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Long-Acting Reversible Contraceptives: Their Critical Role in Addressing Today's Reproductive Health Landscape

Announcer:
Welcome to CME on ReachMD. This activity, entitled "Long-Acting Reversible Contraceptives: Their Critical Role in Addressing Today's Reproductive Health Landscape" was presented during Omnia Education's Women's Health 2022: Beyond the Annual Visit.

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Dr. Eisenberg:
Hello, everybody. Welcome to today's Beyond the Annual Visit discussion for Women's Health 2022. My name is Dr. David Eisenberg. I'm a faculty member of the Medical School at Washington University in St. Louis, in the OB/GYN department, and have been working in this contraceptive space for a long time, since the beginning of the Contraceptive CHOICE Project. And we'll be talking about that later today as we highlight long-acting reversible contraceptives and their critical role in addressing today's reproductive health landscape.

And as far as what we're going to cover today, we will discuss the difficulties of unintended pregnancy and how that works out in terms of epidemiology, the American Academy of Pediatricians' and the American College of Obstetrics - Obstetricians and Gynecologists' recommendations regarding long-acting reversible contraceptives. We'll talk about the advantages and disadvantages of LARC methods, such as the IUDs and the implant. We'll want to discuss the difficulties of helping patients make good decisions for themselves regarding contraceptive choices and using a shared decision-making model, and talk about some strategies for making sure patients understand what is the best method for them in a patient-centered approach.

So we'll start by looking at today's landscape regarding unintended pregnancy and reproductive health issues. A landscape that's changed dramatically recently as a result of a Supreme Court decision we'll discuss later. You know, unintended pregnancy is generally the product of people who are either not using a contraceptive method at all, or just not using their method correctly or consistently. This graph from a Guttmacher Institute publication demonstrates that, you know, about two-thirds of people who are potentially at risk of pregnancy are using a contraceptive method consistently. And of the one-third or so folks who are not using a contraceptive method consistently, there's about 3.5 million pregnancies in a calendar year. And that results from more than half being non-use of contraceptives at all, or a little less than half being inconsistent use. Because we know that modern contraceptive methods are really effective, especially when people use them correctly and consistently.

And when we look at the health outcome of unintended pregnancy, it is not a surprise that mimics many of the other health outcomes in our country where people of color and people of lower econ – economic well-being are more likely to experience this health outcome, specifically unintended pregnancy. And what we know is that the increasing utilization of IUDs and implants over the last 10 to 15 years has really helped drive a decline in the rate of unintended pregnancy, especially among adolescents.

As you look at this graph, what you're looking at on the left-hand vertical axis is the rate of unintended pregnancies per 1,000 people of reproductive age, broken out by black, non-Hispanic in purple, Hispanic in the pink triangles, and white non-Hispanic in the blue-teal diamonds, with the black line representing all people who could become pregnant. And so you can see that while the unintended

pregnancy rate has really gone down since about 2008, it has really been driven by certain populations more than others, and the unintended pregnancy rate is much higher for folks of color than it is for people who identify as white. And this has been true over the years. The rate of unintended pregnancy amongst adolescents going down by nearly a quarter in the recent history is really from the increased utilization of highly effective contraceptives.

When you break out the population, not by race and ethnicity, but by income level, and as a reminder, the Federal poverty level in 2022 is listed on the right-hand side of the slide. For an individual with no dependents, we're talking about just under $14,000 a year, a little over $1,000 a month. A family of four is nearly $28,000 a year. And so when you look at the folks who are experiencing unintended pregnancies, again, with the Y axis being the number of unintended pregnancies, per 1,000 people of reproductive age, you can see that the higher rate of unintended pregnancy corresponds with a likelier poverty level. And so when it comes to people who have unintended pregnancies, they are more often concentrated amongst the folks who are poor or below Federal poverty level lines, as well as people of color.

