

# CONTRACEPTION FOR WOMEN WITH SUBSTANCE ABUSE - CONDOMS ARE NOT ENOUGH!



DR ANDREA LEE  
ACTING SMO (HK CLUSTER MCHC)  
FAMILY HEALTH SERVICE, DEPARTMENT OF HEALTH  
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# OUTLINE

1. Facts, myths & statistics about contraception in women with substance abuse
2. Family planning
3. Ideal contraception
4. Different contraception methods + Video sharing
5. Two case scenarios
6. What social workers can do

# CONTRACEPTIVE USE IN WOMEN WITH SUBSTANCE ABUSE (SA)

Most are in their reproductive age

BUT

Only <50% of women have some form of contraception

Contraceptive use and method choice among women with opioid and other substance use disorders: A systematic review. [Prev Med. 2015 Nov; 80: 23–31.](#)

## MYTHS AND BELIEFS

- 冇咁好彩
- 冇諗後果
- Unhealthy lifestyle → 唔會有
- Substance abuse → 唔會有
- Perceived side effects of hormonal contraception/ intrauterine device

Insufficient motivation to avoid pregnancy

IRREGULAR MENSE → 唔會有

WRONG!

- Menstrual cycle varies in different individuals and according to your body condition
- Ovulation = chance of pregnancy

COITUS INTERRUPTUS (體外射精) → 唔會有

WRONG!

- Pre-ejaculation fluid contains sperms and can cause pregnancy

INTERCOURSE DURING MENSTRUATION → 唔會有

WRONG!

- Since sperms can live up to 5 days in a woman's body, one may get pregnant if she ovulates soon after menstruation.

SAFETY PERIOD → 唔會有

WRONG!

- High failure rate
- Exact date of ovulation varies even if you have regular menstrual cycles



VAGINAL DOUCHING AFTER INTERCOURSE → 唔會有

WRONG!

- No evidence to prove its efficacy

## SAD BUT TRUE...

- Trade sex for drugs especially cocaine
- Condoms – less money
- Avoid negotiation
- Condoms – fear that partner would leave
- Condoms – easier access than other contraceptive methods

Condom is the only  
contraception that  
can prevent STDs  
(encourage dual  
method)

## SOME STATISTICS OF WOMEN WITH SA

- ↓ use of contraception
- ↑ unwanted pregnancies and abortions
- ↑ sexually transmitted diseases
- Pregnancy
  - ↑ placental abruption [OR 2.53]
  - ↑ preterm delivery [OR 2.63]
  - ↑ stillbirth [OR 2.54] & neonatal death [OR 2.92]
  - ↑ low birth weight
- ↑ children in out-of-home care

## SOME STATISTICS OF WOMEN WITH SA

- Women with SA other than cannabis were 3.5 times more likely than other women to report an unintended pregnancy
- 86% of women of 202 Australian women in opioid substitution treatment reported a previous pregnancy
- 47% of women had their first pregnancy occurred before 18 years old

(Only 15.8% of all pregnancies was intended)

Improving Access to Long-Acting Contraceptive Methods and Reducing Unplanned Pregnancy Among Women with Substance Use Disorders. Subst Abuse. 2016; 10(Suppl 1): 27–33.

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# FAMILY PLANNING

- Ensuring access to preferred contraceptive methods
- Securing the well-being and autonomy of women
- Supporting the health and development of the community

# FAMILY PLANNING IN WOMEN WITH SA

- ↓ unintended pregnancies
- Autonomy
- ↓ emotional and economic strain
- ↑ time and energy for personal development and societal role, including paid employment

