Provision of Person-Centered Reproductive Health Care via Telemedicine

Protocols developed by Drs. Karlin and Dehlendorf for Converge
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Purpose

To provide guidance about how to facilitate reproductive health and autonomy through telemedicine.

Facilitating *reproductive autonomy* includes:

1) Providing a safe and accessible environment to offer contraceptive counseling and contraceptive methods; and,

2) Providing a safe and accessible environment to offer screening for genital tract infections, sexually transmitted diseases (STD) and cervical cancer as well as education and treatment when needed;

3) Practicing person-centered care, with particular attention to challenges related to sensitive or stigmatized health conditions or need.

Telemedicine is a tool which allows greater access to reproductive health care for some patients and that respects social distancing mandates.

Below, we provide an overall approach for how to facilitate reproductive autonomy through reproductive health care via telemedicine. The first section of the guide discusses contraceptive counseling and provision of methods for people who were not previously using a method, the second section discusses telemedicine for people who call wanting refills, replacements, or removals of their contraceptive methods; and the final section provides guidance about how to facilitate reproductive health through screening and education about STDs and cervical cancer. Of note, services related to preconception health, pregnancy counseling and testing, HIV prevention, and infertility services are not included in this guide; relevant resources should be accessed by those providing this care.

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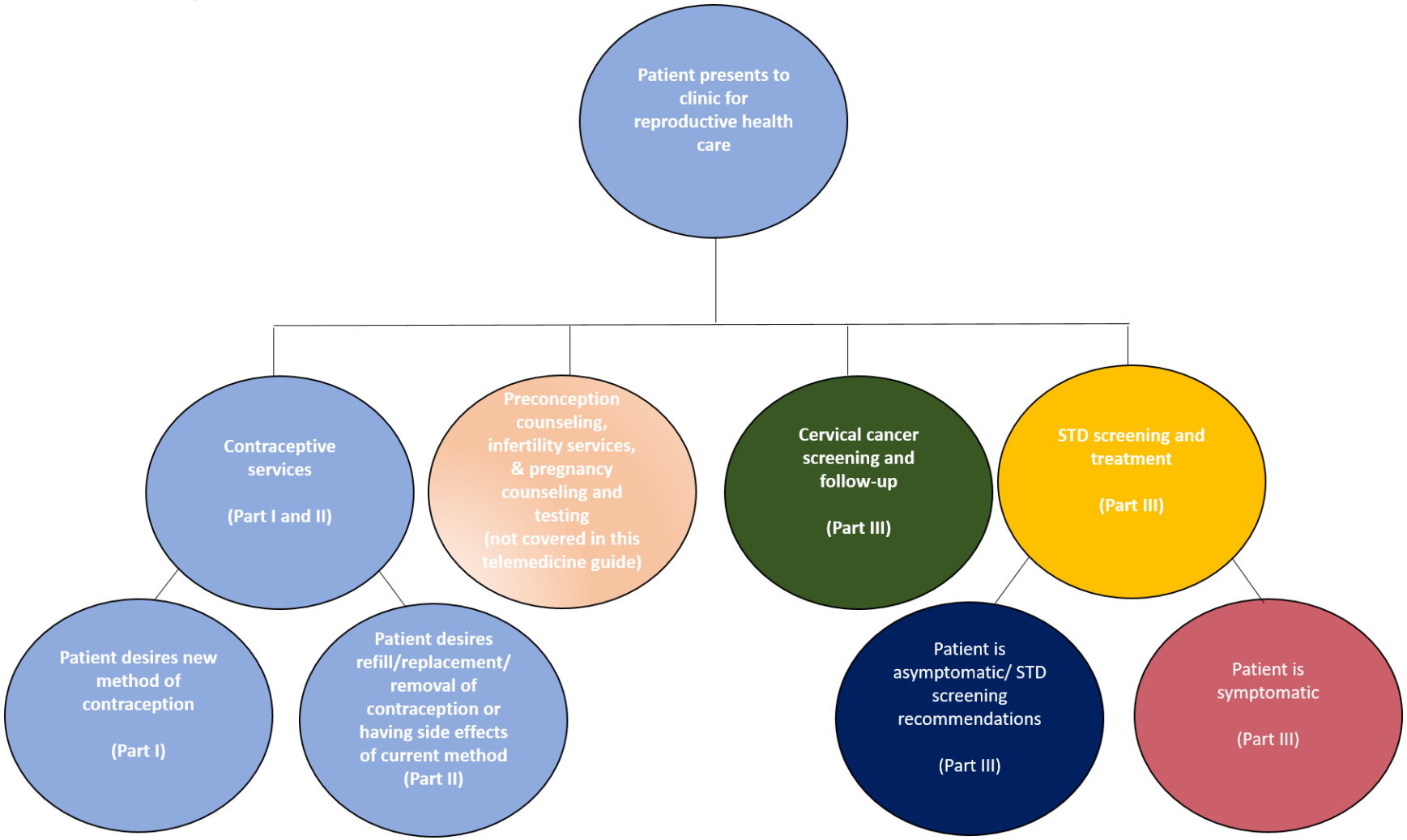

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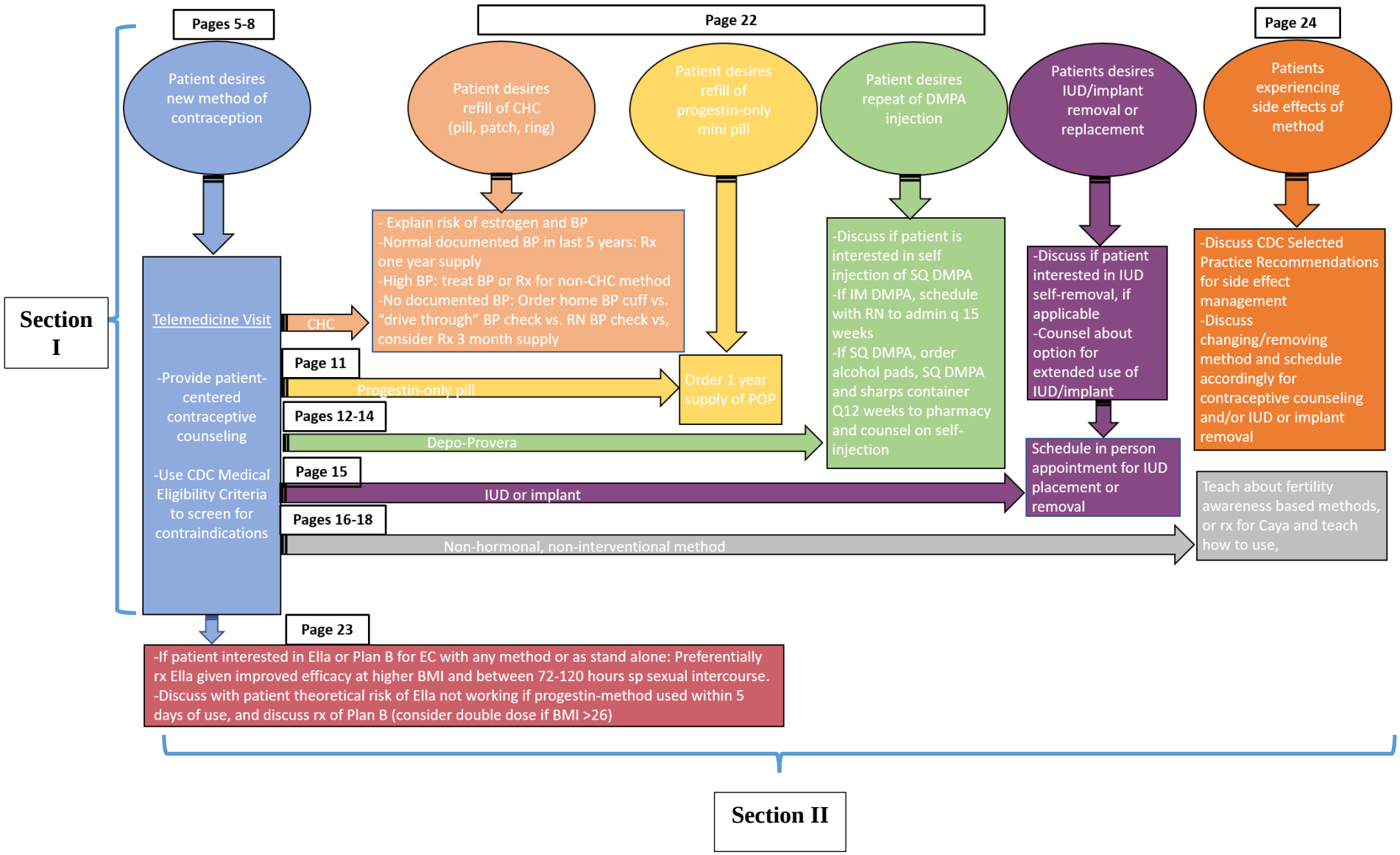

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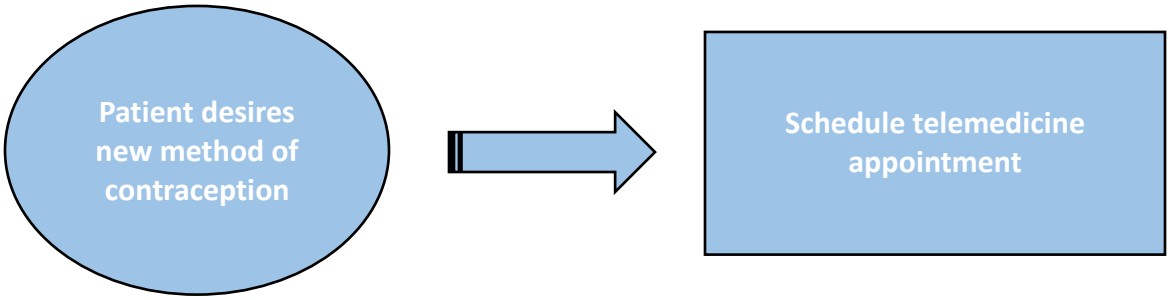
Telemedicine Protocol, Section I



Definitions

Quality, patient-centered interpersonal communication is central to patient-centered care. The quality of interpersonal communication affects health care outcomes, including patient satisfaction, use of preventive care and adherence to medication. [1]

Patient-centered care: One of the 6 domains of health care quality; defined as care that is "respectful of, and responsive to, individual patient preferences, needs and values."

- National Academy of Medicine[2]

Shared Decision Making: One approach to providing patient-centered care; defined as "An approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."[3]

Counseling Process

Below we describe the basic process of patient-centered contraceptive counseling, focusing on three phases:

1. **Identifying individuals who wish to receive this counseling**
2. **Eliciting informed preferences for method characteristics**
3. **Providing decision support to align method choose with preferences**

This counseling process draws upon shared decision making, while also allowing patients who do not wish to share the decision-making process to have their preferences honored.

[1] Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open 2013;3:e001570. doi: 10.1136/bmjopen-2012-001570.
[2] Corrigan JM. Crossing the quality chasm. *Building a better delivery system.* 2005.
[3] Elwyn G, Coulter A, Laitner S, Walker E, Watson P, Thomson R. Implementing shared decision making in the NHS. BMJ. 2010;341:c5146.

For more information on patient-centered contraceptive counseling, see Uptodate starting on page 33.	
1. Identifying individuals who wish to receive this counseling	
Identify people for whom counseling is appropriate	"Do you want to prevent pregnancy now?" "Do you want to talk to a provider about options for pregnancy prevention?"
If patient does not answer definitively about desire to prevent pregnancy, ask open-ended questions to allow people to express ambivalent or mixed feelings about pregnancy	"Do you have a sense about how you would feel if you were to become pregnant?"
2. Eliciting informed preferences for method characteristics	
For patients interested in hearing about contraceptive options, focus on patient preferences	"Do you have a sense of what is important to you about your method?"
If patient has a strong preference, ask permission to discuss other options. If patient not interested in hearing other options, screen for contraindications and provide method of choice if appropriate.	"I understand that you are interested in the IUD because you don't have to think about contraception after it is placed. Just so that I know you understand all your options, could I tell you about some other contraceptive methods that are available for you and might also be good fits for you?"
Provide context for method characteristics and elicit patient's preferences	"There are many different characteristics for contraceptive methods. For some people, the side effects of the method is important and for other people, the frequency of using the method is important. Other characteristics are effectiveness, how you take the method and the ability to start/stop when you want. Do you have a sense of what is important to you?" "There are methods you take once a day, once a week, once a month, or even less frequently. Is that something that makes a big difference to you?"

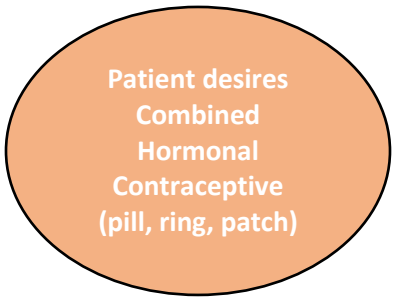
3. Decision Support Once Preferences Are Elicited	
Based on patient preferences for method characteristics, offer contraceptive choices that meet patient preferences. Try to map patient preferences onto method characteristics and discuss the pros and cons of the options.	For example, "I hear you say that you are interested in a method in which you have a regular period and that does not have hormones. Your options are: condoms, diaphragm, fertility awareness, and the copper IUD. Would you like to discuss those more?"
Some examples include the following: • Family Planning National Training Center Methods Chart • Bedsider List of Methods	

Document Medical History and Potential Contraindications

- Screen for contraindications to methods (use CDC Medical Eligibility Criteria). Most screening can be done by history, chart review, and review of symptoms.
- You should be relatively certain that the patient is not pregnant. This can be done by checking the patient's last menstrual period and the last date of sexual intercourse without use of a pregnancy prevention method, per the CDC's Selective Practice Recommendations (SRP). These state that a health care provider can be reasonably certain that a person is not pregnant if they do not have any symptoms or signs of pregnancy and they meet one of the following criteria:
    - Is ≤ 7 days after the start of normal menses
    - Has not had sexual intercourse since the start of last menses
    - Has been correctly and consistently using a reliable method of contraception
    - Is within 4 weeks postpartum
    - Is fully or nearly fully breastfeeding (exclusively breastfeeding or ≥ 85% of feeds are breastfed), amenorrhoeic, and < 6 months postpartum
- If there is concern that the patient could be pregnant, you can recommend picking up pregnancy test at the pharmacy when the patient picks up their chosen method and recommend that patient does a pregnancy test before they start their new method.
- However, remember that the benefits of starting a contraceptive method likely exceed any risk, even in situations in which the health care provider is uncertain whether the woman is pregnant. The risks of not starting to use contraception should

be weighed against the risks of initiating contraception in a woman who might be already pregnant.

- You can consider having patients start a contraceptive method other than IUDs at any time, with a follow-up pregnancy test in 2–4 weeks. Most studies have shown no increased risk for adverse outcomes, including congenital anomalies or neonatal or infant death, among infants exposed in utero to COCs. Studies also have shown no increased risk for neonatal or infant death or developmental abnormalities among infants exposed in utero to depot medroxyprogesterone acetate (DMPA).