And we know that contraception has significant medical benefits. Nearly all people who can become pregnant will be using a birth control method at some point in their lifetime. And any method that reduces the risk of high-risk pregnancies, reduces bad health outcomes, obviously. And we know that when we have the opportunity for people to be able to space their births and have their children when it makes sense for them in their family, there are better health outcomes for mother and baby.

We know that there are some non-contraceptive benefits that are in the medical realm. Things like reduced rates of sexually transmitted infection when using barrier methods for instance. And we know that hormonal contraceptives are frequently used for non-contraceptive reasons to treat other kinds of menstrual disturbances, endometriosis, and other difficulties associated with gynecologic problems.

When it comes to non-contraceptive benefits - I'm sorry, non-medical benefits of contraception, there's many for the individual, not just their ability to achieve what they're looking for in life with regards to their education, work, or finance, but for their family. And we know that that greater investment per child over time is going to allow for that next generation to have higher rates of success. And for society as – as a whole, when you have a lower rate of unintended pregnancy and a higher rate of workforce participation for people who can control their fertility, we have many better health outcomes.

From a public health perspective, investments in family planning services are really one of the top three things to help in terms of improving the health and well-being of a community. Safe water and vaccination programs are the only things that really outperform family planning services.

And so basically, what we're saying is contraception is a basic necessity. The average American woman wants two children according to many surveys over many decades now. And what we know based on the onset of menarche, the onset of sexual activity, and the age of menopause, that 35-ish year period of potential fertility, with someone having a heterosexual male partner as their, you know, relationships change over time, they're at risk of pregnancy for over 30 years. But if they really only want two children, and you take the time it takes to become pregnant, the duration of pregnancy, plus the time postpartum, hopefully, they invest in things such as breastfeeding, and that reduces fertility during that period of time, those 3+ years versus 30+ years of potential reproductive capacity means someone's going to need a contraceptive method that successful and they're happy with for nearly three decades of their life. This is a huge need.

When it comes to the statements from various health organizations, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and others, they all agree that intrauterine contraceptives and contraceptive implants, which are known as long-acting reversible contraceptives, are some of the most effective reversible methods. And the advantage of this is that they are highly effective, they don't require a significant investment of time and attention of the individual user. And once the person has decided they do not want to continue with that method or they're ready to get pregnant, the return to fertility is quite rapid. So there's really quite a few advantages to long-acting reversible contraceptives. This was first recognized in the ACOG Practice Bulletin in 2017. And just reaffirmed last year.

So why is it that ACOG and the American Academy of Fam – of Pediatrics has decided that LARC, or first line contraceptives? Because based on the efficacy, the safety, and the ease of use, they should be considered the default first line contraceptive that we offer to adolescents, as well as people who are older. Why? Because they have the highest effectiveness, the highest rates of continuation and satisfaction, and the lowest need for personal time and attention. The default from sexual activity becomes not being pregnant rather than potential for pregnancy. And so we think it's really important that we take away the barriers that might be in place in your practice, from same-day insertion of IUDs and implants, such as insurance preauthorization and other kinds of challenges, that you do what you can to educate your patients regarding their contraceptive choices. And we'll speak to this in a little bit with regards to what's most important for them. And if effectiveness is the thing that's most important and reversibility, well, LARC may be the way to go.

When you think about how to initiate contraceptives, the Selected Practice Recommendations and the CDC Medical Eligibility Criteria have been now unified into a single document that is referenced here with regards to how to initiate contraception safely. We know that someone who's having an IUD inserted, whether it's hormonal or copper, we need to know of the position of the uterus and their reproductive anatomy before we insert it. And that when it comes to a backup method depending on where you are in the menstrual cycle, you might need a backup method with hormonal contraceptives but not copper. The contraceptive implant and the injectable contraception depo medroxyprogesterone, both do need a backup method, but they don't really need any significant examination to be sure that the patient is appropriate.