# OUTLINE

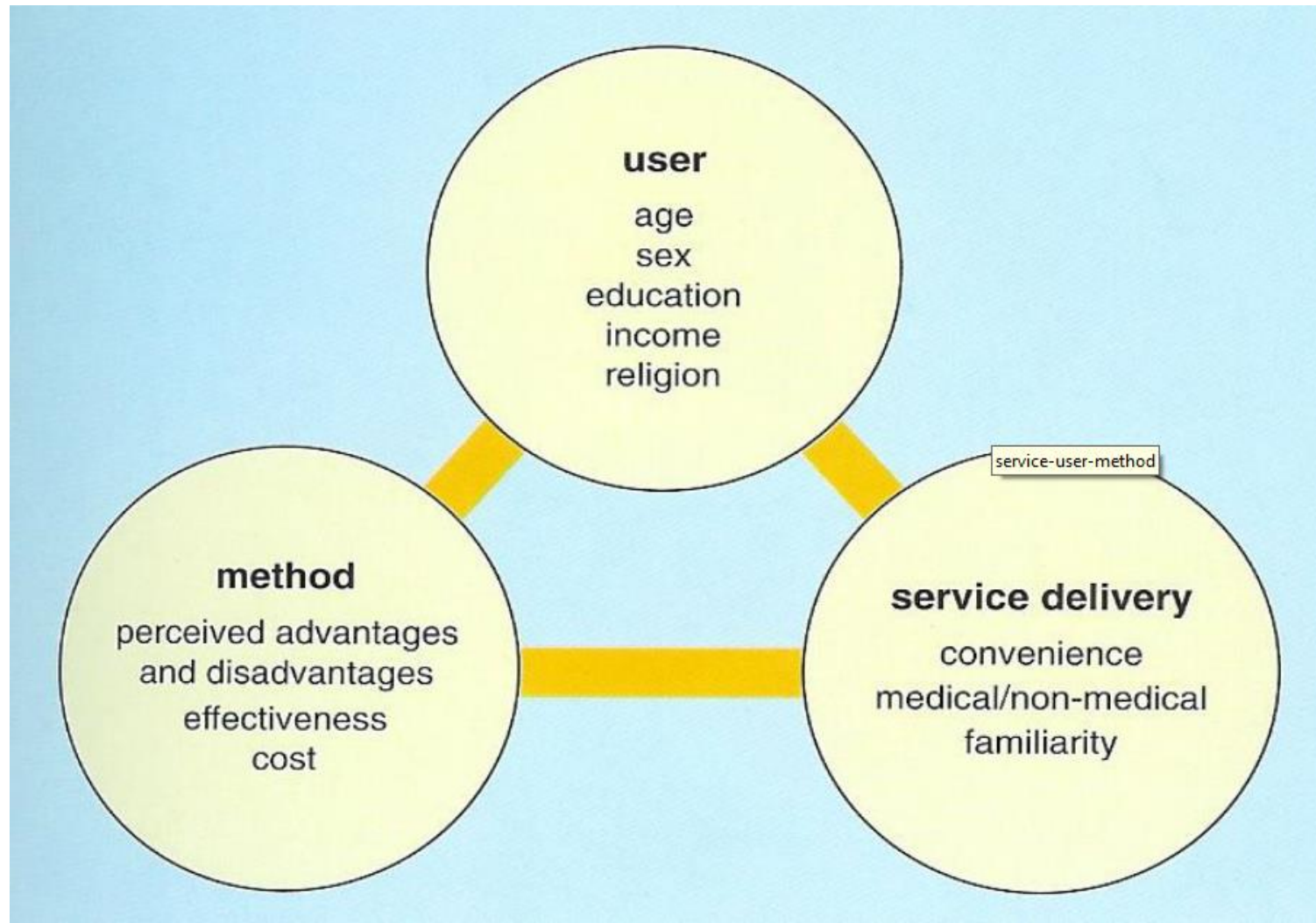
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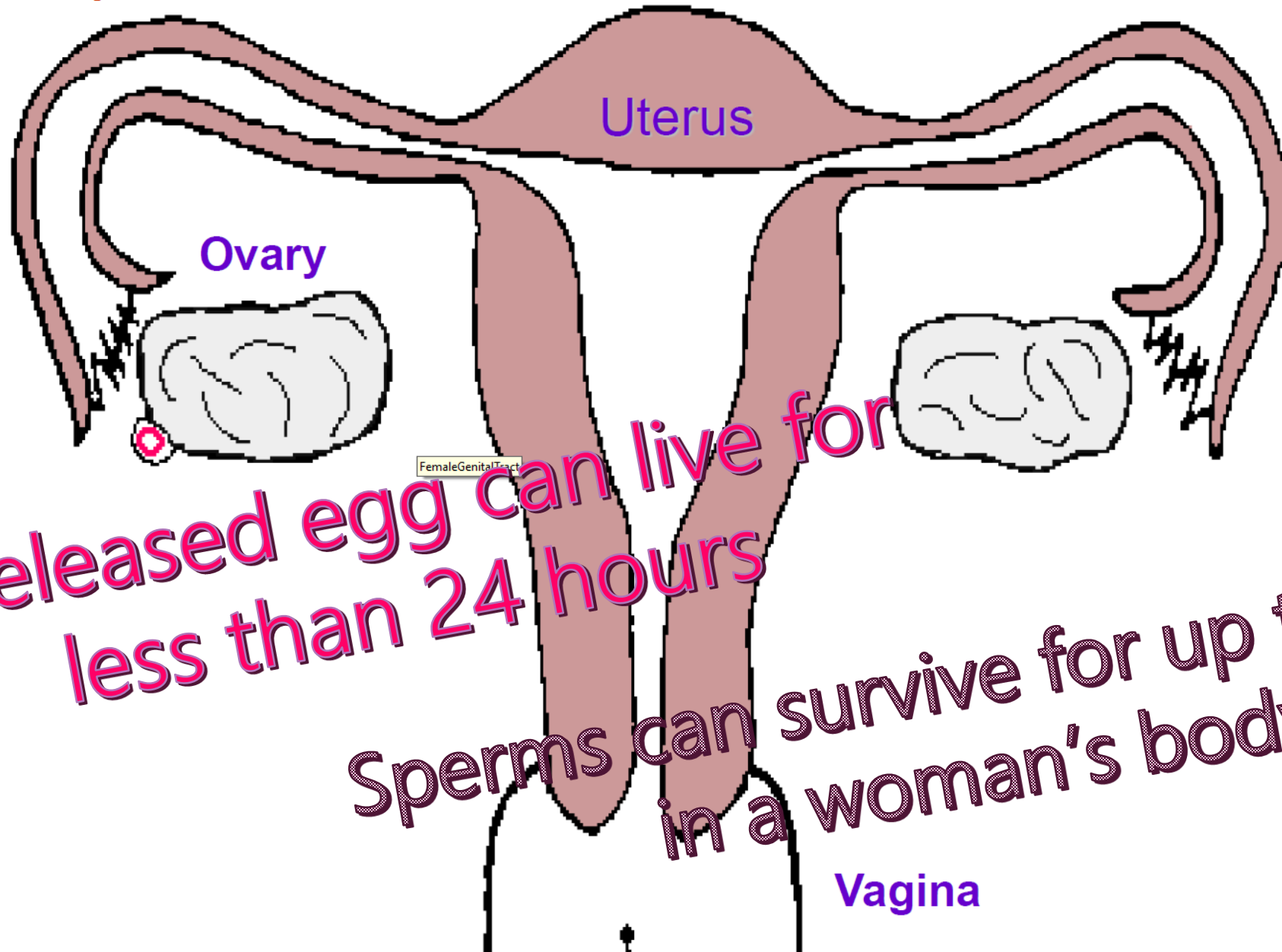
# WHAT ARE THE FEATURES OF AN IDEAL CONTRACEPTIVE?

