Transcript of "S4 E5 Lesser-Known Forms of Birth Control and Downplayed Side-effects: Providing Empowering Contraceptive Care"

Tammy Kremer (00:09):

Coming Together for Sexual Health engages you in shameless conversations about sex-positive, identity-affirming sexual health care. We keep our attention on those most impacted by STIs, HIV, and structural barriers. We're powered by nationally recognized experts in sexual health at the University [00:00:30] of California, San Francisco, and the California Prevention Training Center. All views expressed are those of the person speaking and not at the CAPTC or their employer. My name is Tammy Kremer. Let's come together for sexual health.

(00:48):

Welcome to the second episode of the three-part Family Planning and Reproductive Justice series here on Coming Together for Sexual Health. Today, we're joined by Mariana Horne and Dr. Jen Karlin. We're [00:01:00] going to be talking about the edges of conversations we have about contraception, things that don't often get talked about, types of birth control options, and side effects. I'm going to start by introducing Mariana Horne. She's a health educator and outreach lead at UCSF New Generation Health Clinic. She has a strong commitment to addressing racial inequities and disparities in reproductive healthcare and has been a prominent advocate and educator for anyone in need of reproductive care, particularly, monolingual Spanish-speaking communities. [00:01:30] Welcome, Mariana.

Mariana Horne (01:31):

Thank you so much.

Tammy Kremer (01:33):

We also have Dr. Jennifer Karlin, MD, Ph.D. Jen is a board-certified family physician and family planning specialist whose primary care practice is anchored in caring for patients in a way that encourages their empowerment and autonomy. She's trained as an anthropologist and historian of medicine and her research aims to understand how social, political, and institutional structures affect people's experiences with diagnosis, treatment, and healthcare. [00:02:00] Dr. Karlin is also committed to medical and resident education that aims to encourage physicians in training to approach their practices from an historical trauma-informed and self-reflexive perspective. Welcome, Jen.

Jennifer Karlin, MD, PhD (02:14):

Thanks so much. I'm so happy to be here.

Tammy Kremer (02:16):

I'm so glad to have both of you today and especially to have the two of you in conversation. I want to start us off by talking about what experiences you bring when it comes to supporting people in choosing and getting on birth control. Mariana, if you want to start.

Mariana Horne (02:30):

[00:02:30] I'm a health educator and the first point of contact with patients. I'm a certified family planning counselor. Also, a mandated reporter. I educate people about the birth control methods that are available for them, and I share the information for them to make an informed decision.

Tammy Kremer (02:50):

Great. Thanks. How about you, Jen?

Jennifer Karlin, MD, PhD (02:53):

I am a family doctor, which means that I take care of people from birth until death. [00:03:00] I have focused fellowship training in family planning. I really focus on sexual and reproductive health for my patients. My background is in anthropology and history of medicine and really thinking about how can the healthcare system meet people's needs in ways that are more empowering for them. That has meant different things in different places across the world and throughout time. I really came from this from [00:03:30] an experience earlier on in my life where my mom was pretty sick when I was young, mainly through high school. She had lupus and was constantly seeing doctors and was misdiagnosed for years and had physicians saying all sorts of different things to her like, "You're probably just too stressed and that's the reason why you're feeling this way or it's because your daughter is going to college or it's because you're a business owner."

(03:59):

We [00:04:00] used to sit at home thinking, "Why are people saying these things to you?" I got really curious about the ways in which we think about patients and people were constructed. Later on, actually, my mom ended up passing away from inflammatory breast cancer, and she had missed her mammogram by about six months, and a doctor literally said to her, "Well, you missed your mammogram, now we can't fit you in." She used to tell me that every time she would see him in the hallway of the hospital afterwards, she would want to turn [00:04:30] around and run away. It was a really eye-opening experience as a young kid. So that's the reason why I wanted to get background training in anthropology and history of medicine but also wanted to be able to be a practitioner to see if we could take those lessons and actually put them into action in the clinic setting.

Tammy Kremer (04:54):

Thank you for sharing that. I can understand how growing up and seeing that must be so confusing to [00:05:00] have that contrast and negotiate that.

Mariana Horne (05:03):

I want to say that, Jen, thank you so much for sharing. Your story is very inspiring. My story's a little bit different. I come from a very Catholic family where none of the information was available to us only what we learned at school and a little that we learned from our parents, which was if you kiss buddy, you can get pregnant. I remember some of my friends [00:05:30] went to their first OB appointment, and I was just very curious because it was not until in my late teens that I decided I don't care if my parents know that I went to an OB because I'm using their insurance, but I need to go just to ask questions. I had a professor that she was just talking to us about reproductive health, and she was an OB and I just went to have an appointment with her. I was just like, "I just don't know anything."

(06:00):

[00:06:00] She was like, "You know what? Thank you for coming." I remember that first appointment was like two hours just talking. She was one of the first persons that said, "It's your body, it's your

choice." I'm like, "Oh, wow. I have a saying what happens with my body?" That resonated with me so much. She was like, "There is a career that's reproductive health and public health." I'm from Mexico, so it was a long track to get here, and here [00:06:30] I am advocating for reproductive justice, advocating for people that are monolingual Spanish-speaking, and they feel that they don't have a choice or a say in what happens with their bodies. They're surprised to hear that they can choose. I just love being a health educator.