Patient desires prescription for combined hormonal contraceptive (pill/patch/ring)

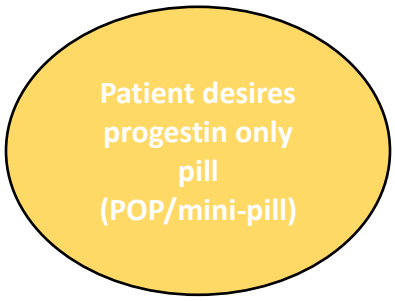
1. Remember to screen for contraindications by history and review of symptoms, as discussed on page 5.
2. BP measurement is the only vital signs that is necessary to obtain. This is because hypertension is one of five risk factors for acute myocardial in women using estrogen-containing hormonal methods (the other four are older age, heavy smoking, diabetes, and abnormal lipid levels [low HDL, high LDL, or high triglycerides]). If a patient has more than one risk factor, the risk of a heart attack increases with each.
3. For combined hormonal contraception (OC, patch, ring), the *CDC US Medical Eligibility Criteria for Contraceptive Use* (MEC) classifies multiple risk factors for atherosclerotic cardiovascular disease as MEC Category 3 / 4, depending on the individual patient's history.
4. Severe hypertension (systolic >160 mmHg or diastolic >100 mg Hg) or hypertension with vascular disease are MEC Category 4 (a condition that represents an unacceptable health risk if the contraceptive method is used).
5. As such, it is recommended that blood pressure is known before starting hormonal contraceptives.
    a. If normal BP documented (this can be documented from any care setting) in the past 5 years [4] → Send Rx to pharmacy if appropriate (1- year supply) along with prescription for Plan B and explain when patient would need to use Plan B and back up condoms.
    b. For abnormal high blood pressure, remember that BP must be documented as high at two separate visits to be defined as hypertensive.
        - Patient is still likely eligible for progestin-only pill
        - You can treat the blood pressure (although adequately treated HTN is still MEC category 3)
    c. For patients without documented normal BP in the past 3-5 years:

[4] The current USPSTF recommendation is that "adults aged 18 to 39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be rescreened every 3 to 5 years," which provides an outer time limit for use of the last BP reading.

i. Patient with home BP cuff: ask them to take BP and report value, prescribe 1-year supply if normal.[5]
ii. Patients without home BP cuff:
    i. Reassure patient that most people of reproductive age have normal blood pressure and explain the risks of estrogen and untreated HTN
    ii. Can order BP cuff to pharmacy and/or advise them to schedule visit in 3 months to ensure normal BP and consider 3-month Rx per clinician discretion.
    iii. Can consider "drive by" BP reading by RN or at clinic.

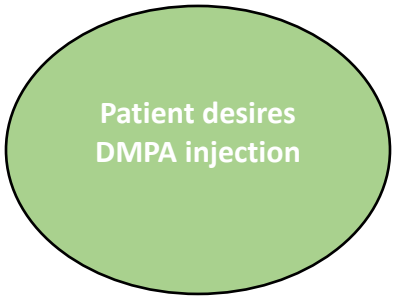
6. Discuss side effects of combined hormonal contraceptives and how to use the method. See SPR.

[5] The US Selective Practice Recommendations states that "BP measurement in other settings is acceptable, pg. 27.



Patient desires progestin only pill

1. Review medical history and screen for contraindications, as per above on page 5.
2. No examinations or tests are needed before initiating POPs. See SPR.
3. Baseline weight and BMI might be useful to track over time, and patients can check their weight on a scale at home, if desired.
4. Discuss need to take the pill at the same time every day.
5. Discuss side effects of POP, which include irregular bleeding, headache, nausea and breast tenderness.
6. If POPs are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
7. If POPs are started >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 2 days.
8. Prescribe up to one-year supply of POPs.
9. Discuss if patient would like Plan B and condoms prescribed for her.



Patient desires Depot Medroxyprogesterone Acetate (DMPA) injection

1. Screen for contraindications, per guidelines on page 5.
2. Counsel about side effects, including: spotting, amenorrhea, change in appetite, weight gain and headaches. While the SPR states that a baseline weight and BMI measurement might be useful to monitor DMPA users over time, self-reporting of weight and height are acceptable and screening for hypertension before initiation of DMPA is not necessary. Finally, in 2004, the FDA gave DMPA a black box warning related to bone density loss (but not fracture). Although DMPA users do lose bone density at first, bone density plateaus after the first two years and recovers soon after injections end.[6]
3. Discuss if patient would like to self-administer DMPA-SC or receive IM DMPA from an in-person provider. Counsel that side effects and dosage are the same. DMPA-SC differs from IM DMPA in the following ways:
   - Uses smaller (26-gauge X 3/8 inch) needle so can inject into skin instead of muscle. That means **LESS PAIN** at injection site.
   - It comes pre-filled and ready to use at home so patient is **IN CONTROL** and does not have to come into a clinic to access contraception.
   - Contains 30% less hormone and may **reduce common side effects.**
   - However, it takes time to learn how to use, so some patients experienced **local site irritation and soreness** on first and second self-injection. This improves over time. 1/100 patients could experience dimpling at the site of the injection. which also improves over time.[7]
4. Good candidates for self-injection of subcutaneous DMPA (DMPA-SC) include patients who are experienced in self-injection of other drugs (such as medications to induce ovulation for IVF, insulin, or drugs for multiple sclerosis), but it can be used by anyone. Use clinical judgement to determine whether appropriate for a specific patient and document in the decision. Discuss that this is off-label use

[6] Lanza LL, McQuay LJ, Rothman KJ, et al. Use of depot medroxyprogesterone acetate contraception and incidence of bone fracture. *Obstetrics & Gynecology.* 2013;121(3):593-600.
[7] Burke HM, Mueller MP, Perry B, et al. Observational study of the acceptability of Sayana® Press among intramuscular DMPA users in Uganda and Senegal. *Contraception.* 2014;89(5):361-367;
Cover J, Ba M, Drake JK, et al. Continuation of self-injected versus provider-administered contraception in Senegal: a nonrandomized, prospective cohort study. Contraception 2019;99:137–41.

because the FDA has only approved DMPA-SC for provider administration. However, DMPA-SC has been shown to have the same effectiveness if administered by a provider or by self-administration.

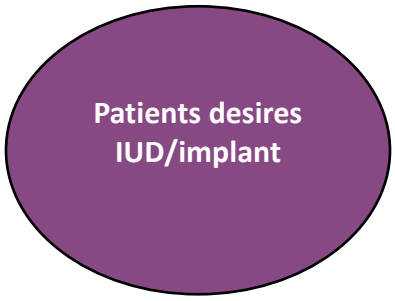
5. If patient wants DMPA-IM injection → schedule appointment every 13-15 weeks
6. If patient wants DMPA-SC self-injection→ order RX DMPA-SC (104 mg/0.65 mL) (NDC code 00009-4709-13) and alcohol pads q 3 months for one-year supply. Communicate with pharmacy that this is for self-injection. Prior to ordering, patient should check with their insurance to make sure it is a pharmacy benefit and if there is a co-pay. A prior approval, or TAR, may be required in order for DMPA-SC to be included as a pharmacy benefit for your patient. For additional counseling tips for patients choosing self-injection, see box below.
7. Consider whether a back-up method is needed:
   - If DMPA-SC started within 7 days of menstruation, no back up method needed.
   - If DMPA-SC started >7 days since menstruation, recommend barrier method or plan B for sexual intercourse within 7 days of starting.
8. For an informational video about DMPA-SC, see Bixby's Innovating Education In Reproductive Health video *This is How I Teach DMPA-SC*.

Patient education on self-injection of DMPA-SC

1. Provide patient education about how to administer (can send videos or written materials to patient to review). This can be done via telemedicine, telephone or in person, depending on how the patient learns best:
2. Consider scheduling a telehealth visit every 12 weeks if patient would like support. Evidence shows that patients' self-injection improves with continuation of method. The first few injections may have site irritation or pain.
3. Counsel regarding disposal of needles: sharps containers may not be covered by insurance but patients can request at pharmacy. (See https://safeneedledisposal.org/ for information on safe needle disposing.)
4. Provide information about safe storage of the medication. DMPA-SC should be stored at room temperature. Tell patients not to put in the refrigerator, freezer, or leave outside or in a car.
5. If patient misses a dose: patient can take DMPA-SC anytime within 14 weeks since their last DMPA-SC and be covered. However, if there is more than 14 weeks since their last DMPA-SC, recommend giving it as soon as possible, use condoms for a week and use Plan B if has unprotected sex during missed window and 7 days after injection. Patient should do a pregnancy test before restarting, if possible.

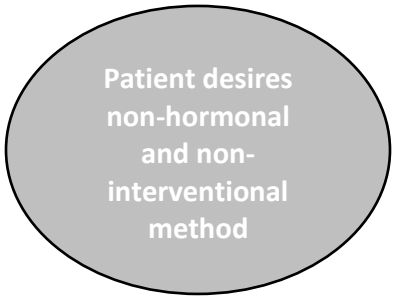
Additional patient resources for teaching about DMPA-SC

- RHAP Guidelines for DMPA-SC self-injection, in multiple languages including English, Spanish, Vietnamese, Hindi, Simple and Traditional Chinese.
- Package Insert for DMPA-SC (Depo-Provera 104mg)
- RHEUMinfo English video about DMPA-SC injection
- Bedsider.org patient English one-pager about DMPA-SC
- Spanish video about DMPA-SC self-injection from Planned Parenthood
- Spanish written patient guidelines for DMPA-SC self-injection from Planned Parenthood
- English video about DMPA-SC self-injection from Planned Parenthood
- English written patient guidelines for DMPA-SC self-injection from Planned Parenthood



Patient desires IUD or Implant:

1. Review medical history and contraindications, per guidelines on page 5.
2. Discuss if patient desires a bridge method, such as an over-the-counter barrier method or a prescription method that can be utilized until it is safer for them to have an insertion appointment, due to COVID19 risk and health care exposure.
3. If services are available and patient desires prompt insertion, schedule for in-person visit.



Patient desires Caya Diaphragm:

1. Fitting for diaphragm is not necessary since Caya is a one-size fits all
2. Discuss how to insert diaphragm with patient: https://www.caya.eu/use/

Teach how to insert Caya diaphragm:

1. Remove Caya from case. Wash with soap and water, rinse and then dry with soft clean cloth.
2. Apply spermicidal gel onto the middle of the membrane.
3. Find a comfortable position: lying down, kneeling down or with one leg elevated.
4. Hold the Caya diaphragm with one hand. Plance the thumb nad index finger on the grip dimples along the rim. The arrow has to point towards your body.
5. Using your free hand, spread the labia. Push Caya along the posterior vaginal wall, towards your back, until cervix rests inside the cup.
6. Use a finger to check that the cervix is covered by the membrane of the Caya diaphragm. The cervix must be completely covered. You should be able to feel it through the membrane. It feels like the tip of your nose.
7. After intercourse, the Caya diaphragm has to remain in place for at least 6 hours, and no more than 24 hours.
8. In the event of repeated intercourse, extra spermicidal gel should be applied in front of the Caya diaphragm without removing it beforehand.

3. Call pharmacy to ensure has stock available. Send prescription to pharmacy.
4. If desires EC, can send to pharmacy (see box on EC)

Patient desires Condoms:

1. Discuss proper use of condoms.
2. If too expensive to purchase over the counter, rx to pharmacy.
3. If patient desires EC, send to pharmacy (see box on EC)

Patient desires Fertility Awareness Based Methods:

1. Discuss methods with patients:

Calendar based methods	Rely on tracking menstrual cycle dates
Mucus based methods	Rely on tracking changes in cervical mucus
Basal body temperature based methods	Rely on tracking changes in basal body temperature and calendar calculation
Symptothermal methods	Rely on tracking changes in biomarkers (including cervical mucus and basal body temperature)
Urinary hormone based methods	Rely on tracking changes in metabolites of oestradiol and luteinizing hormone in urine

2. Possible helpful apps: Natural Cycles is FDA approved for birth control and is free with in-app purchases. Other options which are geared toward towards conceiving but also aid with fertility awareness include: Ovia, Flo Period & Ovulation tracker, Fertility Friend, Period Tracker and Dot Fertility Tracker.

3. Consider sending condoms and EC to pharmacy (see box on EC) if patient desires.

4. Additional educational resources:

Standard days method: online, free 1-2 hours training module (CME). http://archive.irh.org/SDM_Training/index.php
Two day method: online, free toolkit. https://www.k4health.org/toolkits/twoday
Sensiplan materials and training (available at cost). https://www.sensiplan-im-netz.de/?page_id=910
Contraceptive Technology 21st Ed (particularly the chapter on fertility awareness based methods, ch 12, 26. http://www.contraceptivetechnology.org/the-book/
World Health Organization's medical eligibility criteria for contraceptive use, Fifth Edition https://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/
Family Planning Handbook: A Global Handbook for Providers, ch 18, 2018. http://fphandbook.org/sites/default/files/global-handbook-2018-full-web.pdf

Free webinars from the National Clinical Training Center for Family Planning, supported by the US Office of Population Affairs Title X Family Planning Program:

- Understanding and counselling potential users on fertility awareness based methods for pregnancy prevention: https://vimeo.com/264114233
- Effectiveness of fertility awareness based methods for pregnancy prevention: https://vimeo.com/284453322
- Fertility apps: a new approach for fertility awareness based methods: https://vimeo.com/277724852

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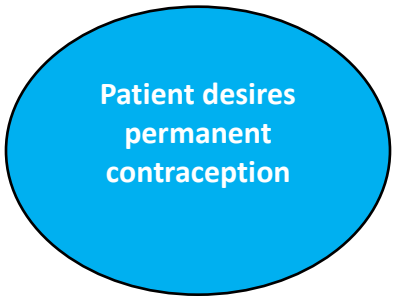
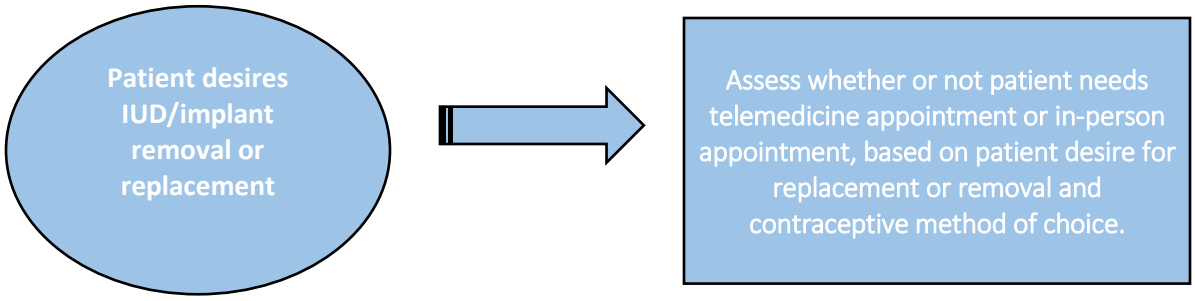


Permanent contraception

1. Discuss if patient would like female or male permanent sterilization.
2. Discuss if patient desires a bridge method, such as an over-the-counter barrier method or a prescription method that can be utilized until it is safer for them to have a procedural appointment, due to COVID19 risk and health care exposure.
3. If services are available and prompt sterilization is desired, schedule for in-person visit and counseling.