- 100% effective
- 100% convenience (non-coital related)
- 100% reversible
- 100% safe
- 100% maintenance-free (i.e. no need medical supervision)
- 100% protective against sexually transmitted diseases
- Acceptable (culture, religion and personal)
- Affordable
- Non-contraceptive benefits
- No side effects

# THE IDEAL CONTRACEPTIVE DOES NOT EXIST



## Fallopian Tube

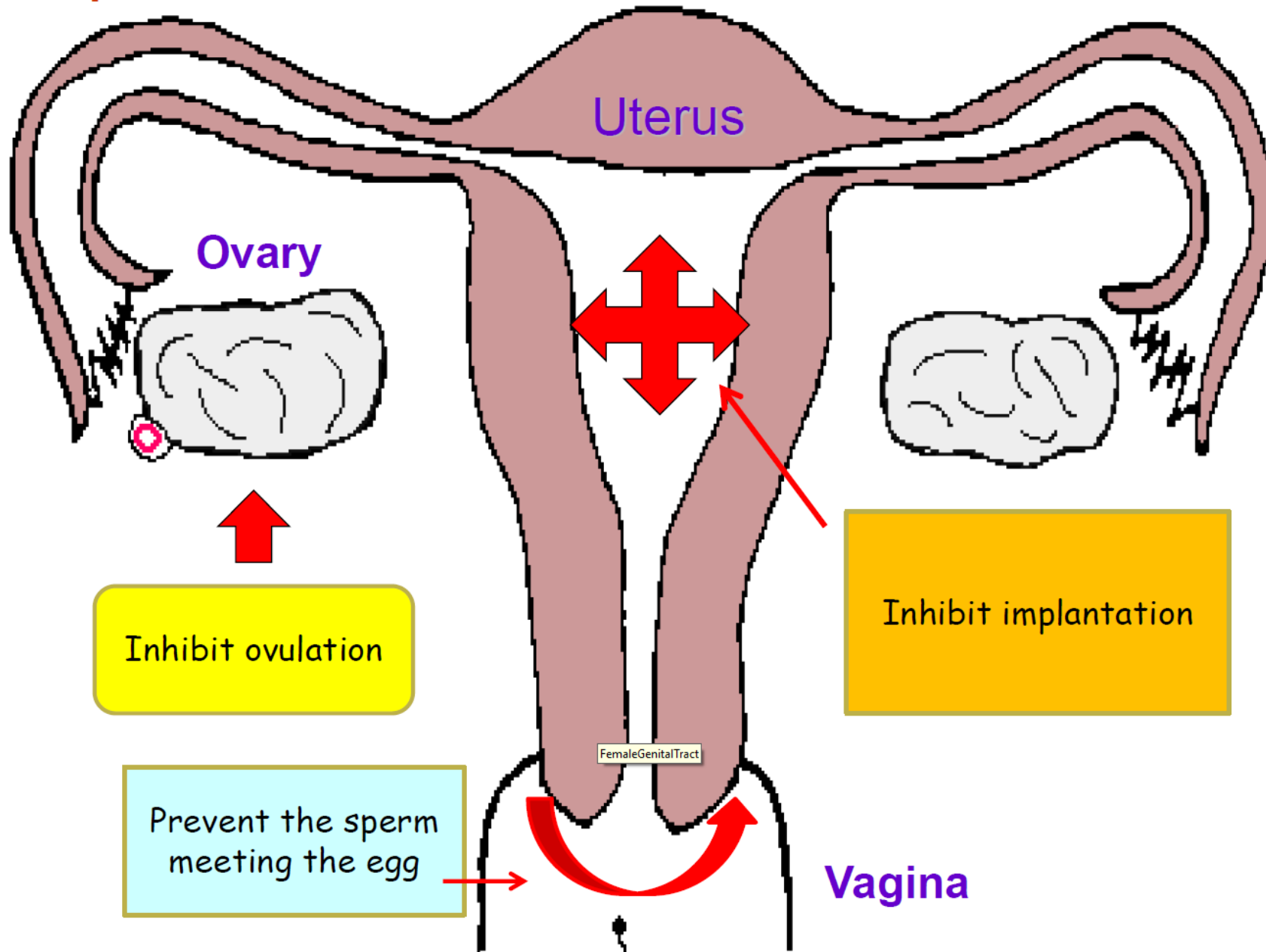