Tammy Kremer (06:47):

That's really powerful to move from the place of your own experience of not having access to information. I want to ask both of you, what are your priorities and values when you're working with clients who are interested in getting on birth control? [00:07:00] Can you share an example of a way that a conversation might play out about that?

Jennifer Karlin, MD, PhD (07:05):

First of all, I also wanted to mention that I was partly trained at New Generation and most of healthcare you have to go to the doctor between 8:30 and 5:00 and that's usually the time that lots of people are working or in school. What is so empowering about the model of care at Newgen is that people can drop in later in the day and on [00:07:30] weekends. The space that creates when you allow people to have a conversation that is maybe intimate for them. For some people talking about contraception is not intimate at all, right? Just allowing them to choose the time and place to do it talks a little bit about my values. I try to be as open-ended as possible and learn what is someone looking for from the conversation. It might not be that someone is looking to start contraception [00:08:00] right then, but they're looking to learn more about themselves and more about their body and the environment. So offer additional options that people may not know about but offer them in ways that doesn't feel coercive at all.

(08:15):

Saying, "Would you like to hear more about this?" For example, I have a patient that came to me. She was an older Latina woman in her 40s and was having a lot of heavy bleeding from [00:08:30] fibroids, and she had had a lot of sexual trauma, also pregnancy loss. A provider had told her previously that a way to deal with her heavy bleeding would be by putting in a progestin IUD, so putting in a Mirena. She had come to me to place that Mirena because the provider who had told her that felt uncomfortable placing it with the fibroids that were in her uterus. [00:09:00] I could just tell that she was so scared of doing this but felt that she had to because she felt like if she didn't place the IUD, she would continue to have heavy bleeding and suffering. This was really the only option that she had been offered.

(09:19):

At some point, I said, "You look scared. Can you tell me a little bit about that?" She started telling me about the pregnancy losses she had had and how she actually [00:09:30] had an IUD before and then had a miscarriage and was scared that was what had caused the miscarriage and held all this guilt and it was complicated with some sexual trauma she had previously. I said, "You do not need to do this. We can find another way to manage your heavy bleeding." Just the fact of being told, "You don't have to do this right now," gave her the space to actually think about other options. Then she left and came back and we [00:10:00] used an injectable contraception Depo-Provera to help manage her heavy bleeding.

(10:06):

Even though I want to have conversations that feel comfortable with people, I'm a white provider, I'm in my mid-40s, I'm highly educated, so there's a lot of power dynamics that go into the conversations that I

have. I think it's really important to pick up cues and be slow and not just try to, "Okay, this person is scheduled for an IUD, we're going to place the IUD [00:10:30] even if they look a little scared and not actually open up that conversation." Because that conversation took 45 minutes in a 15-minute slot.

(10:38):

But those are the conversations that are just so important to how people feel in control of their bodies both within the clinical space and then when they go outside the clinical space, which is actually what's even more important to me because that's where they're spending most of their time. I want them to take that feeling of autonomy of like, "Oh, this is my body. I [00:11:00] get to make choices about it." I want everybody to walk around the world knowing that and feeling that and acting that when they're not in the clinical space.

Mariana Horne (11:09):

I'm so happy to be in a space talking with somebody that shares the same values and the same priorities. The beauty of Newgen is although there's like 20 minutes lots for the patients, we just don't stop right there. If somebody needs to talk over and over again, we just stay there and talk with them. I [00:11:30] feel like a lot of people have this sense of, "If I go to the clinic, I'm committing to something," and just telling them, "You don't have to." They say, "Oh, thank you. I didn't know that was an option." I'm like, "That's always an option." We see all ages when we see young people where, "How comfortable are you choosing this birth control method method? Or is someone forcing you to get on this birth control method?" Check for their safety too. "How many sexual partners have you had [00:12:00] in the last month?"

(12:01):

I have different options here like testings too, "If you need some testing, we can also do that." If the sex is consensual at all times and when we tell to people, "You can say no at any point even if you started by saying yes and in the middle you decide that it's a no, it's your right." Especially youth, they don't know that this is a choice and when you tell them, they're like, "Oh, I feel empowered if I don't want to have sex or if I want somebody to put [00:12:30] on a condom and they didn't, I have people that can help me out." I talk to people about their rights. Especially, in California, if you're in school, you have a right to get out of school at any time. You just have to talk with a nurse and they have to let you come to the clinic for your reproductive care.

(12:49):

We also go into what are the stigmas or beliefs around birth control and how we can have a healthy conversation about it. As somebody that came from a very [00:13:00] Catholic family, we were told, "If you don't bleed, you're accumulating all the blood inside of you." I'm like, "Oh, let's talk about that because that's not what's happening." I bring props and everything, and I'm like, "This is what happens in your body and this is how the hormones work." When they see how the hormones work, they're like, "Oh, I didn't know if I could skip my period every other month, I would do it." We do see a lot of monolingual Spanish speakers, and this is a story that breaks my heart, but I feel [00:13:30] I have to share it. One of the patients came to the clinic, she gave birth on the border.