When we're using something with estrogen, a combination hormonal contraceptive, whether that's the pill, the patch, or the ring, we want to make sure someone's not hypertensive, or borderline for that matter. But really other than that, they don't need to have any other examinations done to safely use the pill, the patch, or the ring. But they might need a backup method depending on where they are in their menstrual cycle.

Progestin-only pills, which we know is the primary mechanism for contraception in all combination hormonal contraception, that progestin component can be initiated as soon as someone wants a contraceptive method with really next to no screening eligibility criteria. And that's why we hope to see a over-the-counter progestin-only contraceptive in the near future. What I will say is that progestin-only contraceptives do require really meticulous dosing, and they do need a backup method depending on when someone initiates that method.

So LARCs, we know, are the most effective contraceptives that are reversible. And so I want to look at how the World Health Organization, the CDC, and many other entities that provide really great educational information for both providers and patients, group contraceptive methods.

So what you see here is on the top line is the most effective methods, the tier one methods. These are people will experience less than one pregnancy per year of use of this method. And while the most common contraceptive method utilized in the United States by heterosexual couples is permanent birth control between vasectomy and tubal occlusion, whether that salpingectomy or a clip or a partial salpingectomy, the fact of the matter is that permanent birth control is the most common thing that our American couples are using.

But when it comes to the most effective reversible contraceptives, you have both the hormonal and the non-hormonal copper IUD and the hormonal implant. They are as effective less than 1 in 100 people will get pregnant per year, but they're totally reversible, as we mentioned before.

When it comes to tier two contraceptive methods, now we're talking about things like the pill, the patch, the ring, that are combination hormonal contraceptives, talking about progestin-only pills, or the progestin-only injectable. Now we're talking somewhere between 4 and 7 out of 100 women per year will become pregnant. Now that does require someone to be using the method correctly and consistently. And we discussed how important that is for contraceptive success.

When it comes to the tier three methods, these are things that are much more coitally dependent, you have to use them with that reactive intercourse. Things like male and female condoms, what you might call an internal condom, things like a diaphragm or cervical cap plus or minus spermicides, which may be impregnated in a spermicidal sponge. Fertility awareness methods are things that people have relied on for centuries. But the bottom line is that there's lots of options in this tier three, where there are potentially greater than 11 out of 100 people getting pregnant per year. These barrier methods and non-hormonal coitally dependent methods such as the new vaginal pH modulator that maintains that pH of the vagina in acidic space so sperm can't swim towards the egg. Very much like spermicides inhibit sperm being able to swim, but it's not a detergent that destabilizes the vaginal epithelium in addition to the sperm membranes. So with that third tier methods, those third tier methods have a higher rate of failure, potentially more than 1 in 10 people getting pregnant per year. And that can be paired together with some of those first and second tier methods.

But this is the way that we think about grouping the contraceptive methods and the way it might be helpful for you to present it to your patients.

As I mentioned earlier, I had the honor of being a part of the Contraceptive CHOICE Trial here at Washington University in St. Louis. We enrolled over 9,200 women in a trial where we followed them for 3 years with the intent to remove the three main barriers to people getting the contraceptive method they want. Education, we made sure everyone got comprehensive counseling regarding all the contraceptive methods, they would be appropriate for. Misunderstanding by healthcare providers about who is or isn't appropriate for which contraceptive method. And cost, we made it free for them to choose whatever method they want, and to switch as often as they wanted in that 3-year follow-up period. They could choose any reversible contraceptive method, IUDs, both hormonal and not, the implant, the injectable method, contraceptive pills, patch, or ring, progestin-only methods, we would even provide them condoms and

other kinds of barrier methods.

And what we saw is when you remove the barriers of cost, misunderstanding about who's appropriate for what, and ensuring comprehensive counseling for all subjects enrolled, 3 out of 4 subjects chose the most effective methods, IUDs and implants. And the continuation rate was seriously amazing. To me, I was really surprised the continuation for IUDs and implants was 86 out of 100 people versus the pill, the patch, the ring, the shot was less than 60 out of 100. And of course, no surprise given the effectiveness difference, the contraceptive effectiveness of the pill patch, and ring being second tier compared to the implant and IUD, we had a much higher effectiveness and, therefore, a much lower pregnancy rate.