A released egg can live for  
less than 24 hours

Sperms can survive for up to 5 days  
in a woman's body

Vagina

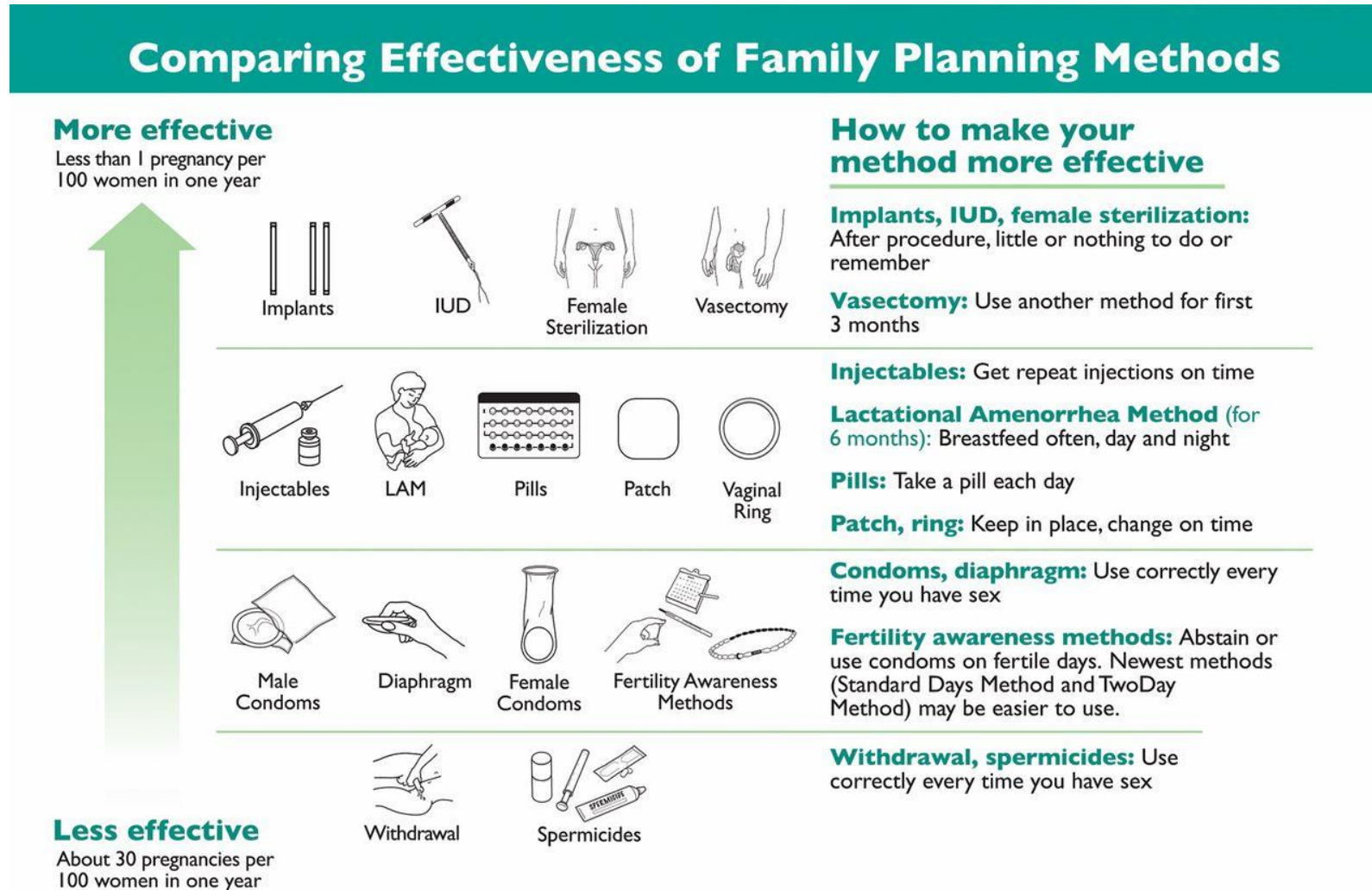
## Fallopian Tube



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World Health Organization Model of Tiered Contraceptive Effectiveness Source: Steiner et al.,<sup>17</sup> Trussell,<sup>18</sup> and WHO.<sup>19</sup>