(13:36):

She said, "They just handed me paperwork in English. I don't understand English, but I had to sign it because they were forcing me to sign something." Before she saw the baby, they just placed the NEXPLANON under her arm and then five minutes later, they brought her baby. She was like, "I don't know what is this that they put under my arm, but it hurts, and I'm [00:14:00] feeling very uncomfortable."

(14:01):

She was sharing all the side effects of the birth control. She was just like, "They told me that I can't take it off in three years." I'm like, "No, how long have you had it?" She was like, "Two months." I was, "We can definitely take it off. You don't have to wait three years and if you decide that you don't want to get on birth control, you don't have to." Historically, Black and brown women have been coerced or forced to use birth control to stop procreating, and my [00:14:30] inside was boiling just, "Why nobody talked to you about this? They made you feel that you don't have a say just because you're new to the country doesn't mean that you don't have a right on what happens to your body."

(14:42):

She was like, "Can we talk about all the birth control methods?" I'm like, "Totally." After talking to her for 45 minutes, she was like, "I don't want it. Right now, I'm scared to use another birth control method." I was like, "Okay, you don't have to get on birth control. We also have resources of [00:15:00] assistance. You need housing, you need food, you need shelter. What can I give you so you can go home with a lot of tools for you to feel that you got something out of us and that you feel safe and you feel comfortable coming back or calling us if you need help with whatever it?"

Jennifer Karlin, MD, PhD (15:19):

Mariana, that story brings up so many important points, I think that I come across to, one, this misconception that if a [00:15:30] contraceptive is placed, especially a long-acting reversible contraceptive, that it can't be taken out. I think it's so important. It's one of the first things I say when I place the NEXPLANON, for example, "This is going to go in really easily, but it's much harder to take out, so I just want you to know that if you get this placed, we can take it out tomorrow, we can take it out in a week, we can take it out a month, we can take it out in five years when the progestin [00:16:00] is running out, and then it's the opposite with an IUD. It's just going to take a little while to put in, but taking it out is super easy and, in fact, you could do it yourself. I can leave the strings really long, and we can talk about you being able to remove it whenever."

(16:17):

I think that's really important because when lots of providers share information about birth control methods, they'll say that can be in for this many years and this can be in for this many years. People interpret that [00:16:30] as I'm supposed to keep it in that long. Then also, what it must feel like have something in your body that you don't know what it's doing, and how uncomfortable that must be. That would make me scared of putting anything else in my body. I think, as a provider, another one of my values when I'm talking about contraceptive options is talking about the side effects and the effects that the hormones have from the [00:17:00] get-go. Because if you minimize them or hide them and then somebody's sitting there being like, "Wait, I got this thing. I totally trusted the person who put it in and now I'm having this experience of my body that I never even heard about." I just like to tell people... This isn't the majority of the people, but some people experience this.

Mariana Horne (17:20):

Yeah. I'm huge advocate for sharing the information about, "Even how uncomfortable a procedure is going to be. Let's talk about [00:17:30] how we're going to manage the pain." We show them the tools that we're going to use, what's going to happen throughout the whole procedure. At the end, we ask them like... Sometimes they're like, "I'm in a lot of pain," and sometimes, "Oh, actually, it was not that bad." Following up with the patient a few days or a few weeks later, we've even had patients that have come, that have private insurance, and they put NEXPLANON or an IUD and private insurance are, "No, you have to wait until [00:18:00] three years, five years, seven years." We just sometimes eat the cost of

the service, and we're like, "Okay, they told you that they can remove it. We will do it because we believe in you have a say in what happens with your body."

Jennifer Karlin, MD, PhD (18:12):

Mariana, that's interesting because that brought up to me the varied experiences that I have seen of people responding to different procedures. Some people have an incredible amount of pain from a IUD placement and some people experience [00:18:30] that as sharp pain, some people experience it as cramping, some people experience it as a tinge or bloating. People describe it and experience it differently. Then some people don't even feel it at all. It's always amazing to me. I never know who is going to have a different experience. So I try a lot not to name the experience that someone is going to have. I try not to say, "You are going to feel pain." I try to just describe, especially while I'm doing the procedure myself, " [00:19:00] I am now touching your leg." You're going to feel my hand on their leg because what if somebody was numb there and didn't actually feel my hand?

(19:09):

I don't know what they're going to feel or experience. So I try to just name what it is I'm doing because sometimes I wonder if that takes out a little bit of the judgment or the idea of like, "Oh, I should be feeling this way." That certainly has been my experience. When someone else is describing to me personally what I should [00:19:30] be feeling, I start having these thoughts in my head of, "Why am I not feeling that, or should I be feeling that?" Because that's my experience as a patient, I try not to do that as a provider.

Tammy Kremer (19:42):

Yeah. I'll say when I had my IUD placed, I was surprised by how little pain there was. Also, once I had it done, I looked back, and I wondered what had scared me so much about getting some long-term birth control method. I think [00:20:00] the conversations that you're describing of really sitting down with folks and going through the different options may have changed my outcome where I did end up having an abortion despite using a barrier and despite taking emergency contraception within six hours. I don't think I knew at that time that getting a copper IUD placed within five days could have prevented a pregnancy.

