care Settings. Third edition. Washington, DC: American College of Obstetricians and Gynecologists; San Francisco (CA): Futures Without Violence; 2013.
2. Family Violence Prevention Fund. Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion. San Francisco: Family Violence Prevention Fund; 2010.
3. Breiding MJ, Black MC, Ryan GW. Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005. *Am J Prev Med* 2008; 34(2):112-118.
3. Campbell JC, Soeken KL. Forced sex and intimate partner violence: effects on women's risk and women's health. *Violence Against Women* 1999; 4:1017-1035.
4. Stockman JK, Campbell JC, Celentano DD. Sexual violence and HIV risk behaviors among a national representative sample of heterosexual American women: the importance of sexual coercion. *JAIDS* 2010; 53(1):136-143.
5. Krebs CP, Linnquist CH, Warner TD, et al. College women's experiences with physically forced, alcohol- or other drug-enabled, and drug-facilitated sexual assault before and since entering college. *J Am Coll Health* 2009; 57(6):639-647.
6. Moyer VA; U.S. Preventive Services Task Force. Screening for inti-

mate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2013; 158(6):478-486. ■

CNE/CME OBJECTIVES & INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below or log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you instantly.



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

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

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511

Fax: (800) 284-3291

Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer

Phone: (800) 688-2421, ext. 5482

Fax: (800) 284-3291

Email: tria.kreutzer@ahcmedia.com

Address: AHC Media
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com

Website: www.copyright.com

Phone: (978) 750-8400

Fax: (978) 646-8600

Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

CNE/CME QUESTIONS

- What is the labeled length of use for the contraceptive implant Nexplanon?
 - Three years
 - Five years
 - Seven years
 - 10 years
- According to the U.S. Medical Eligibility Guidelines For Contraceptive Use, the copper T380A IUD and the levonorgestrel IUD receive what rating for women with a past history of PID and a subsequent pregnancy?
 - 1: no restrictions on use
 - 2: advantages generally outweigh theoretical/proven risks
 - 3: theoretical/proven risks generally outweigh advantages
 - 4: unacceptable health risk
- According to the U.S. Selected Practice Recommendations for Contraceptive Use, 2013, which situation is NOT a sign that a provider can be reasonably certain that a woman is not pregnant?
 - Has not had intercourse since last normal menses
 - Has been correctly and consistently using a reliable method of contraception
 - Is within eight or nine days after the start of normal menses
 - Is within four weeks postpartum (non-lactating)
- What is the progestin found in the investigational contraceptive vaginal ring under development by the Population Council?
 - Desogestrel
 - Levonorgestrel
 - Gestodene
 - Nestorone

COMING IN FUTURE MONTHS

- Study disputes value of routine mammograms
- First guidelines issued to prevent strokes in women
- Abortion rates dip to lowest since 1973
- Cervical cancer screening & HPV vaccine -- what women need to know

EDITORIAL ADVISORY BOARD

Chairman:

Robert A. Hatcher, MD, MPH

Senior Author, Contraceptive Technology
Professor of Gynecology and Obstetrics
Emory University School of Medicine, Atlanta

David F. Archer, MD
Professor of OB/GYN
The Jones Institute for Reproductive Medicine
The Eastern Virginia Medical School
Norfolk

Anita L. Nelson, MD
Professor, OB-GYN
David Geffen School of Medicine
University of California, Los Angeles

Kay Ball, RN, PhD, CNOR, FAAN
Perioperative Consultant/Educator
K&D Medical
Lewis Center, OH

Michael Rosenberg, MD, MPH
Clinical Professor of OB/GYN and Epidemiology
University of North Carolina
President, Health Decisions
Chapel Hill

Melanie Deal, MS, WHNP-BC, FNP
Nurse Practitioner
San Francisco State University Student Health Services
San Francisco

Wayne Shields
President & CEO, Association of Reproductive Health Professionals
Washington, DC

Linda Dominguez, RNC, WHNP
Clinical Consultant
Southwest Women's Health
Albuquerque, NM

James Trussell, PhD
Professor of Economics and Public Affairs
Director
Office of Population Research
Princeton (NJ) University

Andrew M. Kaunitz, MD
Professor and Associate Chairman
Department of OB/GYN
University of Florida College of Medicine
Jacksonville

David Turok, MD, MPH
Associate Professor
Department of Obstetrics and Gynecology
University of Utah
Salt Lake City

Susan Wysocki, WHNP-BC, FAANP
President & CEO
iWomansHealth
Washington, DC

Contraceptive Technology Update is endorsed by the National Association of Nurse Practitioners in Women's Health and the Association of Reproductive Health Professionals as a vital information source for healthcare professionals.