John Stanback et al. Glob Health Sci Pract 2015;3:352-357

Method (Contraception Technology 2018)	% of women experiencing an unintended pregnancy within 1 <sup>st</sup> yr of use		% of women continuing use at one year
	Typical use (As commonly used)	Perfect use (Consistent and correct use)	
No Method	85	85	-
COC & POP	7	0.3	67
DMPA	4	0.2	56
Cu IUD	0.8	0.6	78
Mirena (52mg LNG)	0.7	0.5	80
Male Condom	13	2	43
Female Condom	21	5	42
Spermicide	21	16	42
Female sterilization	0.5	0.5	100
Male sterilization	0.15	0.10	100





# DIFFERENT TYPES OF CONTRACEPTIVE METHODS

(THE BORING STUFF)



# CONTRACEPTIVE METHODS (1)

- Any method of contraception that does not have to be used or applied more than once a cycle or once a month.
- First line for all women including adolescents (ACOG recommendation)

## 1. Short Acting Methods

- Oral contraceptive pills 避孕丸
  - COC (combined hormonal contraceptive pills) 混合荷爾蒙
  - POP (progestogen-only contraceptive pills) 單一荷爾蒙
- Combined hormonal contraceptive injectables 混合荷爾蒙避孕針
- Patch (not a/v in MCHC) 混合荷爾蒙避孕貼
- Vaginal ring (not a/v in MCHC) 混合荷爾蒙陰道環

## 2. Long Acting Reversible Methods (LARC)

- Progestogen-only contraceptive injectable 單一荷爾蒙避孕針
- Intrauterine contraceptive device (IUCD) 子宮環
  - Copper
  - Progestogen-containing (not a/v in MCHC)
- Contraceptive implant (not a/v in MCHC)

## CONTRACEPTIVE METHODS (2)

### 3. Barrier Methods

- Male condom
- Female condom (not a/v in MCHC)
- Diaphragm/ cap (not a/v in MCHC)  
子宮隔膜/ 子宮頸帽

### 4. Emergency Contraception (EC)

- EC pills 事後丸
- Copper IUCD

### 5. Others

- Spermicide

### 6. Permanent

- Female sterilization
- Male sterilization  
(for referral)

# WHO MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

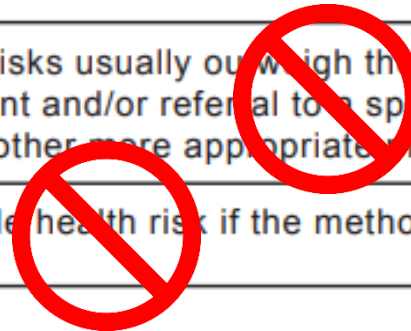
## MEC categories for contraceptive eligibility

1	A condition for which there is no restriction for the use of the contraceptive method
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition which represents an unacceptable health risk if the contraceptive method is used.



# UK MEDICAL ELIGIBILITY CRITERIA

UKMEC	Definition of category
Category 1	A condition for which there is no restriction for the use of the method
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable
Category 4	A condition which represents an unacceptable health risk if the method is used



## STRATEGY FOR WOMEN WITH SA

- Priority: Long Acting Reversible Contraception
- Considered high risk for sexually transmitted disease: Dual methods  
i.e. condom + another contraceptive method

## VIDEO SHARING

This Woman Pays Drug Users Not To Have Kids (HBO)

<https://www.youtube.com/watch?v=kkERSYPLzqc>

## GENERAL CONCEPT ABOUT HORMONAL CONTRACEPTION

- If start within first 5 days of menstruation → no need extra contraception
- Otherwise, add condom for 7 days



# COMBINED ORAL CONTRACEPTIVE PILLS (COC PILLS)

混合荷爾蒙避孕丸



## COC PILLS (1)

- Contains estrogen and progestogen
- Many brands
- Monophasic/ multiphasic
- Most brands with 21 active pills
- Some with placebo pills

## COC PILLS (2)



Simple & easy

Does not interfere with intercourse

Regulates menstrual cycle and pain, helps with acne

Reduces risk of endometrial and ovarian cancer

Must be taken every day

Effectiveness may be affected by other meds

Estrogen hormone risks, breastfeeding moms may have ↓milk supply

# Hormonal Side Effects

- Nausea
- Weight change (no clear evidence for combined hormonal method; weight gain associated with depoprovera established)
- Dizziness
- Headache
- Breast tenderness
- Mood changes

## Combined Hormonal Method (Pills, Injectable, Patch, Ring)

### Cardiovascular Risks

- Associated with an increased risk of MI and ischaemic stroke but that that these events are still extremely uncommon.
- Women with significant additional risk factors for arterial disease should be strongly cautioned or avoided.
- Associated with an increased risk of venous thromboembolism (VTE), but the absolute risk of VTE remains very small.