(20:24):

I don't think I knew at that time that the weight cutoff for emergency contraception, the form that [00:20:30] I took at least was 150 pounds, which was incredibly shocking for me to discover. To me, that feels very low. I think there was this double-edgedness about it's so great that emergency contraceptive pills, at least at that time were very easily available for me. But yet the flip side was I just had in mind, "Oh, this is what I'm supposed to take in this situation." I actually did have more than one choice. I didn't know that.

Jennifer Karlin, MD, PhD (21:00):

[00:21:00] Tammy, thanks for sharing your story with us. I'm sorry that was your experience. I think it is an experience that a lot of people have. Even being in the field, there's new methods all the time and there's nuances to them. We're all constantly learning about them. What feels sad to me about your story is if someone just took a second to say to you, "Hey, there's this other option and what do you think about this?" Maybe you would've explored, " [00:21:30] Oh, I'm scared of getting an IUD placed because I have this idea that it's going to be really, really painful."

(21:37):

Somebody could have said, "Yes, some people experience it really painfully and some people don't have that experience." You could have also troubleshot. I mean, there's a lot of times when I'm placing an IUD where I say, "Listen, you're totally in control. If there's any point where you want to stop placing this at any moment after I place the speculum, [00:22:00] I mean, it's just not a dangerous procedure, so you can stop at any time. If it gets to be too much, just let me know." You have options for anesthetic blocks, so numbing the cervical nerves so that people have less sensation during the procedure. I think what's tricky about all of this is saying there are all these different options and sometimes those conversations take a while because they're not black and white. [00:22:30] Even if we give an anesthetic, some people still have sensation with the anesthetic, but you're never going to know unless you ask.

Tammy Kremer (22:40):

I think there was also, for me, a profound strangeness about the idea of having something that stays in my body. I think particularly as a younger person, at least in my situation, there's maybe been less interaction with the medical system and maybe less need for trying different types of [00:23:00] procedures and medications. There's a bit more of that strangeness of it all. In each of the three episodes on Family Planning and Reproductive Justice, we're showcasing relevant projects by our colleagues at the UCSF Bixby Center for Global Reproductive Health. The Bixby Center focuses on advancing reproductive and sexual health [00:23:30] worldwide. Here's Bixby Center director, Dr. Jody Steinauer.

Jody Steinauer (23:36):

As a contraceptive care provider myself, I have learned firsthand the importance of trusting people to know what's best for their bodies and their lives. There are two programs that I want to mention, especially for people who provide contraceptive care that will help us improve the care we provide. The first program is called the Person-centered Reproductive Health Program, PCRHP, and the Department of Family and Community Medicine at UCSF. [00:24:00] PCRHP, under the direction of Dr. Christine Dehlendorf has developed a set of amazing resources to make contraceptive counseling more responsive to people's needs and values.

(24:12):

My favorite tool that they have developed is called My Birth Control, and this is an interactive online tool that helps patients identify what is important to them in terms of their chosen contraceptive method, and then can be used by clinicians when they interact with the patient to facilitate [00:24:30] really high-quality shared decision-making. You can find this resource on clinic.mybirthcontrol.org. I want to also recommend the site called Innovating Education in Reproductive Health, which they have based at Bixby Center that has many, many free online courses available to anyone. These include courses on abortion and many on contraception, including contraceptive counseling, and methods of contraception. It can be found at [00:25:00] innovatingeducation.org. I want to close by just thanking you all for taking the time to learn about this to improve the contraceptive care you provide.

Tammy Kremer (25:15):

I'm curious to get into some of the specific birth control options that you might discuss with patients. In particular, ones that maybe we don't hear about very often and some benefits, [00:25:30] drawbacks of these different methods. If we can start with NEXPLANON because I know we've been mentioning it, but we haven't explained what it is.

Mariana Horne (25:38):

Yeah. An NEXPLANON is a device that is a size of a matchstick, and it goes under your arm. It's placed at a clinic and it has only one hormone, which is progestin only. Recent studies have shown that it's good for up to five years. Initially, it was only for three years. Some of the side effects are irregular bleeding or spotting, [00:26:00] so we do share that information with people. The lining of the uterus is just creating very thin, so little that it creates little that it's going to start shedding. That's why you have irregular bleeding or irregular spotting. Some people have mentioned they stop bleeding and some other, even though it's a regular cycle, they know their body or start to understand their body to know, "Oh, I'm going to start spotting here and there in the next couple of days." We also share some breast [00:26:30] tenderness here and there or some headaches. Some people have mentioned some weight gain, some weight loss, and mood changes.

Tammy Kremer (26:39):

That's a great example in terms of the information that you might share. If we can talk about IUDs and what are some symptoms people might have or some side effects, in particular, those that folks might not be expecting. Jen, do you want to take this one?

Jennifer Karlin, MD, PhD (26:57):

Oh, sure. I loved your matchstick, [00:27:00] like the size of a matchstick. I was like, "I'm going to use that." IUDs, similar to what Mariana said in terms of size, it's like if you could imagine two matchsticks placed together perpendicularly into a T, it can either contain a hormone or not and just be made out of copper. It's placed through the vagina, through the cervix into the top of the uterus. The copper IUD does not have [00:27:30] any hormones in it, so there are less systemic effects, but it has been known to create heavier periods. People who generally have more painful and heavy bleeding might have heavier bleeding and more painful bleeding.