Telemedicine Protocol, Section II



Patient desires IUD/implant replacement

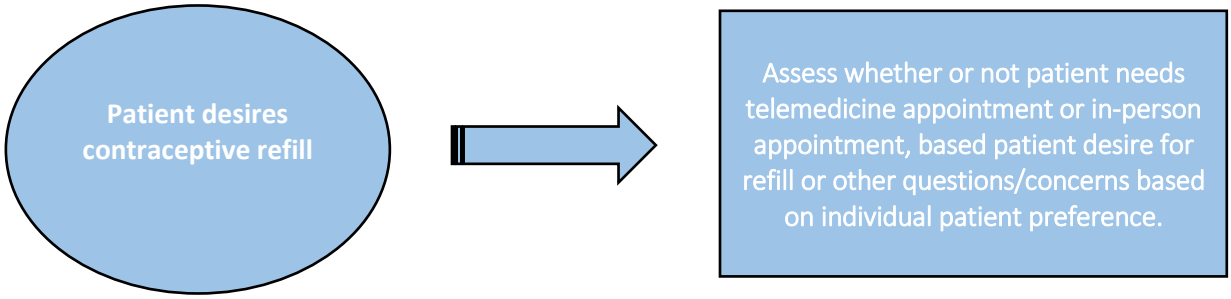
1. Discuss recommendations for extended use with patient and see if patient would like to defer replacement to the evidence-based recommendation:[1]

	FDA-Approved Duration	Evidence-Based Duration
Nexplanon	3 years	5 years
Liletta	6 years	7 years
Mirena	5 years	7 years
Skyla	3 years	3 years
Kyleena	5 years	5 years
Paragard	10 years	12 years
DMPA-IM	12 weeks	15 weeks
DMPA-SC	12 weeks	14 weeks

2. **If device has reached end of extended-use lifetime, there is a clinical reason to replace sooner, or patient prefers replacement based on the FDA-approved time frame, proceed with in-person visit**. Recommend use of barrier or other CHC/POP in the meantime as appropriate.

Patient desires IUD/implant removal

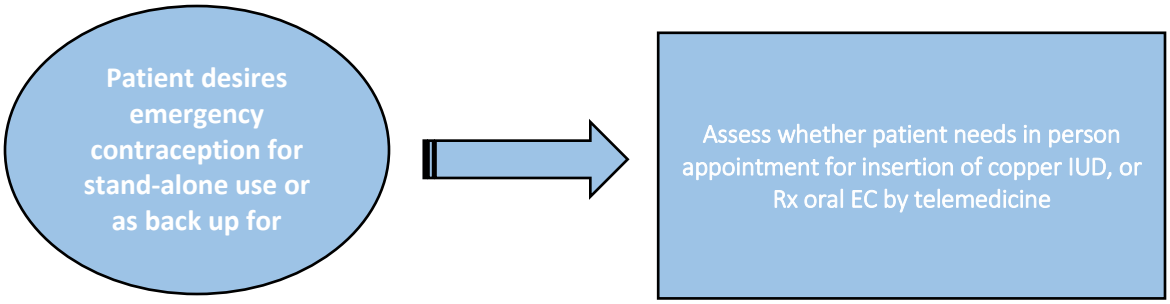
1. Assure patient that removal on request will be facilitated.
2. Assess reason for desired removal. Oftentimes, patients are experiencing side effects which can be relieved with treatment.
3. If desire for removal is related to symptoms of irregular bleeding, assess interest in management per *CDC Selected Practice Recommendations* (NSAIDs vs estrogen).
4. If patient not interested in side effect management, for whom this management has failed, or who have other reasons to desire removal, proceed with scheduling an in-person visit for removal.



Patient desires Refill of pill/patch/ring
1. Send Rx to pharmacy, **telemedicine not needed** unless patient requests. 2. Consider sending Rx for Plan B if is using pill/patch/ring in case patient missed dose (progestins within 5 days of use of Ella can theoretically interact with Ella and make Ella not effective) Consider doubling dose of Plan B if patient is > 156 lb (see box on EC)

Patient desires Refill of progestin-only pill
1. Send Rx to pharmacy, **telemedicine not needed** unless patient requests 2. Consider sending Rx for Plan B if is using pill in case patient missed their dose (progestins within 5 days of use of Ella can theoretically interact with Ella and make Ella not effective) Consider doubling dose of Plan B if patient is > 156 lb (see box on EC).

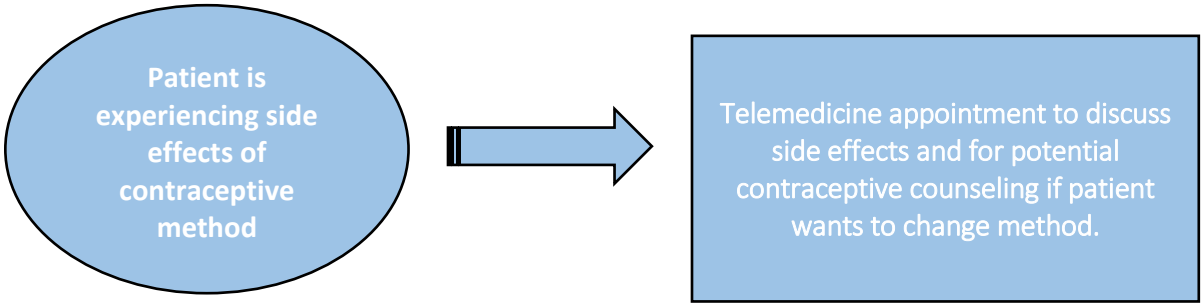
Patient desires Refill of DMPA
1. DMPA IM lasts for 15 weeks (**reschedule patients accordingly**) 2. As patients who are scheduled for in person visit if they would be interested in DMPA-SC. If so, consider scheduling telemedicine visit prior to renewal date for provider to discuss DMPA-SC self-administration. If patient is interested in switching to DMPA-SC, can provide patient information (video and written) about self-administration of DMPA-SC.



Patient desires Rx for emergency contraception (EC)

1. Discuss options of Copper IUD or oral emergency contraception, including: ulipristal (Ella) and levonorgestrel (Plan B).
    - Copper IUD highly effective at any time during the cycle regardless of BMI with pregnancy risk of 0.1%. Effective up to 5 days after unprotected intercourse (or more in select cases, see SPR).
    - Ulipristal effective until LH surge begins with 1.1% pregnancy risk for BMI 25-29.9 and 2.6% pregnancy risk for BMI ≥30. Effective up to 5 days after unprotected intercourse.
    - Levonorgestrel effective until LH surge begins with 2.5% pregnancy risk of BMI 25-29.9 and 5.8% pregnancy risk for BMI ≥30. Effective up to 3 days after unprotected intercourse, but may be effective up to 5.
2. For Copper IUD → schedule in person visit as quickly as possible to maximize effectiveness
3. For oral EC → can Rx via telemedicine. Can send as many refills as patient desires, as long as anticipatory treatment is covered by insurance.
4. Ulipristal is generally the best option
    - Main contraindications to Ulipristal is breastfeeding and if patient is going to start a progestin-containing method within 5 days of Ulipristal.
    - Need to consider BMI: Levonorgestrel is less effective for BMI>26 (and less effective overall as well.)[8] Ulipristal has decreasing effectiveness after BMI 35.

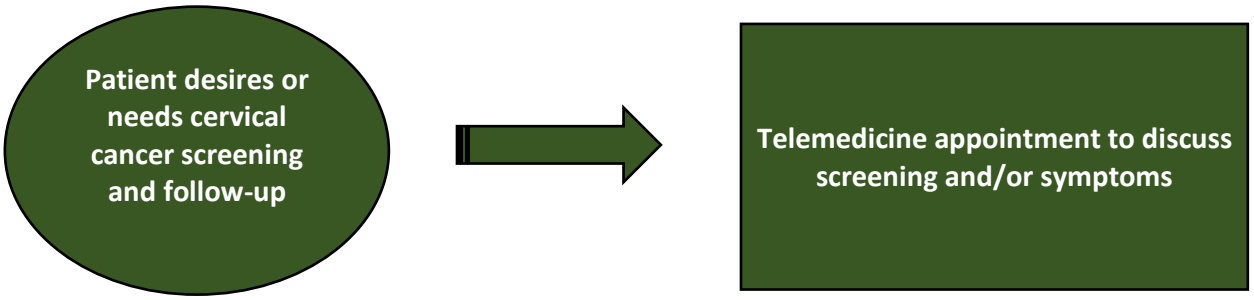
[8] Glasier A, Cameron ST, Blithe D, et al. Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. Feb 2011, 84(2011): 363-367.



Patient is experiencing side effects of contraceptive method

1. Assure patient that method switching, including IUD or implant removal on request, will be facilitated.
2. Discuss CDC Selected Practice Recommendations for side effect management.
3. If patient not interested in side effect management, for whom this management has failed, schedule accordingly for contraceptive counseling and/or IUD or implant removal.

Telemedicine Protocol, Section III



Patient desires or is due for cervical cancer screening and/or follow up

1. Assess if person has a cervix: Screening is appropriate for people who have a cervix and are under 65 years old, or over 65 with inadequate prior screening,. If you would like to clarify if a person has cervix, you may ask, "Have you had your uterus and cervix removed?" or "Have you had any gender-affirming surgeries?"
2. Discuss with patient if they have had cervical cancer screening in the past and what the results were.
3. If patient reports abnormal cervical cancer screening test (or colposcopy, cryotherapy, conization, or laser ablation) within the last year, attempt to obtain medical records.
4. Educate patient about cervical cancer risk and pathology of cervical cancer.
5. Repeat cervical cancer screening according to these cervical cancer screening guidelines. More rationale about screening choices can be found here. Recommendations are for **people ages 21-29** to be screened every 3 years with cytology. For people **30-65 years of age**, screen every3 years with cytology or every 5 years with a combination of cytology and HPV testing. In a limited access area, combination screening with cytology and HPV testing is likely better to decrease need for in-person appointments.
6. Testing at 65 years of age can stop if person has had adequate negative prior screening and no history of CIN2 or higher within the last 20 years. Adequate negative screening is defined as 3 consecutive negative cytology results or 2 consecutive negative co-test results within the previous 10 years and with the most recent test performed within the last 5 years.
7. For programs that use cytology-based or HPV-based screening, HPV testing on a self-collected sample can be used as an additional strategy to reach people who are not participating in regular screening. Self-collected samples are not as sensitive or as specific as clinician-collected samples. Communication with patients is key for follow up of positive self-test and adequate transport of the samples is also necessary.[9]
8. Schedule an in-person clinic appointment for pap smear with or without HPV testing, as per clinical protocols. At that time, can consider and perform STD screening.

[9] Arbyn M, Verdoodt F, Snijders PJ, et al. Accuracy of human papillomavirus testing on self-collected versus clinician-collected samples: a meta-analysis. *The lancet oncology.* 2014;15(2):172-183.

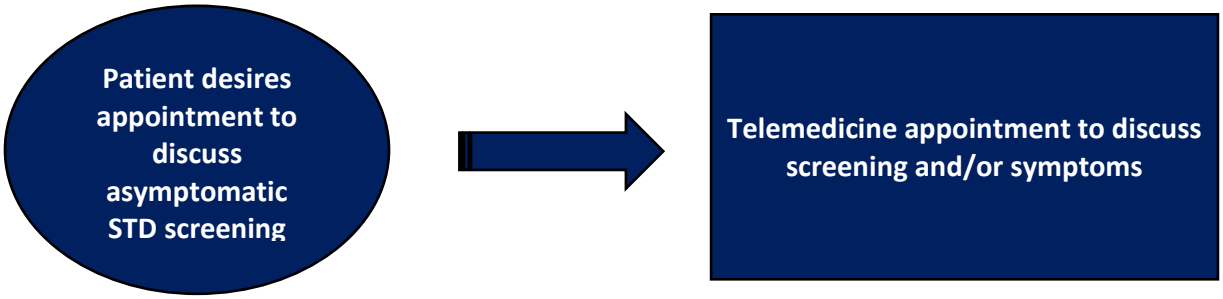
Guidelines for abnormal cytology results

1. Follow management guidelines about needed follow-up evaluation and treatment.
2. In March 2020, during the COVID-19 pandemic, ASCCP issued interim guidance for timing of diagnostic and treatment procedures for patients with abnormal cervical screening tests, and is summarized as follows:

RESULT OF SCREENING TEST	TIMEFRAME FOR NEXT STEP FOR EVALUATION OR TREATMENT
LSIL	Postpone diagnostic evaluations up to 6-12 months
HSIL. ASC-H	Documented attempts to contact and diagnostic evaluation scheduled within 3 months
High-grade cervical disease w/out suspected invasion	Documented attempts to contact and procedures scheduled within 3 months
Suspected invasive disease	Contact attempted <2 weeks and evaluation within 2 weeks of that contact (4 weeks from the initial report or referral)

HPV vaccines

1. During a telemedicine appointment, review history of HPV vaccinations.
2. Follow CDC guidelines for HPV vaccination routinely for people ages 11-12 (although the series can be stared as early as 9 yo) and up to 26 years old for people with cervices and a male assigned at birth (AMAB) who is immunocompromised or MSM. All other AMAB routine vaccination until age 21 (although they may be vaccinated if patient desires).
3. National guidelines imply that the 2nd or 3rd doses are not time sensitive and ***can be*** postponed. The CDC Pink Book states that there are:
    - No maximum interval between doses;
    - If schedule is interrupted, do not restart;
    - If interrupted after 1st dose, the 2nd dose should be given as soon as possible, and the 2nd and 3rd doses should be separated by at least 12 weeks;
    - If 3rd dose is indicated and delayed, administer asap.