## Combined Hormonal Method (Pills, Injectable, Patch, Ring) Breast Cancer Risks

- No overall increase in breast cancer risk among women who had ever used combined hormonal methods.
- Very slight increased risk in current users and within 10 years of discontinuation.
- Absolute number of breast cancer attributable to combined hormonal methods is very small.

## Combined Hormonal Method (Pills, Injectable, Patch, Ring) Cervical Cancer Risks

- Small increase among combined hormonal method users
- Other factors may play a role
- Association is not clear



# PROGESTOGEN-ONLY PILLS (POP) A.K.A. MINI PILLS

單一荷爾蒙避孕丸

## POP (1)

- Contains progestogen only
- Desogestrel 75 microgram
- 28 active pills/ cycle
- All pills are active
- No pill free days



## POP (2)



Simple & easy

Does not interfere with intercourse

Avoid estrogen side effects

Suitable for breastfeeding

Must be taken every day

Menstrual irregularities

Effectiveness may be affected by other meds

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# Progestogen-only Contraceptive Injectable – Depo-provera

單一荷爾蒙避孕針

## DEPO-PROVERA (1)

- Contains progestogen only
- Injected every 13 weeks

## DEPO-PROVERA (2)



Suitable for  
breastfeeding

Improves menstrual  
pain & less flow

Avoid estrogen side  
effects

One shot lasts 13  
weeks



↓ bone mineral density  
(reversible)

Menstrual  
irregularities, may  
cause weight gain

Action cannot be  
stopped immediately

Delayed return in  
fertility (avg 9 months)

One third of users discontinue during the  
first year due to side effects.



# COMBINED INJECTABLE CONTRACEPTIVES (CIC) - CYCLOFEM

混合荷爾蒙避孕針

## CIC (1)

- Contains estrogen and progestogen
- Injected every 30 days
- Estrogen side effects and contraindications

## CICS ADVANTAGES OVER DEPO-PROVERA

- Better menstrual cycle control
- More rapid return of fertility
- Shorter inconvenience if side effects occur
- Similar contraceptive efficacy and acceptability

## CICS DISADVANTAGES OVER DEPO-PROVERA

- Less suitable for breastfeeding women
- Shorter acting & more injections
- Not for women with contraindications to estrogens
- Presence of estrogen side effects



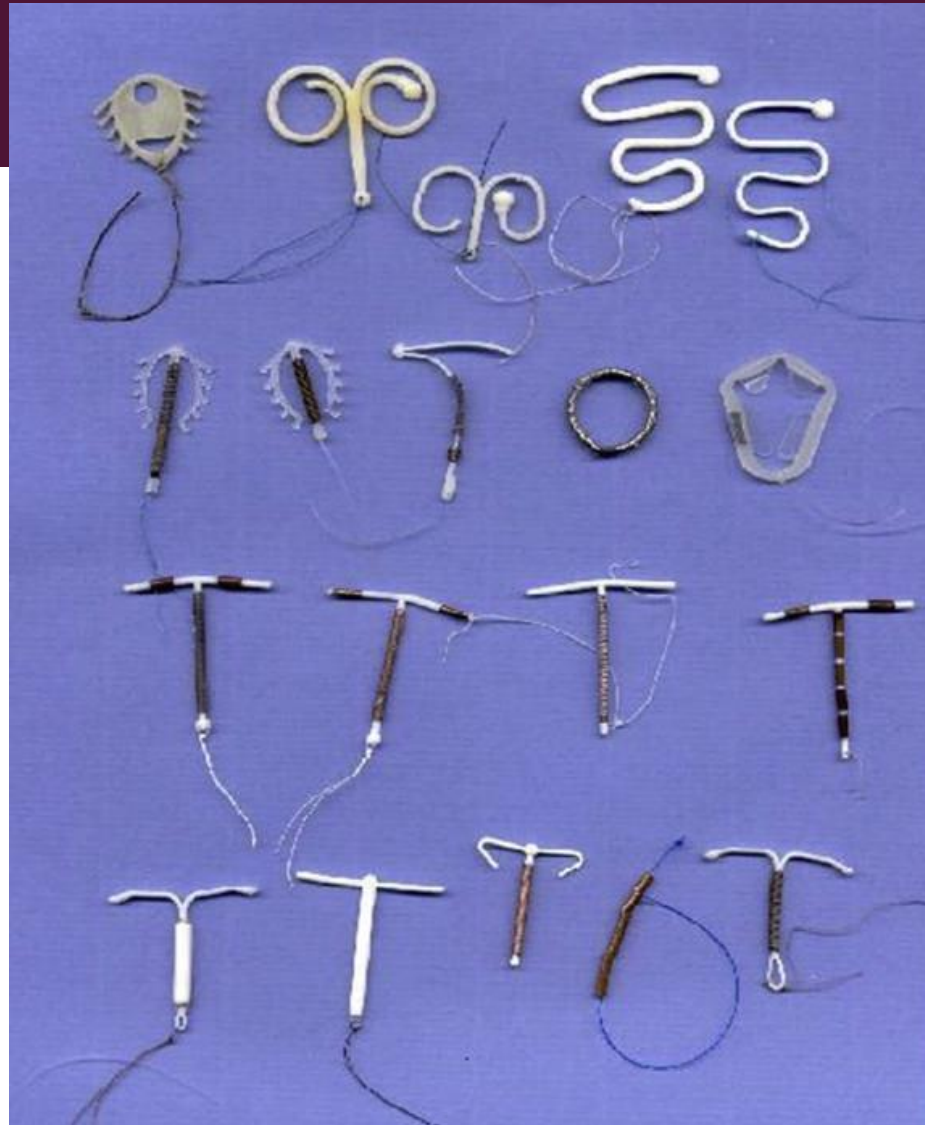
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# Intrauterine contraceptive device (IUCD)

