BEST PRACTICES IN CONTRACEPTIVE COUNSELING

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Disclosure Statement
I have nothing to disclose.

Objectives
Inspire you to practice patient-centered contraceptive counseling and provision
Increase comfort with the CDC Medical Eligibility Criteria and Selected Practice Recommendations for complex contraception decisions
Dispel myths

6.4 Million U.S. Pregnancies Annually

Unintended, despite method used
Unintended, no method used
49% Intended
**Contraceptive Method Use, U.S.*

- Sterilization (male and female): 26%
- IUD & Implant: 11.6%
- Injectable: 11.6%
- Pill: 11%
- Male Condom: 10.5%
- Withdrawal: 8.5%
- Natural Family Planning: 8.5%
- Other: 10%

*A among the 38 million women currently using birth control.

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**Trends in Contraception Use**

- From 2008-14, no change in the proportion of women who used a method among ALL women (60%) or those at risk of unintended pregnancy (90%).
- The largest increase in use was long-acting reversible contraceptive (LARC) methods, from 8% to 14%.
- The largest decrease was in sterilization from 35% to 28%, with lower-income women driving the decline in female sterilization and higher-income women driving the decline in a partner’s sterilization as a primary method.
- Moderate increases in the use of withdrawal and natural family planning.

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**One-Year Contraceptive Use Patterns**

- Gap in use, at risk: 15%
- Gap in use, not at risk: 15%
- A method all year, with switch: 24%
- Same method all year: 38%
- No use: 8%

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**Principles of Quality Counseling (CDC)**

- Establish and Maintain Rapport with the Client
- Assess the Client’s Needs and Personalize Discussions Accordingly
- Work with the Client Interactively to Establish a Plan
- Provide Information That Can Be Understood and Retained by the Client
- Confirm Client Understanding
What is the best approach to contraceptive decision making?

1. Encourage women to choose the most highly effective methods
2. Give them information about all methods and let them decide for themselves
3. Discuss only the method they say they want
4. None of the above

Does contraceptive counseling matter?

- Counseling influences method selection
- Positive provider relationship=higher satisfaction with care
- Satisfaction with care associated with contraception
- Quality of care correlated with continuation

Patient-focused counseling

- "Informed Choice":
  - Provider gives only objective information and no role in method/treatment selection
  - Provider does not assist patient in understanding how preferences relate to method characteristics or tailor information to patient's needs
  - Only information on methods asked about by the patient are discussed

Risk: Can fail to ensure patient is aware of and has accurate information about methods

"Directed Counseling"

- Provide information and counseling designed to promote use of specific methods
- Rooted in the healthcare provider's preferences, or assumptions about the client's priorities
- Emphasis on LARC methods

Risk: can lead to poor satisfaction with method/care

Forrest, Fam Plann Perspect, 1996.
When is directed counseling patient-centered?

- When one option leads to better health outcomes
- When you listen to their preferences, then make recommendations
- When there is no single best option
- When you help patient consider tradeoffs among their preferences and among different outcomes of methods

Contraceptive Choice is Complex

- Women have strong and varied preferences for contraceptive features

<table>
<thead>
<tr>
<th>Feature</th>
<th>Extremely Important</th>
<th>Somewhat Important</th>
<th>Not at All Important</th>
<th>Don't Know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of use</td>
<td>54</td>
<td>16</td>
<td>9</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Effective at preventing pregnancy</td>
<td>78</td>
<td>19</td>
<td>6</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Each person's preferences</td>
<td>89</td>
<td>17</td>
<td>3</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Unnatural method</td>
<td>62</td>
<td>21</td>
<td>6</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>Can be removed at any time</td>
<td>59</td>
<td>26</td>
<td>9</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Can be reversed at any time</td>
<td>53</td>
<td>29</td>
<td>12</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Not a backup method</td>
<td>58</td>
<td>25</td>
<td>12</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Not a method of choice</td>
<td>62</td>
<td>29</td>
<td>12</td>
<td>5</td>
<td>100</td>
</tr>
</tbody>
</table>

Contraception Choice is a Multidimensional Concept

Plans ≠ Intentions ≠ Desires ≠ Feelings

Ambivalence...

"I've already got a kid so I'm not opposed to having children. If it happens, it happens.... I'd prefer we don't have children right now but if it happens, okay."

"I guess one of the reasons that I haven't gotten an IUD yet is it takes the element of surprise out of when we have our next kid, which I kind of want. I'm in that weird position. I just don't want to put too much thought and planning into when I have my next kid."