Patient desires or is due for screening for asymptomatic STDs

1. Ask about any previous last testing, results of previous test, previous treatment if provided, number of current partners and any known exposures to STDs.
2. If needing to inquire about specifics of a patient's sexual history, remember to use transgender-inclusive language, as discussed in this Bedsider article which recommends the following question: "I talk to all of my patients about sex to help them get the health care they need. Tell me about the genders and bodies of your partners." If a person does not provide enough details, you can follow up with an additional question. For example, if someone says, "I just have sex with women," you could then ask, "Are any of your partners transgender women?"
3. Gonorrhea, chlamydia, HIV, syphilis, trichomonas, and herpes and Hepatitis B and Hepatitis C screening, per USPSTF CT/GC screening recommendations and CDC screening recommendations. Below is a summary of GC/CT, HIV and syphilis screening:

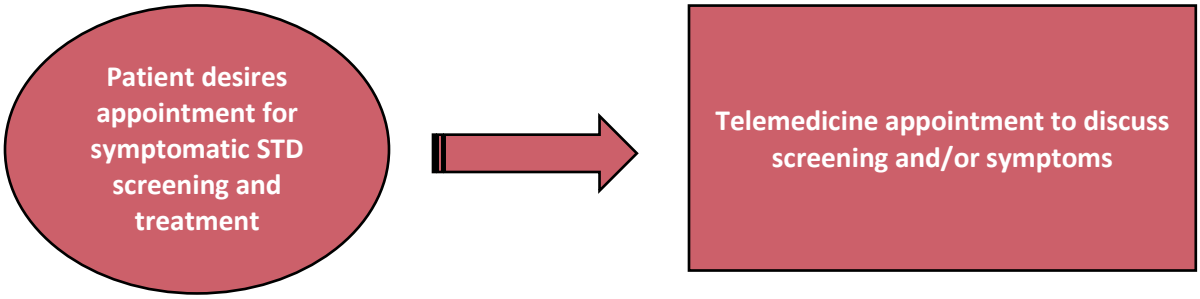
POPULATION	Chlamydia/ Gonorrhea	HIV	Syphilis	Hepatitis B/ Hepatitis C
A person assigned female at birth (AFAB)	-Sexually active and under 25 yo -Sexually active 25 years of age and older, if at increased risk* -Retest approximately 3 months after treatment	-All people 13-64 yo -All those seeking evaluation or treatment for STDs	-People who have been exposed to, or suspects may be infected with syphilis. -Can consider if partner is bisexual male.	-HCV if born btw 1945-1965 -Those at increased risk for hepatitis B or C #†
A person assigned male	-Consider screening in	-All people 13-64 yo	-People who have been exposed to, or	-HCV If born btw 1945-1965

at birth (AMAB)	high prevalence clinical settings	-All those seeking eval or treatment for STDs	suspects may be infected with syphilis.	-Those at increased risk for hepatitis B or C #†
Pregnant people	-All pregnant people -Retest during 3rd trimester in <25 yo -Pregnant people with infection should have test of cure 3-4 weeks after treatment and be retested within 3 months.	-At first prenatal and retest in third trimester if at high risk**	-First prenatal and retest early in third trimester and at delivery if high risk.**	-HBsAg at first prenatal and each pregnancy; retest at delivery if high risk. -HCV if born btw 1945-1965 or other risk factors present †
MSM	-Annually for sexually active MSM at sites of contact. -Every 3-6 months if increased risk	At least annually for those sexually active and if HIV status is unknown or negative, and patient has only one, monogamous sex partner since most recent HIV test.	-Annually and every 3-6 months if increased risk*	-HBsAB for all -HCV If born btw 1945-1965 -Annual HCV in MSM with HIV
Persons living with HIV	-For sexually active individuals, screen at first HIV evaluation and then at		-First HIV evaluation and annually.	- HBsAg and anti-HBc and/or anti-HBs -HCV serologic testing at initial evaluation

	least annually thereafter -More frequent screening might be appropriate depending on individual behavior.			-Annual HCV testing in MSM with HIV	

*Those who have a new sexual partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection as defined by the USPTF here.
** Individuals who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, live in areas with high HIV prevalence, or have partners with HIV infection, see CDC 2015 recommendations here.
# Those at increased risk for Hepatitis B include persons born in regions of high endemicity (>=2% prevalence), IDU, MSM, persons on immunosuppressive therapy, hemodialysis patients, HIV positive individuals, and others per CDC guidelines here.
† Those at increased risk for Hepatitis C include past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hep. C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures, per USPSTF guidelines here.
For **trichomoniasis**: consider for a person assigned female at birth (AFAB) receiving care in high prevalence setting and those at high risk for infection (multiple sex partners, exchanging sex for payment, illicit drug use and history of STD). Recommend for sexually active AFAB with HIV at entry to care and annually thereafter.
For **herpes**: type-specific HSV serologic testing can be considered for everyone presenting for STD evaluation (especially with multiple sex partners), if infection status is unknown in MSM with previously undiagnosed genital tract infection.

4. Note that patient requests for screening should be accepted and that patients have a right to refuse any laboratory test/procedure.
5. Screening tests can be ordered as blood tests for HIV ag/ab, herpes and syphilis and hepatitis serology; and urine tests ordered for gonorrhea, chlamydia, trichomonas without in-person clinic visit.
6. Follow up for treatment, as indicated. See section on treatment here.



Patient with symptoms

1. Discuss with patient which symptoms they are experiencing.
2. Ask about last testing, results of previous test, previous treatment if provided, number of current partners and any known exposures to STDs. See section above about taking a sexual history.
3. If recurrent symptoms of a previously diagnosed condition (e.g., recurrent herpes, BV, or candidiasis), offer presumptive treatment
4. For a new problem, obtain a thorough history via telehealth and consider empiric treatment.
   - E.g., for malodorous vaginal discharge consistent with either Bacterial Vaginosis (BV) or trichomoniasis, metronidazole 500 mg PO BID 7 days will provide adequate treatment to cover both BV and trichomoniasis. If trichomoniasis is suspected, recommend or provide treatment for male partners, per CDC guidelines. See box below on expedited partner treatment for additional information.
5. Some clients may be willing to take a cell phone photograph of their genital skin rash and submit it to the clinician, which may can provide additional diagnostic information to facilitate treatment without an in-person visit.

Self-swabbing tests

1. Some clinics have arranged curb-side pick-up and drop-off of vaginal discharge sampling kits, which include a stoppered-plastic or glass tube filled with 1 cc of fresh saline solution and a pack of sterile cotton tipped swabs.
2. Instruct the client to swab her vaginal walls, immediately place the swab into the tube and cap it, then to drop it off at the clinic as quickly as possible for microscopic evaluation
3. Can be used for gonorrhea/ chlamydia sampling with (separate) appropriate collection container.

Treatment recommendations for STD treatment when in-patient clinic contact is limited

1. After reviewing all available information from telehealth visit, assess if in-person exam is necessary for diagnosis. If necessary → schedule in person appointment.
2. If reasonably certain of diagnosis without in-person physical exam, use the CDC issued interim treatment guidelines when clinic contact is limited to guide treatment regimens, as summarized below:

SYNDROME	PREFERRED TREATMENT (in clinic or other settings where IM route feasible, like receiving at a local pharmacy)	ALTERNATIVE TREATMENT (when only oral regiments are feasible)
Penile discharge or urethritis (presumptive treatment for GC/CT)	-Ceftriaxone 250 mg IM PLUS Azithromycin 1 gm PO (If azithromycin not available and patient is not pregnant, can use Doxycycline 100 mg PO twice a day for 7 days). -Note: If cephalosporin allergy, treat with gentamicin 240 mg IM PLUS azithromycin 2 gm orally.	-Cefixime 800 mg PO PLUS Azithromycin 1 gm PO OR -Cefpodoxime 400 mg PO Q12 hrX 2 doses PLUS Azithromycin 1 gm PO (If azithromycin not available and patient is not pregnant, can use Doxycycline 100 mg PO twice a day for 7 days). -Note: If oral cephalosporins not available or allergy to cephalosporins then azithromycin 2 gm orally can be used as alternative treatment.
Vaginal discharge without suspected pelvic inflammatory disease (PID)	Treatment guided by exam and laboratory results.	-Discharge/odor suggestive of **bacterial vaginosis** or **trichomoniasis**: Metronidazole 500 mg PO twice a day for 7 days . -Discharge (cottage cheese-like) with genital itching suggestive of **candida**: Fluconazole 150 mg PO (X 1 and repeat in

		72 hours X 1 if symptoms not improved).
Genital ulcer disease (suspected primary or secondary syphilis)	Benzathine penicillin G 2.4 million units IM.	Males and non-pregnant females: Doxycycline 100 mg PO twice a day for 14 days. -Pregnant patients: Benzathine penicillin G 2.4 million units IM.
Proctitis syndrome	-Ceftriaxone 250 mg IM PLUS Doxycycline 100 mg PO twice a day for 7 days (If doxycycline is not available or patient is pregnant use azithromycin 1 gm PO).	-Cefixime800 mg PO PLUS Doxycycline 100 mg PO twice a day for 7 days . OR -Cefpodoxime 400 mg POQ 12 hrX 2 doses PLUS Doxycycline 100 mg PO twice a day for 7 days (If doxycycline is not available or patient is pregnant use azithromycin 1 gm PO).

3. Follow up: If treated with alternative oral regimens, counsel patients to seek follow-up in 5-7 days if symptoms do not improve. Counsel patients to be tested for STIs/HIV via lab orders. Patients treated for syphilis with non-benzathine penicillin regimens should have serologic testing done 3 months after treatment.

Expedited partner therapy (EPT) for gonorrhea and/or chlamydia and/or trichomoniasis

1. EPT can be made available to a partner(s) either by writing a prescription in the name of the partner or doubling the dose of the medications dispensed to the client.
2. These approaches are even more critical during a public health emergency in an effort to avoid the need for a client, or their partners, to be seen in a face-to-face visit.
3. If patient diagnosed w/CT, partner treatment is: Azithromycin 1 gm PO
4. If patient diagnosed with GC or presumptively treated: partner treatment is Cefixime 800 mg PO PLUS Azithromycin 1 gm PO OR Cefpodoxime 400 mg PO Q 12 hr X 2 doses PLUS Azithromycin 1 gm PO (If oral cephalosporins not available or allergy to cephalosporins, then azithromycin 2 gm orally can be used as alternative treatment; If azithromycin not available and partner is not pregnant, can use Doxycycline 100 mg PO twice a day for 7 days).
5. If patient diagnosed with trichomoniasis: recommended partner treatment is metronidazole 2 gram orally in single dose OR tinidazole 2 gram orally in a single dose. Alternative regimen is metronidazole 500 mg orally twice a day for 7 days.

Contraception: Counseling and selection

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All topics are updated as new evidence becomes available and our peer review process is complete.

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INTRODUCTION

The choice of a contraceptive method is a complex decision; medical providers have an important role in providing information and supporting patients' decision making about contraceptive methods through contraceptive counseling. In this topic, we will review the goals of quality contraceptive counseling, review different approaches to this counseling and their relationship to health equity, and provide a step-by-step guide to providing high-quality, patient-centered counseling. Information specific to each contraceptive method is presented in detail separately.

In this topic, we will use the term "women" to describe those who use female contraceptive methods. However, we recognize that not all people capable of pregnancy identify as women, and we encourage the reader to consider the specific counseling needs of transgender men and gender nonbinary individuals. Clinicians should ask all patients who identify as male about their contraceptive needs as well. (See 'Special populations' below.)

GOALS

In broad strokes, the provision of family planning care is designed to help individuals achieve their reproductive goals. However, data suggest that family planning care should not have a singular focus of preventing unintended pregnancy, as this is not consistent with all patients' preferences or necessary to optimize health outcomes. Rather, providers can focus on helping women and men reach their desired reproductive outcomes by supporting them to make informed decisions about their fertility and contraceptive use that are aligned with their preferences and reproductive goals (table 1).

HOW TO DO CONTRACEPTIVE COUNSELING

The steps for providing patient-centered contraceptive counseling using shared decision making are laid out in the figure (figure 1) and detailed below.

Personalized counseling with shared decision making — Contraceptive counseling has evolved from either clinician-level directive counseling toward the mostly highly effective methods or provision of education to personalized counseling using shared decision making [1-3]. This approach, which is considered ideal for preference-sensitive decisions that are highly dependent on individual values and needs, is designed to assist patients in making the best decision for themselves [4,5]. In shared decision making, patients are acknowledged as the experts on their preferences, while providers contribute their medical knowledge about the different options and the ways in which they relate to patients' preferences. In this way, patient autonomy and the diversity of preferences for contraceptive method characteristics can be respected, while at the same time, patients are offered support in aligning their preferences with the available options (table 1). Interventions to promote shared decision making have been reported to improve patients' ability to make decisions that are informed and consistent with their values and to increase patient knowledge [6]. Research in contraception specifically has found that women are more satisfied with the counseling experience and their method when they experience shared decision making [7].

A shift toward personalized counseling is consistent with the increasing emphasis on providing patient-centered care, which is defined by the National Academy of Medicine as care that is "respectful of, and responsive to, individual patient preferences, needs, and values" [8]. In addition to the ethical reasons for providing this type of care [9], in the context of family planning, the receipt of patient-centered care is also likely to positively impact women's long-term health care engagement and outcomes. Evidence of long-term impact is provided by studies reporting that receiving patient-centered contraceptive counseling focused on individual preferences is associated with continuing a chosen contraceptive method and using a highly or moderately effective method six months after the visit [10]. Conversely, women who felt pressured during contraceptive counseling reported being less likely to engage with future reproductive health care [11].

An alternative approach to contraceptive counseling that is frequently discussed, especially in the context of low- and middle-income countries [12], is a menu, or consumer-driven, approach, in which the provider's role is only to provide education and not to influence decision making [1]. While this approach is focused on patient autonomy, research has found that many women in fact value receiving support from providers in the decision-making process, as opposed to being left to make the decision on their own [13-17].

Over the last decade, there has also been a movement toward directive models of counseling focused on promoting use of the most highly effective methods. These approaches have included applying motivational interviewing, a patient-centered directive counseling model developed in the context of addiction medicine, to contraceptive counseling designed to motivate use of specific methods [18]. Another prominent model has been a "tiered effectiveness" approach, which structures counseling according to the effectiveness of methods, with a corresponding emphasis on those that are most effective [19]. For the reasons described below (see 'Issues related to contraceptive counseling' below), these approaches are not ideally patient-centered in that they do not prioritize women's preferences for method characteristics and make assumptions about the relative importance of effectiveness at preventing pregnancy.

Establish rapport — While a positive interpersonal relationship is essential for all aspects of medical care, it is of particular relevance in contraceptive counseling given its personal and sensitive context [13]. Communication behaviors, such as greeting patients warmly and making small talk, have been associated with contraceptive continuation [10], further indicating that this is an essential component of the contraceptive counseling encounter. We advise all providers to consciously incorporate small talk into the beginning of their visit to establish a positive therapeutic relationship with their patient.

Identify patient-centered reproductive goals — The first step in providing patient-centered contraceptive counseling is identifying patients for whom this counseling is appropriate. Various models have been proposed, each with its own limitations and benefits. In our practice, we ask women if they wish to prevent pregnancy now (table 2).

- **Identify women who wish to prevent pregnancy now** – To address the limitations of the approaches below, we encourage the use of the question "Do you want to prevent pregnancy now?" as means of identifying those who may become pregnant and who would wish to discuss contraceptive options. Follow-up discussion could address those patients with unsure or ambivalent answers to help them receive the care that best meets their needs, as well as those patients who already have their pregnancy needs meet, whether through sterilization or other means of pregnancy prevention.

