A MINI-GUIDE TO

Contraceptive Care During COVID-19

essential access health

shaping the future of sexual + reproductive health care™

introduction + acknowledgements

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

The spread of the coronavirus COVID-19 has created widespread and unprecedented challenges for our health care delivery system. As a result, providers have had to rapidly adapt and innovate to transform their health systems and service delivery models. This Mini-Guide was created by **Essential Access Health** to support the delivery of quality contraceptive care during the COVID-19 public health emergency and beyond.

Mini-Guide contents have been adapted from a webinar conducted live on April 21, 2020 by Erin Saleeby, MD, MPH, Medical Director at Essential Access and Director of Women's Health Programs + Innovation for the Los Angeles County Department of Health Services; and Jennefer Russo, MD, MPH, Vice Chair of Clinical Affairs, Department of Obstetrics and Gynecology at Harbor-UCLA Medical Center; Associate Professor, University of California, Irvine.

- **Listen to a recording of the webinar here**
- **Webinar slides can be found here**

Designed as a quick-start companion to the webinar, the Mini-Guide contains practical case studies, associated clinical considerations and active links to helpful resources throughout.

Additional resources and learning opportunities can be found through our **Learning Exchange** and on **Telehealth Essentials for Sexual + Reproductive Health Care**.

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- The California Endowment
- The California Health Care Foundation
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case study #1

Case Study #1: Remote Initiation + Continuation of Contraception

- 31 year old G2P2 has telephone visit scheduled for contraception initiation consultation
- She had a normal vaginal delivery 4 months ago
- She is not breastfeeding and has a history of thyroid disease
- She has used the implant and pills in the past
- She is interested in using the contraceptive ring

Clinical Considerations – Step 1: Determine if your patient is pregnant by asking…

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

A health care provider can be reasonably certain that a woman is NOT pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- Is ≤7 days after the start of normal menses
- Has not had sexual intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is ≤7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

If you are reasonably certain the woman is NOT pregnant, you can quick start the birth control method

- The woman should also be instructed to take a home pregnancy test in 2-3 weeks
- **If the test is positive,** she should discontinue the method and be seen as soon as possible in person
  - There is no evidence that any hormonal method of contraception is teratogenic if taken during an ongoing pregnancy

Clinical Considerations – Step 2: Screen for contraindications to estrogen-containing methods…

- Smoker + Age >35
- History of MI, stroke, heart disease or diabetes
- Migraines with aura (any age)
- History of DVT/PE
- Hypertension
- Should have BP prior to prescribing estrogen-containing methods
- Contraindications can be any time in last 3-12 months

Clinical Considerations – Step 3: Evaluate possibilty of other medical disorders….

You *must* check CDC US Medical Eligibility Criteria (US MEC), however these disorders are *not always* contraindicated.

- Liver disease
- Gallbladder disease
- Breast cancer
- Elevated cholesterol
- Medications for seizure disorders, tuberculosis or HIV

Additional Information about Case #1:

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

Clinical Considerations – Step 4: Continuation of Hormonal Contraception

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

Tips + Resources

- CDC US Medical Eligibility Criteria (US MEC)
  https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
- CDC US MEC Free App
  https://www.cdc.gov/mobile/mobileapp.html#M
- ACOG FAQ About COVID
  https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics
  ACOG has made their COVID and Telehealth resources freely available. These include continuously updated algorithms, workflows, care navigation aids and other important resources.

Case Study #2: Medication Abortion + Initiation of Contraception

- 35 year old G2P1 just took her pills for medication abortion calls you with a question about when she can start her pill

Clinical Considerations: Starting contraception in conjunction with abortion…

- Any contraception can be initiated at the time of medication abortion **except for IUD**:
  - Combined hormonal contraceptive can be started same day as misoprostol
  - Implant can be started the same day as mifepristone
  - Depo-provera can be started same day as mifepristone
  - Progestin-only pill can be started the same day as misoprostol
- IUD can be started once patient is no longer pregnant.
- Any contraceptive method can be initiated at the time of aspiration abortion

Advanced provision of Emergency Contraception pills is appropriate at the time of abortion.

Tips + Resources

- U.S Selected Practice Recommendations for Contraceptive Use, 2013
  https://www.cdc.gov/mmwr/pdf/rr/rr62e0614.pdf
- Reproductive Health Access – Mifepristone/Misoprostol Abortion Protocol
  https://www.reproductiveaccess.org/wp-content/uploads/2014/12/mifepristone_protocol.pdf

[If patient is also initiating contraception virtually, please refer back to Case Study #1.]

case study #3

Case Study #3: Long Acting Reversible Contraceptives (LARCs)

Patient A: IUD Removal

- 25 year old G3P3 calls for an appointment to remove and replace IUD “because it has been 5 years”

Clinical Considerations: Extended LARC use

- Based on ongoing clinical studies, many LARCs are actually effective longer than stated on the package insert
  - It is now known that Liletta and Mirena can be effective up to 7 years, Nexplanon up to 5 years, and Paragard 12 years and possibly up to 20 years
- If a patient wants their IUD removed but an office visit is not possible, patient can be counseled in self-removal. Once removed, they should inspect the IUD to make sure it is intact. Light spotting or cramping is normal. Contact care immediately if there is severe pain, cramping or bleeding.