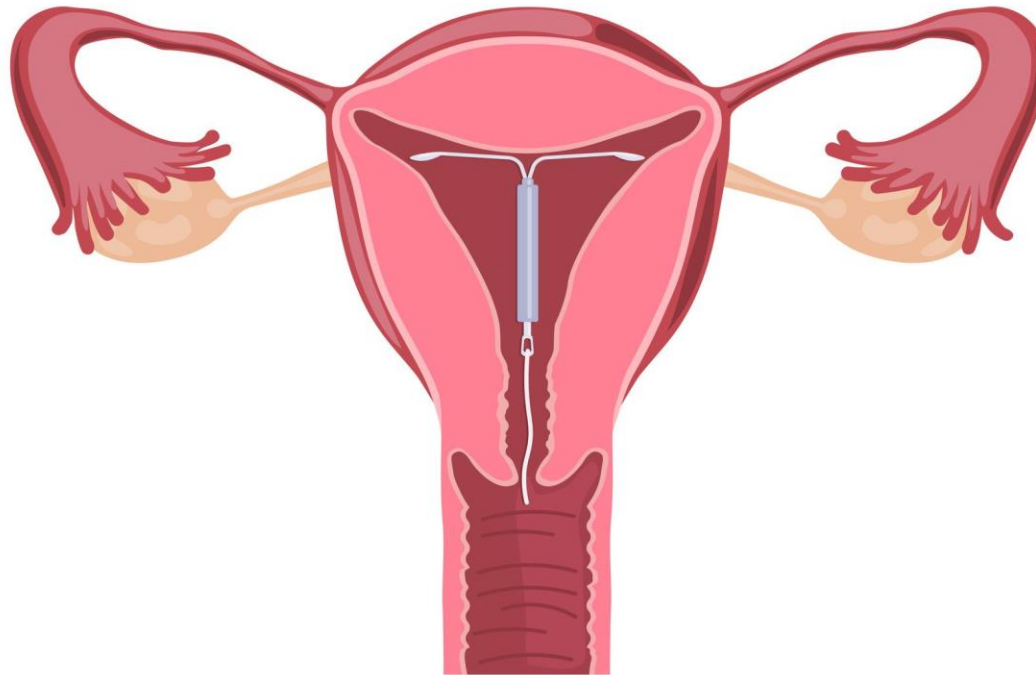
子宮環

## IUCD (1)

- Copper
- Progesterone-releasing



## IUCD (2)



## IUCD (3)

### MECHANISM OF ACTION

- Anti-fertilization by
  - Interfering with sperm motility
  - Impairing viability of sperm and ovum
- Anti-implantation by
  - 'foreign body reaction' in the endometrium
- Progesterone releasing IUCD – progestogen effect -> hostile cervical mucus, atrophic endometrium, ovulation inhibition

## IUCD (4)



User independent

Hormone-free

Long acting (5-10 years)

Rapid return of fertility

May ↑ menstrual  
bleeding & pain

Risks during insertion  
and removal (rare)

Broken IUCD, risk of  
expulsion

## 10. Intrauterine device (IUD) use for women with increased risk of sexually transmitted infections (STIs)

IUD initiation	Many women with increased risk of STIs can generally undergo either copper-bearing IUD (Cu-IUD) or LNG-IUD initiation (MEC Category 2). Some women at increased risk (very high individual likelihood) of STIs generally should not have an IUD inserted until appropriate testing and treatment occur (MEC Category 3).	No new evidence identified, so quality of evidence not evaluated using GRADE process; reviewed for clarity as requested by the GRC
IUD continuation	Women at increased risk of STIs can generally continue use of either Cu-IUD or LNG-IUD (MEC Category 2).	