(27:47):

The irony of this is that when I actually got an IUD placed, a copper IUD, when I was in medical school, I actually, had less bleeding and that was amazing, but I had the worst experience [00:28:00] of placement. It was so painful. They had to try three times. They eventually used an ultrasound. I definitely am one of those people that are like, "It can be terrible to place it." But honestly, my bleeding just decreased. Sometimes you just never know what someone's experience is going to be. For the progestin-containing IUDs, those again, similar to the NEXPLANON can cause irregular bleeding. They have a little bit less of those systemic side effects [00:28:30] that people experience with either progestin injectables or pills or the NEXPLANON because it's more of a local progestin effect, but you could still have some of those experiences.

(28:42):

But mainly, it's the irregular bleeding or not having any bleeding at all. Mariana talked about this before, but there are a lot of people who are uncomfortable with not having any bleeding. It's not just because they've been told that you need to bleed every month, but a lot of people will tell me, " [00:29:00] I just like to bleed every month so I know I'm not pregnant. I know I have this in here, and I know it's effective, but I just want to know for myself and feel for myself."

(29:08):

Also, other people explain that it just helps with their natural cycle. They like to feel this is going to happen every month just like the sun rises every day and sets every day. The other things about IUD is there are slight risks of placing them what's called a perforation or a hole in the uterus. Extremely, rare [00:29:30] but can happen. You can get an infection, but we do this under clean technique, so that's

very, very rare. I will say that I do get a lot of people saying that they can feel their IUD afterwards. If an IUD specifically is misplaced, there could be a sharp pain every once in a while when they make certain movements.

(29:54):

Then the strings, of course, I always talk about the strings. The interesting thing is if you leave [00:30:00] the strings really long, they can wrap around and actually be more comfortable for a partner who has a penis and is placing the penis inside the vagina so that they're not actually feeling the end of the string. But we always offer to trim the strings as much as people want and talk about that.

Tammy Kremer (30:22):

Thank you. You mentioned injectables, and I know that you did a lot of work around creating more access to self-injection. [00:30:30] Can you speak a little bit about Depo-Provera, what it is, and a bit about the work that you did advocating for people to have the option to self-administer?

Jennifer Karlin, MD, PhD (30:38):

Sure. Thanks for asking about that. Depo-Provera, its trade name, its generic name is depot medroxyprogesterone acetate. The injection lasts for 12 weeks, but if you miss it at 12 weeks, up to 15 weeks is effective to do a re-injection. [00:31:00] There are two options. There's an intramuscular injection and a subcutaneous injection. What that means is that an intramuscular injection goes into your muscle, so it's a bigger needle, a longer needle. It is often injected into the upper arm where your biceps are, and then it also can be injected into your gluteus or your buttock.

(31:25):

Then the subcutaneous injection is a smaller [00:31:30] needle and what subcutaneous means is underneath the fat, their lower stomach is usually the most commonplace, but you can also do the anterior thigh. Generally, all over the world, people have been using subcutaneous depo. I'm going to just say that for short, for self-injection, and it's been particularly popular in sub-Sahara Africa, but in the United States, we have mainly used the formulation of the intramuscular [00:32:00] version and mainly given in clinic.

(32:03):

The reason for that is cost. The intramuscular formulation is a lot cheaper than the subcutaneous formulation at this time. There just hasn't been a lot of information about the subcutaneous version, which is perfect for self-injection. During the beginning of COVID, I realized that there was this contraceptive option that we could keep people on [00:32:30] that they might not have to come to clinic for if they didn't want to come to clinic during a time when they were scared of contracting a virus. In California, I finally got in touch with the chief of the pharmacy policy division, and he was able to get it in front of the right people in the Department of Public Health, and he got it approved for the time during COVID. Our clinic had a project with a bunch of medical students and pharmacy students who actually [00:33:00] had been pulled from their classes.

(33:02):

It was perfect because they wanted something to do. I had them call our patients and offered this. About 35% of our patients who were on the [inaudible 00:33:11] version were interested, but only 24% actually effectively injected. A lot of the reasons why they weren't able to inject were entirely administrative because the actual labeling that the FDA does still says that it's not for self-injection, even though we have a ton of evidence [00:33:30] that from around the world and now in the United States also, that people are able to self-inject. In fact, we have better continuation rates among people who

self-inject, particularly, younger people. Pharmacists would say that or there would be a prior approval that was needed or the insurance just wouldn't cover it.

(33:51):

Then we've been talking to people about what their experiences were actually switching and how they would like providers to offer it. [00:34:00] This has become more popular now in many states. What I would say that drives me about it, I often wonder just having a provider say, "You know what? You could do this yourself if you wanted to." What change does that allow for in someone's mind about what they can and can't do? But I'll say again that it's really hard to make change. I just did a large national survey of providers who [00:34:30] are experts in family planning across the country, and while 80% of them knew about the option for self-injection, only 40% were offering it.

(34:43):

We still have a large amount of providers who don't even tell people that it's an option. There's lots of reasons for that. When we ask people about that, they say it's because they think that people won't be interested. They think that maybe it won't be covered. These stereotypes and misconceptions, [00:35:00] again, are just so pervasive and keep us from just offering things that are available.