- **One key question** – A modified version of the Centers for Disease Control and Prevention's (CDC) reproductive life plan approach (bullet below) is the commonly cited "One Key Question" in which women are asked if they would like to become pregnant in the next year [20]. This is responsive to some criticisms of the CDC's reproductive life planning model (bullet below) because it limits the time frame under consideration and also incorporates the possibility that women may not have defined intentions through response options of "okay either way" or "unsure." However, it is not ideal for identifying women's current need for contraceptive counseling, as someone who wishes to become pregnant in the next year may still desire birth control now, women who do not actively desire pregnancy may prefer not to use contraception, and women who do not wish to become pregnant may not be at risk for pregnancy due to previous sterilization or not having sex that could result in pregnancy (eg, same-sex partner).

- **Reproductive life plan** – The CDC has promoted the use of a "Reproductive Life Plan" approach, in which women and men of reproductive age define how many children they wish to have, and when, as a means of determining which services (eg, preconception care, contraceptive care) are appropriate for an individual [21]. This approach has been criticized as being overly proscriptive and not reflecting the ways in which people develop and modify their reproductive goals over time, including the potential of welcoming an unintended pregnancy [22].

Opportunity for preconception counseling — In addition to identifying those who wish to use contraception, family planning providers have the opportunity to identify those in need of counseling related to the impact of their health and health behaviors on future pregnancies (eg, "preconception care"). Recommendations from the CDC and others encourage providing preconception counseling at all visits with women of reproductive age [23-25]. As this can be difficult in time-limited encounters, such assessments can be prioritized for those with chronic medical conditions or with social or environmental risks or exposures. (See "The preconception office visit".)

Providers can ask additional questions beyond the immediate need for contraception to identify those for whom counseling related to future reproduction may be appropriate. One approach that has been suggested is using the "PATH" questions [22], which address pregnancy attitudes and timing in a patient-centered way that acknowledges that many women will not have a well-defined plan. The PATH questions are:

- **P**regnancy **A**ttitudes – Do you think you might like to have (more) children at some point?
- **T**iming – If the woman is considering future parenthood: When do you think that might be?
- **H**ow important is prevention – How important is it to you to prevent pregnancy (until then)?

Document medical history/potential contraindications — Once a woman is identified as being appropriate for and desirous of contraceptive counseling, providers can then assess for medical conditions that could affect the safety of specific methods. Common medical conditions to consider include smoking status, cardiovascular conditions (eg, hypertension or history of venous thrombosis), and history of migraine with aura [26].

Both the World Health Organization (WHO) and the CDC maintain evidence-based recommendations for use of contraceptive methods in the context of a range of medical conditions and personal characteristics [27,28]. The World Health Organization Medical Eligibility Criteria for Contraceptive Use and the US Medical Eligibility Criteria for Contraceptive Use are freely available, easy to use, and provide contraceptive prescribers with definitive guidance on safety across a broad range of conditions for different patient populations. Both label contraceptive methods as category 1, 2, 3, or 4 for each identified condition; those in categories 1 and 2 are considered generally safe and category 4 methods are contraindicated. For those classified as category 3, the recommendations state that the "method is usually not recommended unless other more appropriate methods are not available or acceptable." Importantly, this guidance takes into account whether another method that may be class 1 or class 2 is "acceptable" to the individual patient, and therefore, a category 3 rating should not discourage prescribing that method for a woman who has been informed of the risks and who determines that this method is the most acceptable for her.

Related topics on contraception selection in women with specific health issues include:

- (See "Contraception: Counseling for women with inherited thrombophilias".)
- (See "Contraception: Counseling for females with obesity".)
- (See "Pregnancy in women with nondialysis chronic kidney disease".)
- (See "Pregnancy in women on dialysis", section on 'Contraception'.)
- (See "Bipolar disorder in women: Contraception and preconception assessment and counseling".)
- (See "Approach to the patient following treatment for breast cancer", section on 'Contraception after breast cancer'.)
- (See "HIV and women" and "HIV and women", section on 'Choice of contraception'.)
- (See "Overview of the management of epilepsy in adults" and "Overview of the management of epilepsy in adults", section on 'Contraception'.)

THE SHARED DECISION-MAKING PROCESS

After identifying that a woman should receive contraceptive counseling and identifying any conditions that may limit the range of methods available to her, providers of contraceptive counseling can then begin the process of selecting the method through a shared decision-making process. Examples of how a shared decision-making interaction can proceed can be found in the table (table 3).

Initiate the conversation — We advise beginning the conversation with a question that explicitly lets patients know that their preferences will be respected in the counseling process, such as "Do you have a sense of what is important to you about your method?"

We acknowledge, and have experienced, that many women will not have an answer to this question, in part because they may have experienced past counseling approaches that did not prioritize their preferences. Women's lack of experience with this type of question underscores the importance of leading the conversation with the patient's values, communicating that their preferences will be at the forefront of the discussion, and beginning the process of them considering what in fact those preferences are. As discussed above, common approaches that highlight only specific methods or immediately attempt to narrow down the options do not engage women regarding their preferences. (See 'Personalized counseling with shared decision making' above.)

Of note, this question is also distinct from another commonly used approach, in which providers ask "Which method are you interested in?" While on the surface, this question appears to prioritize the patient's preferences, it also assumes that patients are aware of their options and how those options relate to their preferences for different method characteristics, such as changes in bleeding patterns or efficacy. This question then drives the conversation to specific methods, rather than opening the conversation around the patient's preferences. Keeping the conversation open is particularly important given that women may not feel empowered to ask questions of providers if not explicitly given the opportunity [1,29].

When opening the conversation by asking patients if they have a sense of their preferences, some women may, in their responses, communicate explicitly or implicitly a desire for a non-shared decision-making approach. For example, some women may immediately indicate that they know which method they wish to begin and convey a lack of interest in further discussion (autonomous decision making). By contrast, other women respond by asking providers which method they think is best is or which method they think the woman should use (provider-driven decision making). In both cases, patient-centered clinicians need to be aware of and responsive to those decision-making preferences (table 3) [30]. However, given the personal nature of contraceptive use, as well as the complexity of contraceptive selection, clinicians should take care to ensure patients' decision-making ability is maintained. In the case of the patient who wishes to make an autonomous decision, clinicians can offer to discuss other contraceptive methods and thus maintain the woman's option of receiving further education. For the (less common) patients who wish to defer some or all of the decision making to the clinician, clinicians can facilitate a preference-concordant decision by eliciting patient preferences, as described below, and then taking a more active role in mapping those preferences on to specific methods. (See 'Facilitate decision making' below.)

Elicit informed preferences — Once the conversation has been opened by stating a focus on the patient's preferences, the next step in the shared decision-making process is to help women identify those preferences. These decisions should be informed by evidence, which necessitates an interactive educational conversation between the clinician and patient about the different ways that methods vary, including [31]:

- How they are taken
- How often they are taken
- Efficacy
- Effect on menstrual bleeding (including regularity and flow)
- Other side effects
- Noncontraceptive benefits
- Privacy
- Effect on future fertility

We begin with a general overview of how the contraceptive methods vary and use language-appropriate visual aids to provide additional information and start the conversation (figure 2) [32]. When starting this process, it is important to first respond to any priorities expressed in response to the initial question about preferences. For example, if a woman indicates that the most important thing about her method is that she does not have to remember it all the time, clinicians can acknowledge this preference, provide the range of options described above, and ask which of these options for frequency of remembering a method would be acceptable to her.

Next, we review general characteristics (eg, efficacy, how often the method is used, and resultant menstrual changes) and discuss the range of options within each characteristic. To avoid triggering preconceptions about specific methods, we advise using general descriptions, rather than identifying specific methods, with language such as "There are methods you take every day, every week, every month, every three months, or even less often. How do you feel about these different options?"

The degree to which the clinician should elicit patient preferences prior to moving to the next step will vary by patient. While ideally a clinician will ask about all of the above method characteristics, in many cases, a few strong preferences will be expressed which adequately narrow down the options. In that case, it may be appropriate to begin the decision-making process without reviewing all method characteristics, while being aware that additional preferences may emerge during the decision-making process that change the course of the conversation. As an example, for a woman who prioritizes getting regular periods and desires a method that will decrease her acne, a clinician can begin the decision-making process by focusing on methods that align with these preferences, such as short-acting hormonal contraceptives (eg, oral contraceptive pill, contraceptive ring, and contraceptive patch). (See 'Facilitate decision making' below.)

Discuss method characteristics — Below, we provide specific tips for how to discuss method efficacy, changes in menstrual bleeding, other side effects, noncontraceptive benefits, and effect on future fertility in order to elicit informed preferences for these characteristics.

- **Efficacy** – Misconceptions about both the absolute and relative efficacy of different methods to prevent pregnancy are common [33]. Therefore, understanding a woman's preferences around method efficacy, which is a high priority for many women, is essential [34,35]. One data-supported strategy to improve patient knowledge is to use a tiered efficacy chart (figure 2) [36]. In addition to the use of visual aids, best practices for risk communication include stating natural frequencies rather than percentages (eg, stating "with typical use, method efficacy varies from 1 in 100 to 20 in 100 women getting pregnant in one year of use").

- **Changes in menstrual bleeding** – Available prescription methods all have some effect on menstrual bleeding (figure 2), and women have strong and varied preferences related to these changes [37,38]. Importantly, the same change, such as amenorrhea, can be viewed as a benefit by some women yet a negative side effect by others [39]. Therefore, we recommend specifically eliciting preferences about bleeding by asking a nondirective question such as "How do you feel about your method causing changes in your period, such as making it less regular, making it more or less heavy, or making it go away entirely?" Importantly, some women's preferences are due to misconceptions about the safety of changes in their bleeding patterns, specifically with respect to amenorrhea [40-42]. Therefore, expressed preferences to avoid amenorrhea should be nonjudgmentally explored to determine whether this preference is based on misconceptions, while providing education to dispel any misinformation (table 3).

- **Other side effects** – Women frequently receive information about contraceptive methods from their social networks, and negative information is more commonly communicated than positive [43-46]. Therefore, many patients have concerns about potential negative impacts on contraceptive methods that will influence their choice of method. While it is not possible to systematically go through all evidence for side effects for all methods in a standard contraceptive visit, we advise directly asking women if they have concerns about side effects of specific methods. This approach will allow clinicians to both understand women's preferences and to address any misconceptions. When providing evidence-based information, clinicians should be aware of, and sensitive to, how much women value and trust information received through social networks about the lived experience with a contraceptive method [44]. Clinicians should avoid being dismissive of such experiences, acknowledge that "everyone is different," and emphasize the evidence for what is common (table 3). By not discounting the experience relayed through peer networks, clinicians avoid triggering distrust and allow women to hear the evidence and consider how it may relate to their experience with that method.

- **Noncontraceptive benefits** – In addition to preventing pregnancy, contraceptives have numerous noncontraceptive benefits that may influence patient selection (table 4).

- **Effect on future fertility** – If not previously elicited, clinicians can assess whether pregnancy is desired in the short or long term. Such a conversation provides clinicians the opportunity to address common misconceptions about the effect of contraceptive methods on fertility [33,47]. We review that only sterilization has a permanent effect on fertility, while the contraceptive injection has a shorter term impact.

Facilitate decision making — The goal of this phase of counseling is to help patients identify the most appropriate method for them given their preferences and the contraceptives' characteristics. Specific scenarios that may be encountered during the decision-making process include:

- **One strong preference** – For a patient who has identified one dominant preference, such as the desire to use a highly effective method, this process can be as simple as informing the patient that given her preference, intrauterine devices (IUD), implants, and sterilization may be the best choices and asking follow-up questions to help her determine which of these is most appropriate.

- **More than one expressed preference** – In cases where patients have identified more than one preference, clinicians can educate patients about how these values overlap with the characteristics of available methods. Again, visual aids (figure 2) can be helpful in this process, as can pelvic models or samples of contraceptive methods. For patients with preferences that align with one method (such as the desire to minimize acne and to have lighter, regular periods), clinicians can help patients choose among the appropriate methods (in this case, the contraceptive pill, patch, and ring) using follow-up questions. When preferences are in conflict (eg, the desire for the most highly effective method and the desire to have a method that is not placed into the body), clinicians can discuss how these preferences do not overlap and ask patients to consider how to weigh their preferences relative to each other. An example of this conversation is provided in the table (table 3).

- **Newly disclosed preference** – When women reveal a new contraceptive preference during the process of decision making, it may be necessary to move back and forth between determining preferences and facilitating decision making in response to those preferences. These new preferences can then be incorporated into the decision-making process, as described in the previous bullet.

Specific issues that can arise during the decision-making process:

- **Clinician preference or bias** – In facilitating the decision-making process, we avoid expressing any partiality that does not reflect the patient's own expressed preferences. Indicating such a bias is not consistent with the preference-sensitive nature of contraceptive decision making and is particularly problematic given that the priorities of clinicians around contraceptive methods have been found to vary significantly from those of patients [48]. In addition, as patients who feel their clinician had a method preference are less likely to be satisfied with their method [7], and those who felt pressured to use a contraceptive implant are more likely to discontinue their method [49], counseling in this way can interfere with patients' contraceptive use. Phrases such as "Based on what you are telling me, these methods may be a good fit" can help to avoid any appearance of partiality.

- **Discussion of personal experience other than the patient's** – The question of whether or not clinicians should disclose personal experience with contraceptive methods during the course of counseling can arise, either because patients directly ask clinicians or because clinicians want to use their lived experience as part of the educational process. In other areas of health care, whether or not clinicians should disclose personal information is a source of controversy, and the ethical issues are heightened in contraceptive counseling given its personal and social context [50]. However, one study using audio recordings of contraceptive counseling visits found that brief incidences of self-disclosure were not disruptive to the clinical encounter and did not elicit negative reactions from patients [50]. Whether or not such disclosures were beneficial to the patients' decision-making process could not be determined. One study did report that clinicians sharing personal experiences of IUDs was associated with increased uptake of this method [51]. As this suggests that self-disclosure has the potential to be influential, clinicians should be cautious when giving personal information to ensure that it does not inappropriately bias decision making.

- **Avoidance of less available or familiar methods** – Clinicians should be conscious of a tendency to be less likely to counsel about methods with which they have less experience or do not provide in their clinics. Such selective counseling may lead to patients being less likely to be offered methods requiring procedures (such as IUDs, implants, and female and male sterilization) or nonprescription methods (such as fertility awareness-based methods) even if they are a good fit for the expressed preferences. Clinicians should be aware of resources in their communities to provide these methods and make appropriate referrals as needed. Detailed reviews of these contraceptive methods are presented in individual discussions.

  - (See "Intrauterine contraception: Background and device types".)
  - (See "Etonogestrel contraceptive implant".)
  - (See "Overview of female permanent contraception".)
  - (See "Vasectomy".)
  - (See "Fertility awareness-based methods of pregnancy prevention".)