"I don't want more kids and was hoping to get my tubes tied. We can't afford another one. But if it happened I'd still be happy. I'd be really excited. We'd rise to the occasion...nothing would really change."
What if a woman’s top priority is not method efficacy?

- Conflict between public health and patient-centered perspectives
- Requires clarity on our feelings about:
  - Pregnancy ambivalence
  - Unintended pregnancy
  - Abortion

Provider Preference Decreases Use

- Provider expressing a preference results in lower likelihood of patient being satisfied with method
- Choosing method that provider recommended is associated with:
  - Less satisfaction with method
  - (45% vs. 64%, p=.004)
  - Lower chance of starting method
  - (66% vs. 81%, p=.05)

Shared decision-making in family planning

- Start with her priorities and preferences (women will weigh effectiveness differently based on age, relationships, security)
- Structure visit around patient preferences, not a particular method
- Use qualitative and quantitative data focused on her preferences

Women of color and poor women are counseled differently

- Women of color are more likely to report being dissatisfied with their family planning provider
- Women of color and low-income women are more likely:
  - Being pressured to use a birth control method and limit their family size
  - Black women much less likely to use any contraception at last intercourse, not due to differential access to healthcare

Dehlendorf: Contraception, 2013
Dehlendorf: Contraception, 2014
Grady, Contraception July 2015
Thorbun & Bogart, Women’s Health: 2005
Downing, AJPH, 2007
Dehlendorf, AJOG, 2010
Grady, Contraception, 2015
Optimal Contraceptive Counseling

- Preference-sensitive decision
- Respect diverse priorities, concerns, experiences
  - Control over method
  - Safety questions
  - Side effects
  - Route and frequency of administration
  - Personal and friends’ experiences
  - Convenience
  - Return to fertility
  - Efficacy

Sharing decision making

- Provide scaffolding for decision making
  - Given their preferences, what information do they need?
  - Actively facilitate, while avoiding stating opinions not based on patient preferences

Examples of facilitation

“\textquote I am hearing you say that avoiding pregnancy is the most important thing to you right now. In that case, you may want to consider either an IUD or implant. Can I tell you more about those methods?\textquoteclose”

“You mentioned that it is really important to you not to have irregular bleeding. The pill, patch, ring and copper IUD are good options, if you want to hear more about those.”

Contraception Methods

- Least Effective
- Most Effective

- NFP
- OCs
- Patch
- Ring
- DMPA (IM or SQ)
- Progestin IUD
- Copper IUD
- IUD
- Sterilization

<table>
<thead>
<tr>
<th>Method</th>
<th>Least Effective</th>
<th>Most Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFP</td>
<td>&lt;88%</td>
<td>&gt;99%</td>
</tr>
<tr>
<td>OCs</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>Patch</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>Ring</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>DMPA (IM or SQ)</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>Progestin IUD</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>IUD</td>
<td>94%</td>
<td>91%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>94%</td>
<td>91%</td>
</tr>
</tbody>
</table>
### Contraception Methods

#### Barrier Methods

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Perfect Use</th>
<th>Typical Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>2%</td>
<td>18%</td>
</tr>
<tr>
<td>Cervical Cap (parous/nullip)</td>
<td>26%/9%</td>
<td>32%/16%</td>
</tr>
<tr>
<td>Sponge (parous/nullip)</td>
<td>20%/9%</td>
<td>24%/12%</td>
</tr>
<tr>
<td>Female Condoms</td>
<td>5%</td>
<td>21%</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6%</td>
<td>12-17%</td>
</tr>
</tbody>
</table>


#### Hormonal Methods

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Perfect Use</th>
<th>Typical Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progestin-only Pills</td>
<td>0.3%</td>
<td>9%</td>
</tr>
<tr>
<td>Combined Pill/Patch/Ring</td>
<td>0.3%</td>
<td>9%</td>
</tr>
<tr>
<td>1-month Injection</td>
<td>0.25%</td>
<td>6%</td>
</tr>
<tr>
<td>3-Month Injection</td>
<td>0.2%</td>
<td>6%</td>
</tr>
<tr>
<td>Implants</td>
<td>0.05%</td>
<td>0.05%</td>
</tr>
<tr>
<td>LNG IUD</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

**Public Health Framework**

- **LARC FIRST**
  - Bias about superiority
  - Ignores variability in preferences
  - Does not prioritize autonomy
  - May feel coercive