Tammy Kremer (35:08):

I love the way that work subverts these power expectations and hierarchy and sense of who can administer. I want to talk about barriers, internal condoms, external condoms, and dental dams, in particular, I personally got really interested in understanding the history of internal [00:35:30] condoms. I got really curious about how internal condoms might provide an option for people to take control of their own bodies. An internal condom is essentially the inverse of the condom that most people think about, which is designed to go around a penis. An internal condom is designed to go inside someone's body, so the vagina or front hole, depending on what language a person wants to use.

(35:55):

In particular, thinking about how that could afford a gender-affirming [00:36:00] form of barrier for folks who might not relate to their bodies in a way where it would feel good for a partner to wear a condom and for whom it might be empowering to wear one. Also, thinking about folks who may not have full control over a situation. There could be many reasons for that, but thinking about sex workers, in particular, who might just prefer to have control over what condom is used. I'd love to hear from you maybe Mariana if you want to start about conversations you've had about barriers, both those [00:36:30] ones that are more and less known.

Mariana Horne (36:32):

Yeah. We have internal condoms at the clinic. Also, less known barriers such as spermicides or actually dental dams are becoming more popular these days. We've been talking a lot about to prevent pregnancy, but what we've found is internal condoms are also used for people if they want to be more safe with the tools that they use for sexual intercourse, such as toys to [00:37:00] prevent sexual transmitted infections. An internal condom can be a good option for people that are sharing toys. Also, for people that are having penis, vagina sex. They're very popular, and I'm very happy about that, the dental dams at the clinic.

(37:15):

They're flavored and they're often used for oral and anal sex. They're actually like a satin latex. It's only for one-time use only. I've been giving people more than five, and I'm like, "Use them and let me know [00:37:30] if you need more." A lot of people have tried them and they come back to the clinic, they're

like, "Actually, they're really good. They prevent an STI, and they were flavored." I'm like, "Wonderful." I feel like this is important to share. There are some methods that can prevent an STI. It's not only the external condom, it's internal condom, dental dam, and external condom.

Tammy Kremer (37:50):

I appreciate that we're talking about these different barriers that folks might be less familiar with. I recognize that we haven't talked about one of the first [00:38:00] methods of contraception that people think about, which is the pill, which of course, is a category of options, but people might relate to it as a monolith. I know that there have been a lot of different kinds of experiences people have about that form of contraception and the side effects. I want to share personally that's something that has impacted me is learning from people I'm close to about, I think fairly rare side effects, things that relate to changes [00:38:30] in vaginal tissue and pain. But I'm curious to hear from both of you in this broad category of "the pill," what are some side effects that you are aware of that people might not know about or that may be controversial even?

Jennifer Karlin, MD, PhD (38:47):

People definitely have mood changes with the pill and describe that a lot. Mood changes, weight changes. I guess this is slightly controversial, but changes in blood pressure. I do notice a lot of times that [00:39:00] people, their blood pressure will increase once they've been on the birth control pill and the evidence doesn't necessarily bear that out, but I have experienced that for sure. If people are concerned about that, I think that's totally reasonable.

Mariana Horne (39:15):

Yeah. Just mentioning that estrogen-containing birth control pills can potentially increase the risk of a stroke in individuals with migraines with aura. I think migraines with aura itself, it's already considered a risk factor for a stroke, and adding estrogen [00:39:30] to the whole mix in your body can elevate the risk if you have experienced migraines with aura or if you see lights around you or that the light bothers you when you have a migraine and talk about the other options that are available for you.

Jennifer Karlin, MD, PhD (39:49):

I mean, in terms of side effects, not even just talking about the pill, but any type of side effects when someone comes to clinic and [00:40:00] describes how they've experienced a contraceptive method, even if the evidence doesn't bear out on a population level that is statistically significant, I still normalize that for the patient because that was that patient's experience with the method. I just think it's important to say that data on a population level doesn't always bear out on the individual [00:40:30] level.

(40:30):

We see individual differences that wouldn't be captured in studies. One other thing is that lately from the international community specifically, I've heard people say, "Oh, in the United States, everybody's on the pill." I just think that's a really curious narrative. When we talk to people about their histories of contraceptive use, tons of people tell a story of, "When I was 15 years old, my mom [00:41:00] took me to the doctor, and put me on the pill." That was all they were told about.

(41:07):

It's like this self-fulfilling prophecy that we say that everybody is on the pill in the United States. Then people go to the doctor and then ask for the one thing that they know. But a lot of people that we talk

to then narrated stories about how they didn't have a great experience on the pill. That is how they then got [00:41:30] to other contraceptive options as time went on. As they were in different relationships and in different situations. That is something else that I think is really important to remember is that we're all different people at different times. One thing that works for any of us in one particular time and place isn't necessarily going to work for us the next day or the next week or in 10 years depending on what our gender and sexuality and experiences [00:42:00] look like at that time.

Tammy Kremer (42:02):

Thank you for naming that. I'm a queer woman. So that was one of the elements for me in making birth control choices where I felt like, "Why would I want to get on a birth control option that is always there when I don't always need it?" Being able to talk openly about how identity connects with birth control, I think is really important, and we're going to be doing another episode in this series where we're really going to focus on family planning and reproductive care [00:42:30] for folks who are trans and gender-nonconforming. I know we want to talk about fertility awareness. Jen, do you want to take that one?