Selecting a method — While the process of eliciting preferences and mapping them to the available methods is shared, the ultimate decision about which method to use should be made by the woman, unless she explicitly asks for guidance from her clinician. In those cases, clinicians can rely on their knowledge of the patient's preferences to identify the method that is likely to be the best fit for her. Clinicians can precipitate the final decision by asking questions such as "Given what we talked about, and what is important to you about your method, what do you think would be the best choice for you at this time?"

Starting a method — We follow the Centers for Disease Control and Prevention (CDC) US Selected Practice Recommendations for Contraceptive Use (US SPR) to guide start time, assess the patient's need for contraceptive back-up, and identify any necessary preinitiation testing [52]. Most contraceptives can be started on the same day as the visit and require minimal examination or testing prior to initiation (table 5). Screening for sexually transmitted infections (STIs) is done per the CDC Sexually Transmitted Diseases Treatment Guideline [53]. The US SPR also provides guidance to reasonably exclude pregnancy prior to method initiation and to assess the need for back-up contraception (table 6). When it is not possible to reasonably exclude pregnancy, contraceptive methods other than the IUD can still be initiated immediately with appropriate counseling and consent (algorithm 1). The need for emergency contraception should be considered for all women. If the patient is a candidate for emergency contraception and interested in the copper IUD, this method will provide emergency contraception and then can remain in place for continued contraception (the levonorgestrel-releasing IUDs do not provide emergency contraception). (See "Emergency contraception".)

New-start counseling should also include information and support to optimize the patient's correct use of the method in the context of her unique life circumstances (eg, how can she best remember to take a pill every day given her life's demands). Additionally, the US SPR provides information about what to do if one or more doses of a short-acting contraceptive method is late or missed [52].

Counseling about side effects is a continuous process; we revisit this discussion once a method is chosen and at follow-up visits. Anticipatory counseling about potential side effects has been associated with both method satisfaction and method continuation [54,55]. We next discuss how to arrange timely follow-up visits and obtain contraceptive refills, if relevant. Lastly, we specifically inform patients of the acceptability of method switching (eg, that patients are welcome to come back at any time for a different method for any reason). Rather than framing discontinuation as a failure, we recognize that method discontinuation and switching is a normal occurrence among contraceptive users that helps ensure that women are comfortable accessing care when they need it [56].

Assess risk of sexually transmitted infections — We assess a woman's risk of acquiring an STI as a routine part of contraceptive counseling. All women at risk for acquiring an STI are advised to use condoms (male or female) in addition to their chosen method for pregnancy prevention. Detailed information on the prevention of STIs is presented separately. (See "Prevention of sexually transmitted infections".)

Additionally, concern has been raised that hormonal contraception, and particularly the contraceptive injection, could increase the risk of a woman acquiring HIV infection. In the absence of definitive data, we agree with the World Health Organization and CDC assessments that women at high risk of and living with HIV can continue to use all existing hormonal contraceptive methods, as the benefits generally outweigh the risk [57]. Although still a subject of debate, progestin-only contraceptive injection does not appear to increase the risk of HIV acquisition. (See "HIV and women", section on 'Risk factors for HIV acquisition'.)

SPECIAL POPULATIONS

- **Adolescents** – Adolescent and young adult women have unique contraceptive needs that reflect variations in individual development, barriers to contraceptive access, and lack of information [33,58,59]. While there may be a tendency toward more directive counseling with adolescents because of their perceived higher risk for adverse reproductive health outcomes, adolescents are also resistant to authority, and counseling viewed as overbearing has the potential to interfere with engagement with reproductive health services in the short and long term. The contraceptive issues specific to adolescents are reviewed separately. (See "Contraception: Issues specific to adolescents".)

- **Postpartum women** – Best practices for the provision of peripartum contraceptive counseling include discussing contraceptive options multiple times over the course of prenatal care, providing women with information about the safety of different contraceptive methods in the immediate postpartum period, and including the potential effect on lactation [27,60]. Women should be provided with the option of immediate postpartum contraception, including insertion of intrauterine devices (IUDs; within ten minutes of delivery), and should be informed about the increased risk of expulsion when provided in this manner [61]. In addition, clinicians should discuss potential increased risks associated with a short interpregnancy interval and simultaneously recognize that each woman will weigh these risks differently with respect to her own reproductive goals.

  - (See "Postpartum contraception: Counseling and methods".)
  - (See "Interpregnancy interval and obstetrical complications".)

- **Postabortion women** – Surveys of women receiving abortion care have found that over 60 percent do not wish to discuss contraception at the time of their abortion [62,63]. Therefore, while contraceptive methods should be available to all women having an abortion, clinicians should be responsive to individual patients' preferences for information and decision support in the context of providing this care. Insisting on providing counseling when not desired by patients has the potential to contribute to further stigma associated with receiving abortion care. (See "Contraception: Postabortion".)

- **Chronic medical conditions** – As described above, the World Health Organization Medical Eligibility Criteria for Contraceptive Use and the US Medical Eligibility Criteria for Contraceptive Use review the safety of specific contraceptive methods in women with chronic medical conditions [27,28]. While clinicians may wish to promote the most effective contraceptive methods for women at risk of medically complicated pregnancy, patient reproductive autonomy must be maintained. Careful education and detailed counseling about contraceptive efficacy, risks associated with pregnancy, possible role of emergency contraception, and the availability and safety of abortion in case an undesired pregnancy occurs can support women in making autonomous, informed decisions.

- **Obesity** – Women with obesity can be offered all contraceptive options, including combined estrogen-progestin contraceptives [26,27]. (See "Contraception: Counseling for females with obesity".)

- **Women with substance use disorders** – As there is a documented unmet need for family planning services among women with substance use orders, those providing care to these women should ensure they have access to quality contraceptive counseling and services [64-66]. Clinicians caring for these patients may be biased toward specific methods given the higher risk for pregnancy complications in this population [67]. However, this tendency can trigger the heightened mistrust of the medical community by those with substance use disorders and has the potential to interfere with reproductive autonomy [68]. Therefore, a shared decision-making model grounded in the patient's preferences can both build trust and help patients identify a method of contraception that is best suited to their social and medical contexts.

  In giving decision support, providers should be aware of the association between use of opiates with menstrual disturbances, including prolonged amenorrhea [69]. As this amenorrhea may lead women to underestimate their risk of pregnancy, education about the possibility of ovulation and resulting pregnancy, even when menstruation is irregular or absent, should be provided. In addition, given the frequent co-occurrence of substance use disorders with experiences of intimate partner violence and other forms of trauma, as well as posttraumatic stress disorder, providing trauma-informed care can be particularly important for this population [70,71]. (See "Health care for female trauma survivors (with posttraumatic stress disorder or similarly severe symptoms)".)

- **Women who request IUD or implant removal** – When women seek IUD or implant removal for reasons other than desiring a pregnancy, some clinicians may promote continued use of the IUD or implant because of high efficacy, despite the patient's expressed desire for removal [72-74]. We strongly advise against this practice as it has the potential to result in mistrust of family planning clinicians and impinges on the patient's autonomy. Instead, we first assure the woman that we will remove the method at her request. We then ask her if she would like to discuss her concerns or experiences of side effects prior to removal. This approach allows us to address any issues and provide additional education when appropriate and acceptable to the patient. For women who still desire method removal, we then proceed as requested. (See "Intrauterine contraception: Management of side effects and complications" and "Evaluation and management of unscheduled bleeding in women using contraception".)

- **Intellectual or physical disability** – Women with intellectual or physical disabilities have unique needs. The contraceptive selection process may involve a guardian as well as the patient. Data to guide the decision-making process are often lacking, and the benefits, risks, side effects, and consequences of an undesired pregnancy must be balanced against one another. As an example, the magnitude of thrombotic risk from estrogen-containing hormonal contraceptives in women with limited mobility (eg, patient in wheelchair) is not known. However, hormonal contraceptives can be desirable for these women because they reduce menstrual frequency or flow in addition to preventing pregnancy. (See "Hormonal contraception for suppression of menstruation".)

  Additional challenges can include the patient's limited capacity (intellectual, physical, or both) to use a method, problems with menstrual hygiene, and inability to undergo an office-based examination or procedure. Some women with intellectual disabilities cannot tolerate pelvic examinations, which makes pelvic examination or placement of an IUD in an office setting unrealistic.

Sterilization in women with intellectual or physical disabilities raises the ethical issues of patient autonomy and informed consent [75]. Sterilization in women with disabilities is reviewed separately. (See "Overview of female permanent contraception", section on 'Vulnerable populations'.)

- **History of cancer** – In 2012, the Society of Family Planning (SFP) published clinical guidelines for contraception in women with cancer [76]. While the subsequent World Health Organization Medical Eligibility Criteria for Contraceptive Use and the US Medical Eligibility Criteria for Contraceptive Use approved hormonal contraception for most non-hormone-dependent cancers (ie, except for breast cancer), the SFP guidelines contain additional considerations that we believe are important.

  For the following groups of women, the SFP advised:

  - Women with active cancer or who have been treated for cancer within six months – Avoid estrogen-progestin contraceptives because both cancer and combined hormonal contraception are risk factors for venous thrombosis. (See "Combined estrogen-progestin contraception: Side effects and health concerns", section on 'Effects on cancer development'.)
  - Women with a history of breast cancer – Consider use of a copper IUD, unless they are taking tamoxifen. In the latter case, off-label use of a levonorgestrel-releasing IUD can reduce the risk of tamoxifen-induced endometrial changes without increasing the risk of breast cancer recurrence. (See "Approach to the patient following treatment for breast cancer", section on 'Contraception after breast cancer' and "Intrauterine contraception: Candidates and device selection", section on 'Endometrial protection'.)
  - Women at risk of breast cancer or recurrence – Emergency contraceptive pills are not contraindicated. (See "Emergency contraception".)

- **Transgender men** – Not all people capable of pregnancy identify as women. Transgender men and gender nonbinary individuals have specific counseling needs. (See "Primary care of transgender individuals", section on 'Fertility'.)

ISSUES RELATED TO CONTRACEPTIVE COUNSELING

Contraceptive need — Worldwide, the United Nations has found that 63 percent of women of reproductive age who are married or in a union use contraception, with 92 percent of these methods being modern contraceptive methods [77]. Contraceptive prevalence varies by region, being lowest in Africa at 36 percent, and highest in Latin America and the Caribbean at 75 percent (figure 3). Africa also has the highest level of unmet contraceptive need at 22 percent.

In the United States specifically, at any given time, approximately two-thirds of women of reproductive age wish to avoid pregnancy, and an average American woman spends three decades not wanting to become pregnant [78]. The majority of contraceptive methods, including all of the most effective methods, require a visit to a provider for either a prescription or a procedure. As a result, women frequently seek out health care services related to contraception, with over 50 percent of sexually active women in the United States reporting having received birth control-related care in the past 12 months [79]. One option for increasing access to contraception is to allow pharmacists to prescribe hormonal contraceptives (oral pill, transdermal patch, vaginal ring) [80]. In addition to providing an additional source of hormonal contraceptives, pharmacist-generated orders have been associated with longer duration prescriptions, which reduce gaps in contraceptive coverage. In a survey study of 410 individuals that compared prescriptions for hormonal contraceptives from pharmacists (n = 144) and from traditional clinician prescribers (n = 266), pharmacist prescriptions were more likely to be for a six-month supply or longer (7.0 versus 1.5 percent) and less likely to provide only a one-month supply (29 versus 44 percent) [81].

Myths of contraceptive counseling — Over the past few decades, the goal of family planning has been interpreted as equivalent to helping individuals avoid unintended pregnancy; the assumption has been that unintended pregnancies are uniformly negative outcomes for women and for society [82-85]. To this end, many family planning programs and policies have prioritized use of the most highly effective methods [86,87]. Over time, the appropriateness of this focus has been questioned based on the diverse perspectives women have about unintended pregnancy, data about the health impacts of pregnancy intention for mothers and babies, and what is known about women's preferences for contraceptive methods.

- **Unintended pregnancy is not always unwelcome** – Research on women's feelings about pregnancy intention in the current literature has advanced the assumption that an unintended pregnancy is an inherently bad outcome [88]. Rather, women have varying perspectives about whether, and to what degree, an unintended pregnancy would be a positive or negative experience in their lives [88-91]. In fact, some women embrace the lack of predictability of their fertility and consider unintended pregnancies to be welcome surprises [92].

- **Unintended pregnancies are not necessarily unhealthy pregnancies** – It is also increasingly understood that the literature about the association between pregnancy intention and poor maternal and child health outcomes is not as robust as previously thought, especially in developed countries [83,93]. This is consistent with the understanding that an unintended pregnancy does not result in the same negative reactions in all women [88]. In addition, it is likely that other confounders or mediators could impact pregnancy outcome when attempting to asses for the impact of pregnancy intention [93].

- **Contraceptive efficacy is only one important contraceptive characteristic** – Commensurate with the above findings about women's views on pregnancy, research has revealed that women have diverse and strong preferences for contraceptive methods [34,35,94]. Data indicate that efficacy is not the only, or always the most important, characteristic for women choosing a contraceptive method. For example, one study stated that, on average, women reported 11 characteristics that were important to them, with the following percentages of women noting these characteristics were "extremely important" [35]:

  - Very effective at preventing pregnancy – 89 percent
  - Easy to use – 80 percent
  - Few or no side effects – 74 percent
  - Woman has control over when and whether to use the method – 71 percent
  - No one can tell that the woman is using the method – 55 percent
  - No change in menstrual periods – 44 percent

Promotion of health equity — Contraceptive counseling occurs in an historical and social context in which family planning providers and services have participated in coercive and unethical practices designed to limit the fertility of specific populations, including women of color, poor women, and women with disabilities [95]. Examples include nonconsensual sterilization and targeted marketing of the contraceptive injection Depo-Provera [96,97]. This history remains in the consciousness of the communities impacted, with one study reporting that over 40 percent of black and Latina people think that the government promotes birth control to limit minorities [33]. A different study documented that over one-third of black women believe "medical and public health institutions use poor and minority people as guinea pigs to try out new birth control methods" [75].

While this history has the potential to affect how women perceive contraceptive counseling regardless of the counseling provided, there is also evidence from studies of ongoing bias in counseling according to the race/ethnicity of the patient. These include findings that women of color are more likely to report being advised to limit their childbearing than are white women in the context of prenatal care [98], and that black women are more likely than white women to report having been pressured by a clinician to use contraception [99]. In addition, studies using standardized case scenarios have found that providers are more likely to recommend the intrauterine device (IUD) to low-income black and Latina women than to low-income white women [100], and are more likely to agree to sterilize women of color and poor women than white women or non-poor women [101]. These findings are consistent with the broader literature on health care disparities in the United States, which has documented that patients of color receive different, lower quality care than do white patients, even with identical clinical presentations and access to care [102]. (See "Racial and ethnic disparities in obstetric and gynecologic care and role of implicit biases".)