This is a graph from an article we published in the *New England Journal of Medicine* back in 2012, describing our experience following subjects for 3 years in the Contraceptive CHOICE Trial, demonstrating a 20-fold higher effectiveness for LARCs compared to the pill, the patch, or the ring. And what you're looking at on the vertical axis is participants who experienced a contraceptive failure, a pregnancy, despite using the method that they had chose from the CHOICE trial, versus the first, second, and third year grouped into LARC methods in the teal, Depo-Provera, the medroxyprogesterone injectable, in pink, and the purple being the pill, patch, and ring users. And you can see there was a 22-fold higher hazard ratio with a pretty wide confidence interval. But still, that confidence interval at the low end was a 14-fold higher effectiveness for LARC compared to users of the pill, patch, and ring.

So the bottom line messages we concluded from the Contraceptive CHOICE Trial is that LARCs provide top-tier, most effective, but reversible contraception. And subsequently, the American Academy of Pediatricians and the American College of Obstetricians and Gynecologists, and many other organizations have concluded that LARCs should be the first line contraceptive method for people who do not want to be pregnant in the next year.

And it really is important that we eliminate those barriers to access, whether it be cost, whether it be those multi-visit procedures that are required for insurance preauthorization, and of course, making sure we provide adequate counseling to our patients, not our research subjects, regarding what's the best option for them.

And it's really important to recognize that LARCs really meet today's needs for many reasons, both now and in the future, with restrictions around sexual and reproductive healthcare access that were put in place because of the COVID-19 pandemic, or might be put in place again for the next pandemic. But also with the recent Supreme Court decision overruling a person's ability to choose when and if to continue a pregnancy, we now know that many states make it illegal for people to access the abortion they need if they need it. And so people having access to the most effective contraceptive methods like LARCs is going to be even more important to ensuring people's health and well-being in the future.

So what has changed in the last several years? Well, besides that Supreme Court decision over the last decade or so, as I said that *New England Journal* article was published in 2012, 10 years ago, there's really increasing success and enthusiasm about LARC methods. However, it's really important that we recognize that there is a long history of unfortunate reproductive coercion in our society. And we need to make sure that we center our patients in their contraceptive decision-making options. And it's not about providers, it's about patients, and that we use inclusive language. Not everybody who needs a contraceptive method will identify as a woman. I hope you've heard me say things like people who could become pregnant, because that kind of language is inclusive. And it doesn't exclude the option to use the word woman.

I think it's really important that we think about contraceptive methods as that tiering approach, grouping things into the most effective, moderately effective, and maybe less effective, but still reasonable choices for people to make. But it's not just contraceptive effectiveness that people value. There are many other reasons why people choose a contraceptive method. And we'll speak to that in a minute.

And lastly, I think it's really important to talk about reversibility. And when someone chooses to stop their method with the intent to get pregnant, and whether we want to incorporate that into the contraceptive decision making, or that conversation that we're having with people regarding reproductive life planning.

There has been some recent data to demonstrate the prolonged use of the implant and IUDs. So another new development in the last 10 years or so, specifically with regards to the implant and the hormonal IUD, 52-milligram levonorgestrel IUD specifically, there were initially reports coming out of my institution and where my colleagues in 2015. And then a publication from 2017 from the American College of OB/GYN that described the prolonged use of IUDs and implants being not only safe, but just as effective in the 4th and 5th year for the implant, and the 6th and 7th year for the 52-milligram IUD. That extended use is something that I think is important to help people understand they don't have to choose to continue it. But it is a perfectly reasonable off-label prescription. You don't really have to do anything different for your patients other than document the conversation that you help them understand that the hundreds of people who have been followed for many, many months beyond the FDA approval, have shown that the IUDs and implants are effective

beyond their original FDA approval.