Jennifer Karlin, MD, PhD (42:45):

Sure. One of the reasons why I think it's important to bring up fertility awareness is because it's really one of the least talked about options. One of the reasons for that is because there's not much money that can be made off of it. [00:43:00] There have been apps that have been developed, but it's not a device, it's not a pharmaceutical. There's no way of making millions or billions of dollars off of it. It is actually surprisingly more effective than we give a credit for. I actually think it's really important to talk to people about fertility awareness, both when they're choosing a contraceptive device or a pharmaceutical, and [00:43:30] when they're choosing to solely use fertility awareness methods. There are various names for it, there's a two-day method where you think about the type of cervical mucus that you have on that day or the day before, and you ask yourself, "Has it changed to be like an egg white?"

(43:52):

If it has, then you don't have sex that day because that means that you are more fertile that day. There's that [00:44:00] method. There's calendar methods where you learn about the regularity of your ovulation, which is when an egg is released from your ovaries, and you're the most fertile. I always pull up a image to show people what is happening at different times with the uterine lining and with the hormones and with cervical mucus, and then with an egg moving through [00:44:30] the tubes into the uterus.

(44:32):

I just think it's always important to remind people that it is very effective. If people choose fertility awareness and condoms, that is choosing a method. I think just correcting, again, that misconception that it has to be a device or a pharmaceutical for you to actively be doing something to be both preventing STIs and pregnancy. There's lots of things that we can do to prevent infections [00:45:00] that aren't condoms. Paying attention to symptoms, talking to your partners about their symptoms, getting tested beforehand. It has to do with relationships, communication, and knowing our own bodies and being in our own bodies.

Tammy Kremer (45:19):

I think there's a profound way that things like the fertility awareness method really have to do with trusting people to care for their own bodies and make [00:45:30] choices for themselves, which is something that as we know traditionally medicine has not always done. If we had more time, we would

also go into the sponge, the diaphragm, perhaps spermicide, which came up briefly. We haven't talked about the NuvaRing, which is a silicone ring that contains hormones that can be inserted into the vagina or front hole and removed monthly. We've talked mostly about supporting folks who have a uterus, [00:46:00] have a vagina in choosing a form of contraception. I wonder if in those conversations questions come up about contraceptive options for partners who produce sperm.

Jennifer Karlin, MD, PhD (46:11):

Yeah. Those questions come up. Often, people will say, "Listen, I really don't want to use hormones, and I don't want to get tubal. Is there anything my partner can do?" There are options for people who produce sperm, which include a vasectomy, which is where you cut the [00:46:30] vas deferens, and it's actually a same-day procedure. It's external to the body as opposed to people with ovaries where you cut the tubes, which is a tubal ligation. It is something we didn't talk about yet today, but that is an option for people who want permanent sterilization.

(46:54):

It also actually has benefits for decreasing the risk of ovarian cancer in [00:47:00] the tubes. Oftentimes, it'll take larger portion of the tubes to decrease that risk, but those both are permanent sterilization for people who produce sperm and people who produce eggs.

Tammy Kremer (47:15):

Vasectomies are also reversible though, I think. Within a certain amount of time, there's a fairly high chance in case they do make a different decision within a number of years. I don't know the stats on that, but just wanted to share that too.

Jennifer Karlin, MD, PhD (47:26):

Yeah. In addition to cutting of [00:47:30] the vas deferens, there is an option for injecting a gel that is more temporary for blocking sperm to getting outside of the penis. Those are other options that can be used.

Mariana Horne (47:45):

I would say some people do come to the clinic asking... We don't do vasectomies. We don't talk that much about the vasectomy gel, although we don't do tubal ligation at the clinic. There's [00:48:00] one patient that came and she was under 30, and she was like, "I know that I don't want to have kids. I don't want to be pregnant. I don't want to put my body through it. But everywhere I go, they tell me that I'm very young and that I should wait just in case I want to change my mind. I know that if I end up wanting a kid or a baby, I go to the route of adopting somebody. If you're going to talk to me about all the birth control methods that are long-lasting, [00:48:30] I'm just going to cut to the chase. I'm not interested in any of those. What else do you have available?"

(48:36):

I told her, "I hear you. How can I help you?" She was like, "If you can make a referral of the provider, give me the phone number of somebody, that will be very helpful." I told her, "You know what? Let me go and talk to the provider." The provider made a referral, made the appointment right there for her, and she cried at the appointment with us. She was like, "For the past three years, I've [00:49:00] been hearing provider after provider just telling me that I need to wait." She was like, "That's not bodily autonomy." After that, she made another appointment, and she was like, "Thank you. Finally, it happened because you heard what I had to say, and I got what I needed."

Jennifer Karlin, MD, PhD (49:19):

I love that story. Thank you so much for doing that work and listening to her. I agree that there are so many people who are turned away because of their age from getting [00:49:30] sterilization. It's surprising to me because it's not the provider's life and it's so important for gender-affirming care. I think part of that story that I just want to lift up is the importance also of providers directly reaching out to the people who can do the surgery and actually explaining to them like, "I sat down with this person and it is my recommendation that they get this." My worry is always that then the patient is referred, and then [00:50:00] turned away again. You just don't want that situation to happen to your patients. What's so beautiful is also the effective handoffs. Thank you so much for making that happen. One other conceptual framework talking about contraceptives, there are people who talk about menstrual regulation, which is where people use misoprostol, which causes cramping and contractions [00:50:30] of the uterus, and they use that monthly as a way to bring on a period.