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**IUD Comparison**

<table>
<thead>
<tr>
<th>NAME</th>
<th>HORMONE</th>
<th>DOSE</th>
<th>APPROVED FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ParaGard</td>
<td>N/A, non-copper</td>
<td>N/A</td>
<td>10/12 years*</td>
</tr>
<tr>
<td>Mirena</td>
<td>levonorgestrel</td>
<td>20 mcg/day (12 mg total in the device)</td>
<td>5/7 years*</td>
</tr>
<tr>
<td>Levette</td>
<td>levonorgestrel</td>
<td>16.6 mcg/day (52 mg total)</td>
<td>4-5 years</td>
</tr>
<tr>
<td>Kyleena</td>
<td>levonorgestrel</td>
<td>17.5 mcg/day (80.5 mg total)</td>
<td>5 years</td>
</tr>
<tr>
<td>Skyla</td>
<td>levonorgestrel</td>
<td>14 mcg/day (52.5 mg total)</td>
<td>3 years</td>
</tr>
</tbody>
</table>

Additional studies show that the devices are effective even longer than originally approved: 12 years for copper; 5-7 years for 52 mg LNG IUS.

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**Copper IUD**

- Polyethylene wrapped with copper wire
- Approved for use up to 10 years
- Mechanisms of action:
  - Inhibition of sperm migration and viability
  - Change in ovum transport speed
  - Damage to or destruction of ovum
  - Damage to or destruction of fertilized ovum
  - All effects occur before implantation
- Highly effective

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**LNG IUS**

- Releases 20 mcg levonorgestrel/day
- Approved for use up to 5 years, may be effective up to 7 years
- Mechanisms of action:
  - Similar effects as copper IUD
  - Also causes endometrial suppression and changes in cervical mucus
  - All effects occur before implantation
- Highly effective
Most Effective

- Copper IUD - <0.1% failure
- VERY effective as EC up to 5+ days
- Can place beyond 5 days after UPSI if not >more than 5 days after ovulation
- More effective than LNG EC

[Image: Copper IUD]

Cheng, Cochrane, 2008

Insertion Protocols

- Routine antibiotic prophylaxis is not recommended before insertion
- Current data do not support routine screening for STIs prior to insertion for women at low risk
- Treat mucopurulent discharge or known STI before insertion

Backup Contraception

- Not needed at any time after Copper IUD insertion
- Needed for 7 days unless LNG IUS inserted:
  - Within 5 days of menses
  - Immediately postpartum or post-abortion
  - Immediately upon switching from another hormonal method

LNG IUS Menstrual Effects

- Bleeding duration and amount decreases initially and over time
- 70% experience oligomenorrhea or amenorrhea within 2 years of insertion
Postpartum IUD insertion

- Safe and does not have higher risks of complications
- Risk of IUD expulsion can occur in both vaginal and cesarean deliveries
- Expulsion rates vary widely across studies, without clear evidence about the factors that may influence expulsion.

Society of Family Planning Guidelines: Postpartum insertion of intrauterine device, Amy K. Whitaker Jan 2018

Mean Bleeding/Spotting Days
Per 90 day reference period

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding</td>
<td>7.3 days</td>
</tr>
<tr>
<td>Spotting</td>
<td>10.4 days</td>
</tr>
<tr>
<td>No spotting or bleeding</td>
<td>72.3 days</td>
</tr>
</tbody>
</table>

Other Procedures

- Can be performed with IUD in place:
  - Endometrial biopsy
  - Cervical colposcopy
  - Cervical ablation or excision
  - Endometrial sampling
Implant (Nexplanon)

- Get it and forget it!
- If you’re a busy person who does not want to worry about remembering birth control, the implant may be for you. Once it’s in, it lasts for 3-5 years.
- Hands free
- No packages or prescriptions to pick up at the pharmacy, so there’s nothing to get lost or forgotten
- Privacy
- There’s no tell-tale packaging, and nothing you need to do the night before you have sex
- The pregnancy question—it is as good as tubal ligation
- You can return to fertility any time after the implant is removed

Nexplanon®

- Replaced the Implanon®, which was the most widely used implantation system in the world
- Contains 68 mg of ENG placed at the sub-dermal level, and provides contraceptive coverage for at least 3-5 years
- Irregular bleeding, especially for the first 6-12 months or longer
- Some women get no periods at all