Given this history, the recent emphasis on directive counseling toward methods of contraception that require a provider to both insert and remove a device (ie, IUDs and implants) has raised concerns about the potential to recreate, or appear to recreate, historical injustices related to reproductive control [95]. This is particularly relevant given that women of color have been found to be less likely to desire a contraceptive method that they are unable to remove or discontinue on their own [35]. Therefore, directive counseling toward these methods is more poorly aligned with their preferences than it is for white women, while also having the potential to heighten preexisting mistrust of family planning providers.

In contrast to directive counseling, shared decision making provides a structure for counseling, described above, that protects against perceived or actual bias in counseling by explicitly focusing on women's expressed preferences. Given that bias can influence how

decision support is provided, however, those practicing shared decision making should be aware of the potential for bias to influence their counseling in subtle ways and should work to guard against overemphasizing specific methods based on assumptions about what women do or should want.

- (See 'Personalized counseling with shared decision making' above.)
- (See "Racial and ethnic disparities in obstetric and gynecologic care and role of implicit biases", section on 'Mitigation of implicit bias'.)

RESOURCES FOR PATIENTS AND CLINICIANS

- bedsider.org: A free website developed by the National Campaign to Prevent Teen and Unplanned Pregnancy, a private nonprofit group
- The Family Planning National Training Center: The website for federally funded contraceptive resources developed with the support of the Office of Population Affairs
- Center for Young Women's Health: A free website run by Boston Children's Hospital that addresses reproductive health needs of teens and young adults
- Beyond the Pill: A free website run by the University of California San Francisco
- SexualityandU.ca: An educational site run by the Society of Obstetricians and Gynaecologists of Canada that includes descriptions of various methods and a tool to help with selection of birth control
- Planned Parenthood: A nonprofit organization dedicated to reproductive health with resources for patients and clinicians
- ACOG Contraceptive FAQs: American College of Obstetricians and Gynecologists addresses frequently asked questions (FAQs) about contraception
- ACOG LARC Program: American College of Obstetricians and Gynecologists Long-Acting Reversible Contraception Program
- United States Medical Eligibility Criteria for Contraceptive Use
- United States Selected Practice Recommendations for Contraceptive Use
- World Health Organization Medical Eligibility Criteria for Contraceptive Use

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Contraception".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword(s) of interest.)

- Basics topics (see "Patient education: Choosing birth control (The Basics)" and "Patient education: Vasectomy (The Basics)")

- Beyond the Basics topics (see "Patient education: Birth control; which method is right for me? (Beyond the Basics)" and "Patient education: Vasectomy (Beyond the Basics)")

SUMMARY AND RECOMMENDATIONS

- Data suggest that family planning care should not have a singular focus of preventing unintended pregnancy, as this is not consistent with all women's preferences or necessary to optimize health outcomes. Contraceptive counseling has evolved from clinician-level directive counseling and provision of education to personalized counseling that includes shared decision making. (See 'Goals' above and 'Personalized counseling with shared decision making' above.)

- The first step in providing patient-centered contraceptive counseling is identifying patients for whom this counseling is appropriate. In our practice, we ask women if they wish to prevent pregnancy now (table 2). (See 'Identify patient-centered reproductive goals' above.)

- Once a woman is identified as being appropriate for and desirous of contraceptive counseling, providers can then assess for medical conditions that could affect the safety of specific methods. The World Health Organization Medical Eligibility Criteria for Contraceptive Use and the US Medical Eligibility Criteria for Contraceptive Use are freely available, easy to use, and provide contraceptive prescribers with definitive guidance on safety across a broad range of conditions for different patient populations. (See 'Document medical history/potential contraindications' above.)

- Contraceptive counseling using shared decision making should first elicit informed preferences for method characteristics, and then support patients in considering how these characteristics relate to the available methods, while leaving the ultimate decision up to the patient. (See 'The shared decision-making process' above.)

- Preferences for characteristics of contraceptive methods to consider when providing counseling include those related to method effectiveness, how often the method is taken/used, how the method is taken/used, menstrual changes, other side effects, noncontraceptive benefits, return to fertility, and privacy. (See 'Elicit informed preferences' above.)

- Providers can address misconceptions and misinformation about methods, especially those transmitted through social networks, in a respectful way that does not dismiss these concerns but provides evidence-based information about the known effects of specific methods. (See 'Discuss method characteristics' above.)

- Use of visual aids, such as the Title X contraceptive method options chart (figure 2), can help to structure and guide counseling. (See 'Facilitate decision making' above.)

- Counseling after method selection should provide each woman with information about how to start her method, how to optimize her use of the method, side effects she may experience, how to access necessary follow-up care including refills, and how to access care if she wishes to discuss discontinuation and/or method switching. Emergency contraception and protection from sexually transmitted infections are also discussed. (See 'Selecting a method' above and 'Starting a method' above and 'Assess risk of sexually transmitted infections' above.)

- Counseling for specific populations, including adolescents, women with substance use disorders, women with chronic medical conditions, and women with mental or intellectual disability, should prioritize these patients' reproductive autonomy and provide tailored education to support their informed decision making. (See 'Special populations' above.)

- Providers should be aware of the potential for unconscious bias about patients' race/ethnicity to influence their counseling. Use of a shared decision-making model explicitly focused on patient preferences can limit the impact of such bias. (See 'Promotion of health equity' above.)

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Topic 5459 Version 130.0

GRAPHICS

Potential pitfalls and patient-centered alternatives in reproductive goals counseling

Potential pitfalls	Patient-centered alternatives
Assuming all women will have a binary intention to either pursue or avoid pregnancy.	Asking open-ended questions that allow women to express ambivalent or mixed feelings about pregnancy.
Assuming that all ambivalence can and should be resolved.	Working collaboratively with women to identify strategies that meet their needs in the setting of ambivalence (ie, preparation for possibility of pregnancy).
Assuming that women will perceive unintended pregnancy as a universally "bad" outcome.	Recognizing that some women who do not have an active intention to pursue pregnancy may welcome unintended pregnancy.
Assuming that "pregnancy planning" is a concept that all women find meaningful and relevant.	Recognizing that some women may not value planning, or may feel that planning is not attainable due to their life circumstances (ie, lack of financial or relationship stability).
Allowing personal judgment of women's reproductive desires or goals to influence counseling.	Providing nonjudgmental counseling and support, which respects women's reproductive autonomy.
Assuming all women who could potentially become pregnant will be receptive to preconception counseling.	Tailoring information delivery to women's preferences and needs, based on open conversations about reproductive goals.

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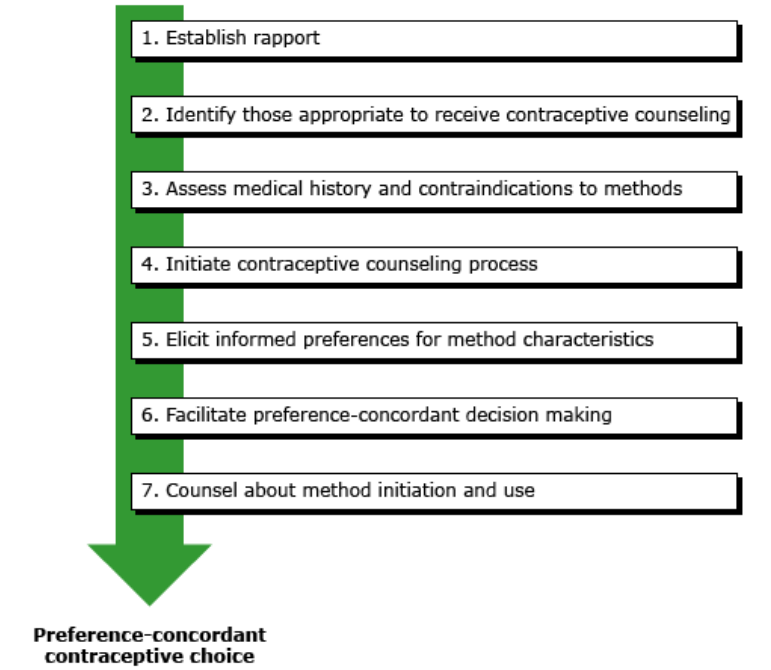
Graphic 120176 Version 1.0

Outline of contraceptive counseling process



Courtesy of Christine Dehlendorf, MD.

Graphic 119764 Version 1.0

Approach to initiating reproductive goals counseling discussion

Approach	Questions	Advantages	Limitations
Reproductive life plan[1]	▪ Do you have children now? ▪ Do you want to have (more) children? ▪ How many (more) children would you like to have and when?	▪ For those with defined plan, allows for provision of preconception care as appropriate	▪ Does not account for how people develop and modify their reproductive goals over time ▪ Does not acknowledge that unintended pregnancy may be welcomed ▪ Not ideal for indentifying current contraceptive needs
One key question[2]	▪ Would you like to become pregnant in the next year?	▪ Limits time frame under consideration ▪ Allows women to be unsure about plans	▪ Not ideal for identifying current contraceptive needs
Screen women for need for contraceptive counseling	▪ Do you want to prevent pregnancy now?	▪ Identifies women's current contraceptive needs	▪ When used alone, does not address need for preconception counseling
PATH questions[3]	▪ Do you think you might like to have (more) children at some point? ▪ If women are considering future parenthood: When do you think that might be? ▪ How important is it to you to prevent pregnancy (until then)?	▪ Can open conversation about preconception care when appropriate ▪ Provides information about preferences related to contraceptive effectiveness	▪ Is not focused on current need for contraception

PATH: Parenthood/pregnancy attitude, timing, and how important is pregnancy prevention.

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Graphic 120259 Version 1.0

Examples of counseling exchanges

Phase of counseling	Provider question	Possible patient responses	Provider follow-up
Initiating the conversation	"Do you have a sense of what is important to you about your method?"	"I haven't really thought of that before. What do you mean?"	"Well, methods vary on a bunch of factors, like how you take them, effectiveness, and how they change your period. Can we talk a bit about how you feel about those?"
		"I just don't want something that is going to change my period."	"Thanks for sharing that. Can you tell me more about what types of changes in your bleeding bother you?"
		"I just want to get my depo shot and get out of here."	"Absolutely, if that is what you want, we can do that. Would you be interested in hearing about any other methods, just to make sure you know about all your options?"
Eliciting informed preferences	"Birth control methods can be taken by mouth, be a patch on your skin, be a ring in your vagina, be a shot, go inside your arm, or go inside your uterus. What do you think about those options?"	"I don't want something inside my body – I want to make sure that I can stop it at any time."	"Great, that's really helpful to know. Now I want to find out how you feel about how often you take your method."
	"There are methods you take once a day, once a week, once a month, or even less frequently. Is that something that makes a big difference to you?"	"Any of those would be fine with me."	"Great – then that isn't something that will limit your choices."
	"While all methods prevent pregnancy for most women, there are differences in how frequently they prevent pregnancy. For some methods, 20 in 100 women get pregnant in a year, while for others, less than 1 in 100 women get pregnant. How important is effectiveness at preventing pregnancy to you?"	"It would be the end of the world for me if I got pregnant."	"Ok, I have noted that, and we can talk about that more after we review a few other method characteristics."
		"What I am most worried about is side effects."	"Thanks for telling me that. What side effects are you most worried about?"
	"Most methods cause changes in your bleeding, with some making it lighter, others making it heavier or less regular, and some making it go away completely. How would you feel about those changes?"	"Having a lighter period sounds great, but I wouldn't want my period going away."	"Some women don't like the idea of not having a regular period for a range of reasons. But I do want to make sure you know that it is safe not to have a period when using these methods, in case safety is a concern for you."
		"What do you mean by less regular?"	"Great question. Some methods cause frequent bleeding either between periods, or instead of periods. How would you feel about that?"
	"Can you tell me if there are any other side effects of birth control methods you are particularly worried about?"	"My friend told me the ring made her crazy."	"That's too bad your friend had that experience. I haven't heard of that before, and I can tell you it definitely doesn't happen frequently. In general, no contraceptive methods have an effect on mental health. Since everyone is different, I wouldn't expect the same thing that happened to your friend to happen to you."
	"Some birth control methods have benefits, such as decreasing acne, making period cramps less, or lowering your risk of cancer." Are any of those particularly important to you?"	"Well, I love the idea of a lower risk of cancer."	"Great. When we go over the methods, I can tell you which ones have this benefit, and you can see if that makes a difference for you."
	"Is it important to you that other people can't tell that you are using birth control?"	"Well, I just don't want my roommate to know about my private life."	"Ok, let's talk about what methods you would be able to keep private from your roommate."
	"When or if you might want to become pregnant in the future is something you want to consider in choosing a method. Do you think you want to become pregnant in the near future?"	"Definitely not for a few years, but then maybe."	"Ok, so permanent methods – like sterilization – won't be a good fit, but since no other methods affect your fertility in the long term, we can consider all of them."
Facilitating decision making	"I have heard you say that an important thing to you is to use something that is the best at preventing pregnancy. Is that right?"	"Absolutely."	"Ok, given that you want to have children at some point, we can't consider sterilization. IUDs and implants are the most effective reversible methods. Is it okay if I tell you more about those?"

	"You've told me that it is really important to you to not have to remember a method and that you want something that makes your acne better. Are these the most important things to you?"	"Yes, it would also be great if they could lower my risk of cancer like you mentioned."	"As you can see on this chart, unfortunately, the methods you don't have to think about – IUDs and implants – don't affect your acne. The pill, patch, and ring do help your acne and also lower your risk of ovarian and uterine cancer. What more information can I give you to help you think about these different types of methods?"
	"Given what you have said about wanting to have a regular, lighter period, do you want to focus just on the pill, patch, and ring, since those are the methods that have that effect on your bleeding?"	"Sure. But I forgot to mention that I really can't remember to take medicines on a regular basis."	"In that case, taking the pill, patch, or ring might be hard for you. Do you want to think about whether remembering something every week or every month – like the patch or the ring – would work for you? If not, we can talk about other methods and the effect they would have on your period."
Making the final decision	"Given what we talked about, and what is important to you about your method, what do you think would be the best choice for you at this time?"	"I guess I will try the ring."	"Great, that seems like the best fit since it will make your period lighter. If you find it is too hard for you to remember to take it out every month – or want to change for any other reason – there are a lot of other options we can talk about, so please come back and we can talk other options."

IUD: intrauterine device.

Courtesy of Christine Dehlendorf, MD.