Specifically, the contraceptive implant is the one we highlight here, because it has not yet been FDA approved for that extended use, where those 52-milligram levonorgestrel IUDs recently have been approved out to 8 years. The contraceptive implant is clearly as effective in years 4 and 5 as it was in years 1, 2, and 3, as demonstrated by these two reports here.

So there are barriers that people experience when trying to access LARCs. We know there are clinicians who are misinformed about who is or isn't appropriate, whether they've had a child or not, for instance, whether they have multiple sexual partners. There are really great guiding documents from the CDC, and many other organizations that help us understand what is or isn't necessary before choosing - helping a patient choose the contraceptive method for them.

Insurance challenges I've mentioned a couple of times, whether that's Medicaid or private insurance, making sure people are preauthorized for their desired LARC, making sure that they understand what's their out-of-pocket cost. We know that the Affordable Care Act has changed contraceptive prescription out-of-pocket expense for many, many patients, but not for everybody. And so, it's important that people know what they are on the hook for. But at the same time, recognizing that the long-term expense is a lot less than getting a contraceptive method filled at the pharmacy every month.

I do think there's a lot of folks out there who have mistrust of people who look like me, a person who's practicing medicine for 20 something years, who isn't capable of getting pregnant, and maybe not look like them when they look at themselves in the mirror. We need to meet our patients where they are and understand their cultural values. And so, ask them the kinds of questions that will help you be a better advocate for your patient. And make sure that we help dispel the myths and misconceptions about who's appropriate for what type of method.

And so, I'd like to move on to talking more about how do we counsel patients.

And so I'd like to move on to talking more about how do we counsel patients about LARCs. And I think centering the patient in that conversation and making sure their preference is clear is critically important.

There are many different ways to approach contraceptive counseling, similar to many other healthcare services that we provide. Informed choice, where we let everybody know and what the different choices are and they make a decision versus directive counseling where we decide what we think might be best versus something in the middle what we call shared decision-making. And we're going to dig into shared decision-making here.

I think it's really important that you recognize there are very concrete identifiable steps for shared decision-making, that your staff or you yourself could do in helping patients be successful in their contraceptive choice for them. It's really important to establish rapport and identify who's appropriate to receive which methods, making sure that we are clear about the kinds of medical history and other contraindications, which are few and far between, in many ways. That we make sure patients understand that if they want a contraceptive method such as the implant, they might not need to get undressed if they're wearing a short sleeve shirt, and helping them be comfortable with what is or isn't necessary as a part of their contraceptive journey.

When we start that contraceptive counseling visit, I think it's important that we try to get from them what are the things they prefer out of their contraceptive method? And what's the timeline that they're looking for to avoid pregnancy versus when they are interested in pregnancy? And we have to facilitate the patient's preference in helping them get the contraceptive method that they think is right for them, even if there might be a temporary contraindication, such as a recent act of unprotected intercourse. We can help them bridge to their desired LARC method, for instance.

And then lastly, counseling on the front end about what to expect when they're choosing a contraceptive method such as an implant, a hormonal IUD, a copper IUD, how will their bleeding pattern change? What can they expect with regards to side effects? What do they need to know about having it removed if they choose to have it discontinued for problems, or because they're looking for pregnancy? How fast is fertility return? Can they get pregnant right away? There's a lot of things beyond the actual initiation of the contraceptive method that I think are important to talk about before you help that patient start their method.

What does that shared decision-making conversation look like? It can look lots of different ways. There are different approaches for different people, whether that be young people, whether that be people who haven't had children or people who have. You know, one of the things that I would point out is, you know, people may be unaware of the range of contraceptive options out there. Many people when they hear the term birth control, pill is all they hear. Birth control pill, that's all they hear, but they may not be aware of the fact that they're a great candidate for something that's more effective, with less side effects and a higher continuation rate, like an IUD or an implant. And I think helping people understand that all of our patients, adolescents and adults are really great candidates for IUDs and implants as their first line.