Patient B: LARC Initiation

- 19 year old G1P0 calls about a LARC but is concerned about coming to clinic because of COVID

Clinical Considerations: Bridge method for immediate pregnancy prevention

- Educate the patient about precautions that are in place to address the risk of COVID
- If patient still does not want to come in, offer to prescribe a “bridge method” (combined hormonal method-pill, patch, ring) which can be called into the pharmacy until they can come in

Tips + Resources

- National Institute for Reproductive Health – Increasing Access to LARC
  https://www.nirhealth.org/wp-content/uploads/2019/03/NIRH_BWH_TOOLKIT.pdf

Case Study #4: – Self-Administered Subcutaneous Depo Medroxyprogesterone Acetate (SubQ Depo/DMPA)

- 21 year old G1P1 is due for DMPA but isn't excited about coming to visit the clinic in the time of COVID

Clinical Considerations: Acceptability of self-administered SubQ Depo

- A study by Kohn et al. showed increased continuation of DMPA at one year among the self-administration group compared to clinic group in a randomized controlled trial at Planned Parenthood
  - Patients in the self-administration group reported self-administration was very or somewhat easy
  - Additionally, 52% of the clinic group would be interested in self-administration
  - Reasons for interest include not having to return to clinic for injection and cost-savings

Clinical Considerations: Counseling on how to use SubQ Depo

- Do not refrigerate, should be at room temperature
- Medicine should be white in color with no particles floating inside
- Place needle (with safety shield) on prefilled syringe
- Clean area on abdomen or upper thigh with alcohol pad
- Let skin dry, then give injection at a 45 degree angle
- Dispose of needle in sharps container
- Apply pressure to the spot

Tips + Resources

- Contraception. 2018 Mar;97(3):198-204. doi: 10.1016/j.contraception.2017.11.009. Epub 2017 Dec 12 https://www.ncbi.nlm.nih.gov/pubmed/29246818

case study #5

Case Study #5: Emergency Contraception

- 32 year old G2P1011 calls clinic stating she had unprotected intercourse 2 days ago and she is worried about becoming pregnant
- Patient is a smoker and has cHTN. LMP 1 week ago. Weight 167 lbs
- Only reported contraception is intermittent condom use

Clinical Considerations: Initiating Emergency Contraception (EC)

- Ulipristal acetate (UPA) 30mg: Anti-progestin. Taken as soon as possible but within 120 hours after unprotected intercourse. 85% effective. Less effective in people with weight greater than or equal to 195 lbs—consider an IUD in those patients.
- Levonogestrel (LNG) 1.5mg: Progestin. Taken as soon as possible - preferably within 72 hours - but within 120 hours after unprotected intercourse. 75-89% effective. Likely not effective in people with weight greater than or equal to 155 lbs—consider UPA or an IUD in those patients.
- Copper IUD: May be inserted up to five days after unprotected intercourse. 99% effective. May be used as continuing contraception.

Clinical Considerations: Initiation of hormonal contraception after EC use

- If using Copper IUD for EC and ongoing contraception, no backup method is necessary
- If patient is taking EC prior to starting progestin-containing method:
  - Birth control method should not be resumed prior to 6 days after UPA
  - If LNG given, the method may be started immediately (use a back-up method for 7 days)

Tips + Resources

- Bedsider.org – Does Body Weight Change How Effective EC Is? https://providers.bedsider.org/articles/does-body-weight-change-how-effective-ec-is

additional resources

- ACOG FAQ About COVID
  https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics
- CDC MEC
  https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
- IUD Self-Removal
  https://vimeo.com/211761364
- SubQ Depo Self-Administration
  https://www.bedsider.org/features/789-depo-subq-the-do-it-yourself-birth-control-shot
- RN Prescribing
  https://www.guttmacher.org/state-policy/explore/nurses-authority-prescribe-or-dispense
- Pharmacist Prescribing
  https://www.bedsider.org/features/1192-can-pharmacists-really-prescribe-birth-control
- Telehealth Essentials for Sexual + Reproductive Health Care
  https://www.essentialaccess.org/programs-and-services/telehealth-essentials
- Essential Access Health Learning Exchange
  https://www.essentialaccess.org/learning-exchange