

KAHF: Birth Control Potpourri!!

Contraception & Sexual Health

Drs. Brittany Badal and Mandakini Sadhir

In Kentucky the birth rate in 2023 was 20.2 teen births per 1000 adolescent females, this is higher than the national teen birth rate of 13.3. Many counties have Teen birth rates 2-3 times higher than the State. As the primary physicians for many adolescents throughout the state it behooves us to feel comfortable addressing this need for adolescents in our communities.

Taking a Sexual Health History

- Supporting sexual health and exploration in a safe, confidential, non-judgmental and inclusive environment is important for adolescent health and development
- Offer empathy and positive feedback, and display a willingness to discuss contraception.
- Utilize the 5 Ps” to obtain sexual history: partners, practices, protection from STIs, past history of STIs, and pregnancy intention.
- Help adolescents/young adults identify their risk behaviors and consider whether these behaviors reflect their goals and aspirations, which may involve delaying pregnancy.
- Offer support for their efforts, highlight their strengths and ability to change their behavior.
- Guide adolescents in selecting contraception appropriate for them.
- Roll with resistance, avoid confrontation and follow up

Contraception

- Centered on what values and characteristics are important to the patient i.e. is it important to have predictable bleeding vs no bleeding; daily administration vs long acting methods?
- Highlight the role of condoms for STI prevention throughout your discussion of contraceptive methods.
- Consider using a visual tool like [Bedsider.org](https://bedsider.org) ; [Birth control methods chart](#) ; [Reproductive Health Access Project’s “Your Birth Control Choices Fact Sheet,”](#) or [Pharmacy Access Forms Provider Toolkit.](#)

Combined Hormonal Contraception methods (Pill, Patch, Vaginal Ring)

Ensure no contraindication to estrogen- consider migraine with aura, hypertension, VTE risk

Discuss options for administration - daily, weekly, monthly

Pros: Can help menorrhagia, dysmenorrhea, acne, PMDD; May be protective against endometrial and ovarian cancer

Cons: Nausea, Low libido, Breast tenderness

Patch: May have risk of skin irritation; Vaginal ring- Vaginal irritation

Pills – Consider starting estradiol dose of 30-35 microgram

Progestin Only Pills

(Mini-pill- norethindrone 0.35mg, "O-pill" - 0.075 mg norgestrel; Slynd- drospirinone 4mg daily)

- Do not have estrogen thus may be safer choice for patients in history of conditions with a contraindication to estrogen
- Opill and Norethindrone mini pill
 - Do not consistently suppress ovulation; need to be taken within same 3 hour time window daily
 - It is dispensed in packs of 28 active pills, which are taken continuously (ie, no pill-free or nonhormonal pill week)
- Side effects: Unscheduled bleeding and menstrual changes, follicular cysts are more common in POP users than in those not using hormones

Nexplanon

A small, thin, implantable progestin-only hormonal contraceptive that is effective for at least 3 years

- 99.95% effective
- Primary Mechanism: suppression of ovulation

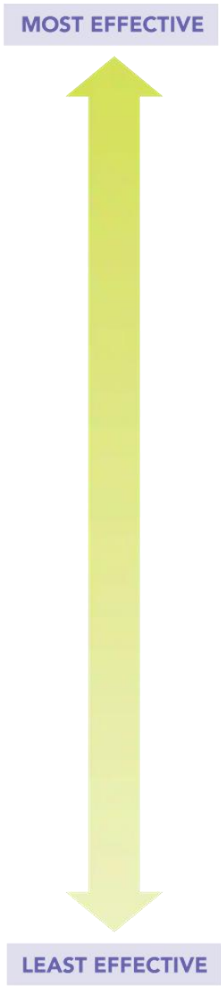
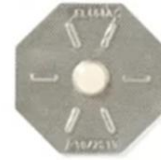
- Bleeding is unpredictable on this method
- Many women have fewer days of bleeding, but about 1/5 have more
- Primary reason for early discontinuation
- Does not appear to affect bone density

IUDs- Mirena (Levonorgestrel 20 mcg/day) vs Kyleena (Levonorgestrel 17.5 mcg/day)

- Primary Mechanism: thickens cervical mucus, inhibition of sperm motility and function
- 99.8% effective
- FDA-approved for heavy menstrual bleeding & contraception
- Reduces menstrual bleeding by 90%
- Effective for 5 to 7 years

DMPA (Depo-Provera)

- Long-acting progestin that is injected every 3 months
- Advantages include easy use, reduction of uterine bleeding, and improvement in dysmenorrhea.
- Disadvantages include the need for regular injections and menstrual cycle irregularities that occur in nearly all patients initially but typically improve over time.
- Potential side effects include headache, mastalgia, hair loss, change in libido, and weight gain.
- Weight gain status at 6 months after initiation is a strong predictor of future excessive weight gain with ongoing DMPA use.
- In 2004, the FDA issued a “boxed warning” regarding the risk of decreased bone mineral density (BMD) among DMPA users. The ACOG, citing substantial recovery of BMD after discontinuing DMPA, does not advise limiting the duration of DMPA use nor routinely monitoring bone density but does recommend a shared decision-making approach.
- It is good practice to include counseling to promote skeletal health, including meeting recommended daily intake of 1300 mg of calcium and 600 IU of vitamin D, and regular weight-bearing exercise.



The Implant
 Inserted by HCP under skin of upper arm for up to 3 years

IUD (Hormonal)
 Inserted in uterus by HCP for up to 3 – 7 years

IUD (Non-hormonal)
 Inserted in uterus by HCP for up to 10 years

Sterilization for men & women
 Procedure performed by HCP for both men and women to prevent pregnancy permanently unless it is reversed.

Less than 1 pregnancy per 100 women in a year

The Shot
 Injected by your HCP every 3 months in your buttock or upper arm

The Pill
 Taken by mouth every day

The Patch
 Applied weekly to belly, upper outer arm, buttock, or back

The Ring
 Inserted vaginally every month

Diaphragm
 Inserted vaginally every time you have sex

6-12 pregnancies per 100 women in a year

Condoms
 Worn by men & women

Withdrawal
 Man removes penis from vagina before ejaculation

Sponge
 Inserted vaginally

Fertility Awareness
 Requires consistent tracking of fertility signs

Spermicide
 Inserted vaginally

18 or more pregnancies per 100 women in a year

Must be used every single time you have sex