Sexually transmitted infections (STIs)								
a) Chlamydial infection (current)	I	C	I	C				
(i) Symptomatic	4	2	4	2	1	1	1	1
(ii) Asymptomatic	3	2	3	2	1	1	1	1
b) Purulent cervicitis or gonorrhoea (current)	4	2	4	2	1	1	1	1
c) Other current STIs (excluding HIV & hepatitis)	2		2		1	1	1	1
d) Vaginitis (including Trichomonas vaginalis and bacterial vaginosis) (current)	2		2		1	1	1	1
e) Increased risk for STIs	2		2		1	1	1	1

STI  
Risks

## IUCD (5) DISPELLING MYTHS

### IUCDs

- Are not abortifacients
- Do not cause infertility
- Do not cause discomfort for the male partner
- Do not travel to distant parts of the body
- Can be used for women with no children



# SPERMICIDE





## SPERMICIDE (1)

- Disables sperm
- High pregnancy rate if used alone
- Should be used with diaphragm or cervical cap

## SPERMICIDE (2)



Suitable for  
breastfeeding women

Hormone-free

May provide lubrication

Must be available at the  
time of intercourse

Risk of allergy, vaginal  
irritation, infection



# EMERGENCY CONTRACEPTION (PILLS OR COPPER IUCD)

事後避孕

## EMERGENCY CONTRACEPTION (1) – EC PILLS

### KEY COUNSELLING MESSAGES

- Use and effectiveness (not effective if ovulation has occurred)
- More effective the sooner they are begun
- Side effects
- Next menses may come early/ late
- DO NOT provide contraception for future intercourse
- Subsequent regular contraception should be used

## EMERGENCY CONTRACEPTION (2) – EC PILLS

Selective Progesterone Receptor Modulator	Progestogen only
Ulipristal acetate 30mg	Levonorgestrel 1.5mg
<= 120 hours of unprotected intercourse	<= 72 hours of unprotected intercourse
Failure rate: 1-2%	Failure rate: 2-3%
Action: inhibits or delays ovulation	
Side effects: nausea, vomiting, irregular bleeding prior to return of menses, headache, dizziness, breast pain, abdominal pain	

## EMERGENCY CONTRACEPTION (3) - COPPER IUCD

- Can be inserted  $\leq 120$  hours of unprotected intercourse or within 5 days of earliest estimated day of ovulation
- **Most effective method** of emergency contraception (anti-fertilization and anti-implantation) – Overall pregnancy rate 0.1%
- Can be kept in place for regular contraception



# STERILIZATION



## STERILIZATION (MALE/ FEMALE)

- Considered permanent
- Anesthetic and operative risks (male: local anesthesia ; female: general anesthesia)
- Failure rate (male 1:2000 ; female 1:200)
- MCHCs make referrals to hospitals.
- Male sterilization also available at Family Planning Association and no referral is needed.



## CONTRACEPTIVE USE IN WOMEN WITH SA

- Condoms – most commonly used method (62%)
- Very effective methods (Implant/ intrauterine device/ tubal ligation) – 8% only
- Dual use (condom + another contraceptive method) – 7% only

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# CASE SCENARIOS

## Client A

- 39 years old
- Frequent change of partners
- No children
- Amphetamine user, smoker
- Always comes for EC pills

What contraception is best for her?

## CASE SCENARIOS

- Dual methods! **Condom +**
  - X combined hormonal method (>35 years old smoker)
  - ? Depo-provera - 3-monthly injectable (explore fertility wish)
  - ? POP (compliance?)
  - ? IUCD – seems like a good choice (EC + long term)

# CASE SCENARIOS

## Client B

- 16 years old heroin user
- History of chlamydia
- Recent termination of pregnancy

What contraception is best for her?

## CASE SCENARIOS

- Dual methods! **Condom +**
  - ? IUCD (? Chlamydia treated, partner(s) treated, any symptoms); teenage is not a contraindication to IUCD
  - ? Injectables (CIC/ depoprovera) – seems like good choice
  - ? POP/ COC (compliance?)
  - Educate access to EC

## SUMMARY

- Use dual methods  
(condom + another contraceptive method)
- Use one method and understand its limitations
- Client-centered care
- Address the issue and provide factual information
- Informed voluntary choice

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## WHAT CAN SOCIAL WORKERS DO?

- Beware of reproductive health issue and contraceptive need
- Explore the topic and concerns
- Non-judgmental
- Give correct information and keep leaflets handy
- Call MCHCs for special appointment booking arrangement
- Accompany clients to checkup
- Remind them for follow up (Consistent use of contraception is the key!)



THANK YOU

QUESTIONS?