(50:36):

That is also an effective way of making sure that you do not become pregnant. It is not something that is named as a contraceptive method, and it's also not something that is named as a method of abortion because it is done before a pregnancy test [00:51:00] or before somebody knows that if they're pregnant or not. But there are many cultures and many people who do that, and that is an effective way of preventing a pregnancy growing and continuing. I think highlights the issue about where we draw the line between where we're naming things as emergency contraceptive, as abortion, and there's been lots of confusion lately about emergency contraception and whether [00:51:30] or not that is terminating a pregnancy and emergency contraception is certainly not terminating a pregnancy. I would also argue that menstrual regulation is also not terminating a pregnancy.

Tammy Kremer (51:45):

Thank you so much for sharing that. I have never heard of that before, and I've got some learning to do. I love that there are so many different creative ways that people can find that work for them. On the line of this differentiation between [00:52:00] abortion, contraception, emergency contraception, and I wanted to take some time just to talk about what it's like to support patients in finding abortion care now.

Jennifer Karlin, MD, PhD (52:12):

Yeah. I think of reproductive autonomy as more of a spectrum. So even when people choose a contraceptive option, I say contraception isn't always totally effective. If there is a time when you become pregnant [00:52:30] and you do or do not want to be pregnant, I'm here to talk to you about your options. In terms of abortion, we are very lucky right now to be living in the state of California that is both protective of patients who are seeking abortion care, and also of the providers who are providing abortion care. There are pills that you can take.

(52:55):

One of them is a combination of mifepristone and misoprostol, [00:53:00] although you can also do a misoprostol-only medication abortion. Then the other option is a procedure and is a small tube that's a vacuum that helps remove the contents of the uterus when the gestational age gets a little bit higher there are other instruments that sometimes need to be used. In terms of medication abortion, there are various options for receiving pills, and those options include [00:53:30] going to a clinic and then picking up the pills at a pharmacy now because it is now available to receive the medications from a pharmacy and doesn't have to be provided directly from a clinic.

(53:45):

Then there are telemedicine options where you can talk to a provider and then get the medications mailed to you or to pick them up at a pharmacy. Then there are options for receiving the medications online yourself. [00:54:00] From an online pharmacy or from different online sources like Aid Access, and plancpill.org actually is a great resource of a website that both tells people about their options locally at brick-and-mortar clinics, telemedicine options, and then has vetted online sources for pills that are both effective and reliable.

(54:30):

[00:54:30] There is also a hotline of clinicians, All-Options of people who are trained to talk people through all the options, which also includes adoption and termination. There is also a hotline called the M&A Hotline, which is the Miscarriage and Abortion Hotline. That is clinicians who support people who are having a miscarriage or who have already received the pills from an online source and who are managing a miscarriage [00:55:00] or an abortion at their home without seeking care from a brick-and-mortar physician or advanced care provider. That hotline is very helpful and has been able to support thousands of people over the last three years across the country.

Tammy Kremer (55:20):

Incredible. The resourcefulness and tenacity of our community and making sure that people continue to get abortion care, [00:55:30] and of course, naming that not everyone will be able to access the care that they need. Thank you both so much for contributing to making sure these options all remain available. I want to transition to the last question I'd like to ask our guests, which is bringing in the imagination from a perspective of movement building, thinking creatively, and investing in new possible futures is so important. So I like to ask, what's something you hope we can create by Coming Together for Sexual [00:56:00] Health?

Mariana Horne (56:01):

My hope is to create more equity and education surrounding reproductive rights, ensuring that individuals receive the care that they need and they deserve, and keeping in mind bodily autonomy. My hope is also that the information that is given to people in the United States, it's available not only in English but in other languages.

Jennifer Karlin, MD, PhD (56:23):

My hope would be that by coming together, individuals can be in [00:56:30] their bodies without feeling any shame or judgment and really exploring their bodies and feeling that they have the choice in this lifetime while we're here together to choose the things that make them feel good and make them feel like they're living the lives that they want to live and that other people can't tell them whether or not that's a good choice or a bad choice. It's their choice, and that is [00:57:00] the most important thing.

Tammy Kremer (57:03):

Thank you both so much for sharing those visions and the work you do every day to move us collectively towards those visions. It's been really a pleasure to get to talk to you both and learn from you.

Mariana Horne (57:03):

Thank you so much.

Jennifer Karlin, MD, PhD (57:17):

Thank you, Tammy.

Tammy Kremer (57:20):

Thanks for listening, and please follow and rate us wherever you get your podcasts. This will help more people find us. Check out the show notes for the resources mentioned in this episode. [00:57:30] You'll also find the link to the transcript of the show. Connect with us on Instagram at Coming Together Pod, on Twitter @californiaptc and @comingtogetherpod.com. This podcast is produced by me, Tammy Kremer, and is edited by Isaiah Ashburn. Thank you for coming together for sexual health.