But not everybody values effectiveness most, right? We as providers who understand that public health paradigm I spoke to at the beginning about unintended pregnancies, may think effectiveness is the most important, but that may not be what patients want. And I think we need to help patients understand that we do not need to dictate their contraceptive choices. We want to help them make a decision, a shared decision.

Side effects may be critically important for people to understand whether that the hormonal side effects, whether that be changes in their bleeding pattern with a copper IUD, for instance.

I think it's critically important that people understand that IUDs and implants cannot be discontinued on their own. Patients need to come back to their health care provider to have their IUD removed, or their implant removed. If that's something that's important to them, if the idea that they might have side effects from a hormonal contraceptive method, and that they can't discontinue it because of headaches or mood changes, well, maybe the IUD or implant is not the best choice for them. Maybe something that they have better control over would be a better way to go. I think those are critically important things.

And if you want more information, I would highly encourage you to check out the NationalCampaign.org. That's the reference where this all comes from.

As we move through the rest of these decision-making conversations, I think it's important that we recognize language matters. I may like the term long acting, but for some people that may be really disconcerting. Some people may like the idea of more effective. Some people may like the idea of completely reversible without needing to go to the pharmacy on a regular basis. The kind of terminology we use depends on the person's understanding of the language, but also what they value. And I think it's important that patients understand that when we say an IUD or an implant can be used for 5 or 10 or 12 years, that that doesn't mean they have to use it for that period of time. That they understand that we support them - support their choice when and if to discontinue their contraceptive method.

I do think it's important that patients understand that a contraceptive decision is theirs, but it might involve the need for their partner to participate, especially the things such as the barrier methods we described, and things like the vaginal pH modulator and other contraceptive methods that are what I call coitally dependent, used at the time of intercourse.

Patients do appreciate hearing other people's experience. I don't know how often you hear it, but recently, in the last 10 years, especially when I introduce the idea of an IUD or an implant to someone, it's very common for my patients to say, ‘Oh, my sister, my friend, my cousin,’ someone they know in their life has that method. They may have a good thing to relate about it, or they may relate their friend or sister's bad experience. And I think acknowledging the fact that there are people who have good and bad experiences with all contraceptive methods is critically important. And help people understand that what they experience may be different than their friend, their sister, or cousin. And that the process of finding a contraceptive method that works for you may - is a trial and error process. And you're an individual who's different than your friend or sister.

And the most important thing is that they understand that we are with them to support them on their contraceptive journey. If they don't like the method, they can discontinue it. They can contact us and the type of side effect they're having might help us help them find the next best choice for them.

The Reproductive Life Plan is not a concept people are going to be familiar with. But I like to ask things like, Do you – I generally know if a person has children because I have a history that they've taken, or they might have been my patient, and I have some electronic health records on them. But I like the conversation starter to say, are you interested in having children? Are you interested in having more children? If you're interested in having children, do you think it's soon, like in the next year? Or is it maybe longer than a year away? And there is some research to support the idea of one key question. And that one being would you like to become pregnant now or in the next year? And that changes where your conversation is going to go really effectively. And in patients who are interested in delaying pregnancy for greater than a year, we all know the first line default contraceptive method for them should be IUDs or implants. But maybe that won't be the right thing for them. And we'll come to that in a second.

I think there's some great options to use what's called the PATH questions, which the third reference here is a publication arm, which is a series of about three questions about that Reproductive Life Plan, and how often or how far out people are planning for pregnancy.

Some examples of counseling questions that are a little bit different. Things such as you know, how you take your birth control is really important. The idea of having something implanted in your body, in your arm, or in the uterus is a very different experience. We saw during the Contraceptive CHOICE Project that adolescents under the age of 17, were more likely to choose the implant over an IUD compared to 17 old – 17-year-olds and above who were more like their adult colleagues, in that they were equally likely to choose an IUD or an implant. Why? Well, the younger adolescents had never had a pelvic exam almost universally, never had a pelvic exam. The idea of getting undressed and having a pelvic exam and having something inserted in the uterus was really a troubling idea for some of them, versus having an implant place.