Graphic 119762 Version 1.0

Title X birth control methods options chart[1,2]

Birth control method options		Risk of pregnancy*	How the method is used	How often the method is used	Menstrual side effects	Other possible side effects to discuss	Other considerations	
Most effective	Female sterilization	0.5 out of 100	Surgical procedure	Permanent	None	Pain, bleeding, infection	Provides permanent protection against an unintended pregnancy	Counsel all clients about the use of condoms to reduce the risk of STIs, including HIV infection
	Male sterilization	0.15 out of 100						
	IUD	**LNG:** 0.2 out of 100	Placement inside uterus	Lasts up to 3 to 12 years	**LNG:** Spotting, lighter or no periods	Some pain with placement	**LNG:** No estrogen; may reduce menstrual cramps	
		CopperT: 0.8 out of 100			**CopperT:** Heavier periods		**CopperT:** No hormones; may cause more menstrual cramps	
	Implant	0.05 out of 100	Placement into upper arm	Lasts up to 3 years	Spotting, lighter or no periods		No estrogen	
Moderately effective	Injectables	4 out of 100	Shot in arm, hip or under the skin	Every 3 months	Spotting, lighter or no periods	May cause appetite increase/ weight gain	No estrogen May reduce menstrual cramps	Counsel all clients about the use of condoms to reduce the risk of STIs, including HIV infection
	Pill	8 out of 100	Take a pill	Every day at the same time	Can cause spotting for the first few months Periods may become lighter	May have nausea and breast tenderness for the first few months	Some clients may report improvement in acne May reduce menstrual cramps and anemia Lowers risk of ovarian and uterine cancer	
	Patch	9 out of 100	Put a patch on skin	Each week				
	Ring		Put a ring in vagina	Each month				
	Diaphragm	12 out of 100	Use with spermicide and put in vagina	Every time you have sex	None	Allergic reaction, irritation	No hormones	
Least effective	Male condom	13 out of 100	Put over penis	Every time you have sex	None	Allergic reaction, irritation	No hormones No prescription necessary	Counsel all clients about the use of condoms to reduce the risk of STIs, including HIV infection
	Female condom	21 out of 100	Put inside vagina					
	Withdrawal	20 out of 100	Pull penis out of the vagina before ejaculation			None	No hormones Nothing to buy	
	Sponge	12 to 24 out of 100	Put inside vagina			Allergic reaction, irritation	No hormones No prescription necessary	
	Fertility awareness based methods	24 out of 100	Monitor fertility signs Abstain or use condoms on fertile days	Daily		None	No hormones Can increase awareness and understanding of a woman's fertility signs	
	Spermicides	28 out of 100	Put inside vagina	Every time you have sex		Allergic reaction, irritation	No hormones No prescription necessary	

IUD: intrauterine device; LNG: levonorgestrel; STI: sexually transmitted infection.
* The number of women out of every 100 who have an unintended pregnancy within the first year of typical use of each method. Other methods of birth control: (1) lactational amenorrhea method (LAM) is a highly effective, temporary method of contraception; and (2) emergency contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

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Graphic 119765 Version 3.0

Noncontraceptive benefits of reversible contraceptive methods

Combined estrogen-progestin methods	▪ Reduction in menstrual cramps ▪ Reduction in pelvic pain related to endometriosis ▪ Reduction of menorrhagia, with improvement in iron deficiency anemia related to blood loss ▪ Reduction in risk of ectopic pregnancy ▪ Reduction in symptoms associated with premenstrual syndrome and premenstrual dysphoric disorder ▪ Reduction in risk of benign breast disease ▪ Reduction in development of new ovarian cysts (true for higher dose estrogen pills only, which suppress ovulation), but no effect on existing ovarian cysts ▪ Reduction in ovarian cancer, including some hereditary forms, such as those associated with mutations in the *BRCA1* or *BRCA2* gene, presumably due to inhibition of ovarian stimulation ▪ Reduction in endometrial cancer due to the progestin effect ▪ Reduction in colorectal cancer in current users ▪ Reduction in moderate acne ▪ Reduction in hirsutism ▪ More regular menstrual cycles
Hormonal IUD (levonorgestrel)	▪ Reduction in menstrual cramps ▪ Reduction in pelvic pain related to endometriosis ▪ Reduction of menorrhagia, with improvement in iron deficiency anemia related to blood loss ▪ Reduction in endometrial hyperplasia ▪ Reduction in cervical cancer ▪ Reduction in pelvic inflammatory disease
Copper IUD	▪ Continued menstrual cyclicity ▪ Reduced risk of cervical cancer
Progestin-only injection	▪ Reduction in menstrual cramps ▪ Reduction in menstrual bleeding ▪ Reduction in risk of endometrial cancer
Progestin-only pills	▪ Reduction in risk of endometrial cancer

IUD: intrauterine device.

Graphic 119763 Version 2.0

How to start contraception

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (ie, back-up) needed	Examinations or tests needed before initiation*
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection¶
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	Bimanual examination and cervical inspection¶
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days	None

IUD: intrauterine device; BMI: body mass index; STD: sexually transmitted disease; CDC: Centers for Disease Control and Prevention.
* Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception, because all methods can be used (United States Medical Eligibility Criteria for Contraceptive Use 2010, US MEC 1) or generally can be used (US MEC 2) among obese women. However, measuring weight and calculating BMI (weight [kg]/height [m^2]) at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.
¶ Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD Treatment Guidelines (available at http://www.cdc.gov/std/treatment). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (US MEC 4). Women who have a very high individual likelihood of STD exposure (eg, those with a currently infected partner) generally should not undergo IUD insertion (US MEC 3). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

Reproduced from: US Selected Practice Recommendations for Contraceptive Use, 2013: Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd ed. MMWR Morb Mortal Wkly Rep 2013; 62:1.

Graphic 89825 Version 7.0

Checklist used to assess the possibility of pregnancy

The provider can be reasonably certain that the woman is not pregnant if she has no symptoms or signs of pregnancy and meets ANY of the following criteria:
❑ She has not had intercourse since her last normal menses.
❑ She has been correctly and consistently using a reliable method of contraception.
❑ She is within the first 7 days after normal menses.
❑ She is within 4 weeks postpartum (for nonlactating women).
❑ She is within the first 7 days postabortion or miscarriage.
❑ She is fully or nearly fully breastfeeding, amenorrheic, and less than 6 months postpartum.

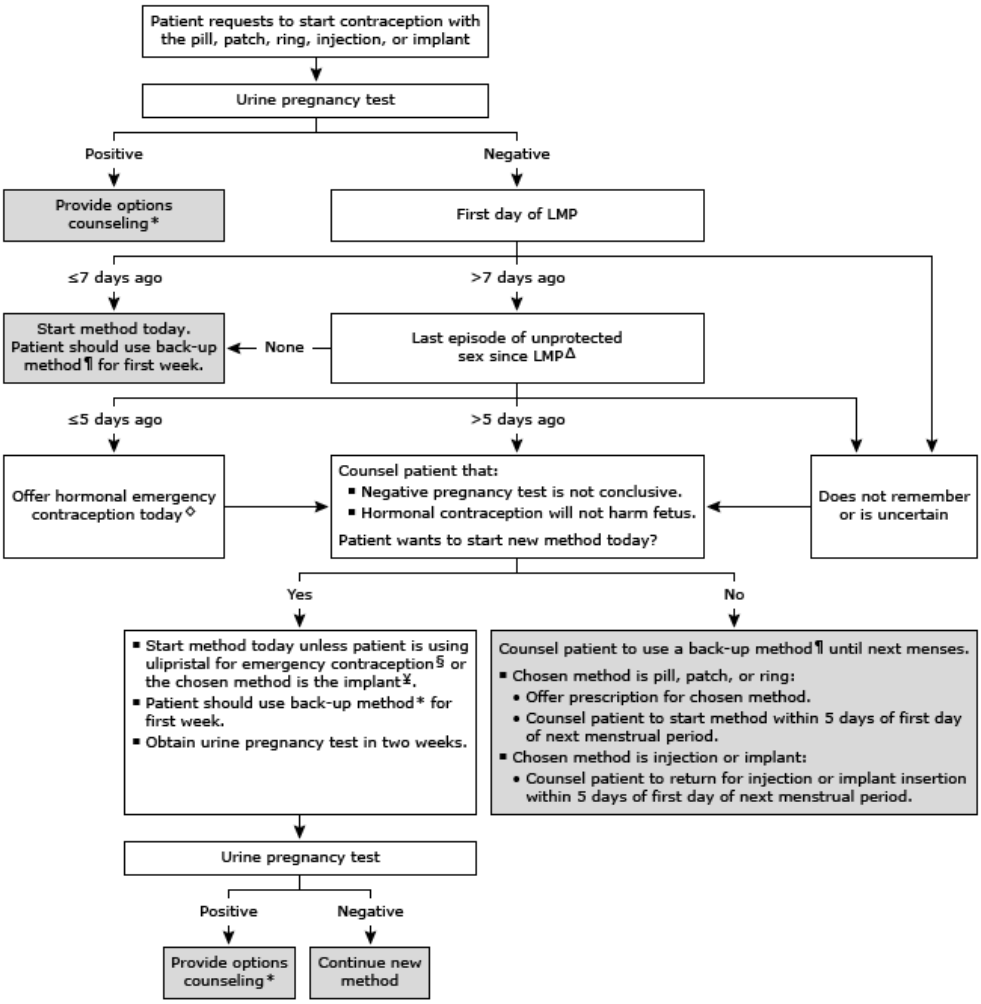
A systematic review of studies evaluating the performance of a pregnancy checklist compared with urine pregnancy test to rule out pregnancy concluded the negative predictive value of a checklist similar to the one above was 99 to 100%.

Data from:

1. *Tepper NK, Marchbanks PA, Curtis KM. Use of a checklist to rule out pregnancy: A systematic review. Contraception 2013; 87:661.*
2. *Curtis KM, Tepper NK, Jatlaoui TC, et al. United States Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016; 65:1.*

Graphic 67567 Version 18.0

Quick-start (same-day start) approach to initiation of new birth control method: Pill, patch, ring, DMPA injection, implant



DMPA: depot medroxyprogesterone acetate; LMP: last menstrual period.

* Refer to UpToDate content on early pregnancy and pregnancy termination.

¶ Patient should use a barrier back-up method such as condoms for the first week after starting a new method.

Δ Unprotected sex includes episodes of sex in which a method of contraception was used but may not have been effective (eg, breakage of condom, multiple skipped pills).

◇ Refer to UpToDate content on emergency contraception.

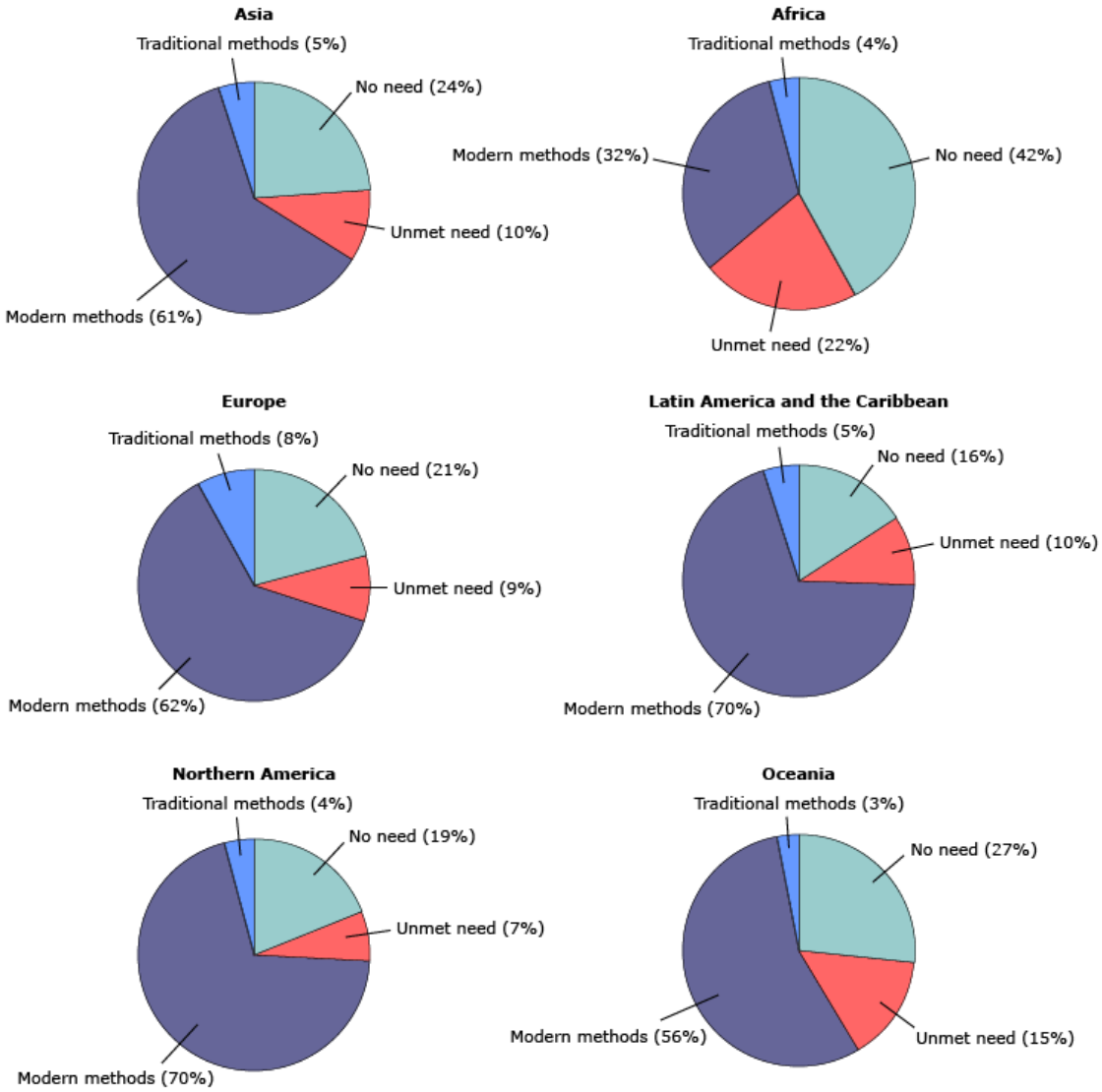
§ For women using ulipristal for emergency contraception, progestin-containing contraception (ie, the pill, patch, ring, injection, and implant) should not be used for 5 days following ulipristal. For women taking levonorgestrel or combined estrogen-progestin emergency contraception, the new contraceptive method can be started after the emergency contraception.◇

¥ If the patient would like the contraceptive implant, some providers prefer to offer a single injection of DMPA today and ask the patient to return for the implant within 5 days of the first day of her next menstrual period (to avoid the need for implant removal if the repeat urine pregnancy test is positive).

Adapted from: Quick Start Algorithm for Hormonal Contraception. RHEDI/The Center for Reproductive Health Education In Family Medicine, Montefiore Medical Center (Accessed on July 7, 2016).

Graphic 56863 Version 11.0

Distribution of contraceptive use (modern or traditional methods) by individuals who are married or in-union and contraceptive need by region, 2017



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Graphic 120498 Version 1.0

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Christine Dehlendorf, MD, MAS Nothing to disclose **Courtney A Schreiber, MD, MPH** Patent holder: Penn, Saul [Medical management of nonviable pregnancy]. Grant/Research/Clinical Trial Support: Bayer [Contraception]; Medicines360 [Contraception]; VeraCept [Contraception]. Consultant/Advisory Boards: Danco Pharmaceuticals [Early pregnancy loss]. **Kristen Eckler, MD, FACOG** Nothing to disclose

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Conflict of interest policy