It's really important that we recognize that some people may have low health literacy. They may not understand the concepts, and we have to sometimes take a step back and try to meet our patients where they are. So really probe these things and try to help people understand the different choices they have, and how that might affect their future.

When it comes to making decisions, and ultimately making the final decision, there's some sample questions here, not statements. These are sample questions about how to facilitate patients making their decision, not statements. 'It sounds like I hear you're telling me you want this method?' Well, actually, let's back up and say, 'Well, given what we've talked about, what do you think is important about your method? And what do you think would be your best choice at this time?' Those kinds of open-ended questions after that counseling and education session, which might have been done by your staff person, can be really helpful to cut to the chase and find out what is it that this person needs or wants today?

So what if they choose something other than a LARC? Those second and third tier methods? Those can be really effective for people and really a good choice. And the thing that I think is important to recognize is a contraceptive method that someone is happy with, and uses for prolonged periods successfully, is going to be more effective than choosing to discontinue a method that they don't like. And helping people be successful in their contraception is critically important for all of us providers, but also for the population as a whole, as we discussed.

The second and third tier methods that are described here are things that are still some of the most common. The most common reversible contraceptive method using the United States is the pill. And how do we help people be successful with that?

So as I mentioned before, the Contraceptive CHOICE Trial had lots of subjects choosing the pill, 75% of our subjects chose IUDs or implants, but 25% chose the pill, the patch, the ring, the shot. And I think it's important that when people choose those methods, they understand that those methods are going to be more effective, the more effective they are as a user. And the reason that things like the IUD implant were more than 20-fold more effective is because they were kind of set it and forget it, they still are. And the idea that someone doesn't have to interact with it on a daily basis, or a monthly basis, or a weekly basis, I think makes it more effective. But there are lots of pill users who are super capable of taking their pill at the same time every day, which we know means it's more effective. There are shot users who are good at coming back every 3 weeks without being late. Those are going to be folk – folks who are going to have a lower failure rate.

Helping people choose a method that's right for them is critically important to reduce those unintended pregnancies we spoke to at the beginning. What happens when people have an unintended pregnancy? Well, we know that there's going to be many people choosing abortion, many people will choose to continue the pregnancy. Some people may have a spontaneous pregnancy loss. We know that

more than half of the unintended pregnancies are due to contraceptive failures or lack of use in the first place. That was some of the discussion we had at the beginning. And that LARC users are generally going to avoid pregnancy and have the highest rate of continuation and satisfaction.

When you look at the 3-year trial that we did, we saw that LARC methods not only had a higher continuation rate, but higher satisfaction. And that's probably because of the satisfaction rate, lower rates of side effects or other problems, helped more than two-thirds of the people who chose an IUD or an implant, still continue using it at the end of the 3 years, compared to less than one-third of our subjects who chose pill, patch, ring, or shot as their initial contraceptive method in enrolling in a CHOICE trial.

So in putting it all together, I think it's really important to recognize over the years that we have been doing research on contraceptive utilization, and best practices regarding contraceptive decision-making, there's been a lot of change both new contraceptive methods coming to the market, as well as the consequences of people who are pregnant when they don't want to be, especially in light of the recent Supreme Court decision and the consequences of not being able to access abortion care in the state you may live in. And the knowledge that 98 out of 100 people who could become pregnant, are going to generally need some contraceptive method for potentially over three decades of their life. I think it's really important that we help patients understand their contraceptive choices, and help them if they choose to access the LARC method that might be best for them. Shared decision-making in a patient-centered approach is critically important for that success.

And so I appreciate your time and attention today. I hope that we have an opportunity to answer some of your questions.

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