Bleeding Patterns with Implant
First 2 Years

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage of 90-day intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent</td>
<td>6.7%</td>
</tr>
<tr>
<td>Prolonged</td>
<td>17.7%</td>
</tr>
<tr>
<td>Amenorrhea</td>
<td>22.2%</td>
</tr>
<tr>
<td>Infrequent</td>
<td>33.6%</td>
</tr>
</tbody>
</table>

LARC Use with Medical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Copper IUD</th>
<th>LNG IUS</th>
<th>Implant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraines with aura</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Obesity</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HIV infection</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>AIDS (on ARV therapy)</td>
<td>2</td>
<td>2</td>
<td>2 or 1*</td>
</tr>
</tbody>
</table>

*depending on the type of therapy
Combined Oral Contraceptives

- Estrogen + progestin
- Yet, the traditional prescription is not ideal for women
  - Daily x 3 weeks / 1 week off
  - Extended cycle pills may ↑ efficacy

Extended Cycle: Fewer Hormone-Free Weeks

- 12 weeks hormone/1 week off
  - 84 days LNG 150 µg/EE 30 µg; 7 days placebo
  - Decreased breakthrough bleeding over time
  - Continuous for one year
    - Increased spotting in first six months
    - Median 1.5 days spotting in last 12 weeks

Extended Cycle: Shortened hormone-free week

- 23, 24 or 26 days hormones + 2-5 d placebo
  - Shorter withdrawal bleeds
  - Similar breakthrough bleeding
- FDA-approved products such as Seasonale or Jolessa

LARC Use with Medical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Copper IUD</th>
<th>LNG IUS</th>
<th>Implant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (controlled)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Multiple cardiovascular risk factors</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>History of DVT/PE/Thrombogenic mutations</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>DVT/PE (on anticoagulant therapy)</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>


24-day hormone pill - lower pregnancy rate
6.7% v. 4.7% over 3 years – HR 0.7 (CI 0.6-0.8)

Choosing a Combined Pill

- Careful with very low-dose estrogen – ↑ bleeding
- Monophasic fine
- Levonorgestrel may cause fewer VTE
- No clear benefit of drospirenone

**Shortened or erased placebo week if possible 30-35 mcg EE + levonorgestrel, monophasic**

Male Birth Control

- The only methods of male birth control available are a vasectomy, condoms or the “pullout” method.
- WHO stopped male injection BC trial in 2016 due to side effects
- Beginning trials of a gel to be used BID
- Reversible inhibition of sperm under guidance
- Pill
- Gene editing

Emergency Contraception
Emergency Contraception

Mechanism:
Delay follicular rupture no harm to existing pregnancy

Levonorgestrel 1.5 mg x 1, up to 5 days post-coitus

Ulipristal Acetate (UPA; Ella)
- Selective progesterone receptor modulator
- 30 mg, up to 5 days post-coitus

Emergency Contraception: Efficacy

Effectiveness:
UPA >> LNG EC at 24-120 hours post-coitus
Obese women have lower EC efficacy
- LNG: No efficacy >70-75 kg (>154-165lb)
  - Large drop in efficacy at BMI >26
  - Doubling the LNG dose may increase efficacy
- UPA: Less efficacy in obese women but still effective
  - May lose efficacy at weight of 90 kg (198 lb) or BMI >35

Do you currently use the CDC US Medical Eligibility Criteria for Contraception?

1. Yes
2. No

A 35 year-old woman comes to you for contraception counseling. She has a h/o a DVT and is not on anticoagulation. What is her best choice?

a. Combined OC pill
b. Nexplanon implant
c. Progesterone only pill
d. Depo-provera
e. Copper IUD
Can my patient use this method?
US Medical Eligibility Criteria (MEC)

<table>
<thead>
<tr>
<th></th>
<th>Can use the method</th>
<th>Should not use method unless no other method is appropriate</th>
<th>Should not use method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can use the method</td>
<td>No restrictions</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Can use the method</td>
<td>Advantages generally outweigh theoretical or proven risks.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Should not use method</td>
<td>Theoretical or proven risks generally outweigh advantages</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Should not use method</td>
<td>Unacceptable health risk</td>
<td></td>
</tr>
</tbody>
</table>

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Medical Condition

Birth Control Methods

MEC Category
Where do you find the US MEC?

Case

After counseling she desires the contraceptive implant. She would like you to place it today.

Selected Practice Recommendations

- When to start method – “anytime if reasonably sure that she is not pregnant”
- How long to use backup
- Special considerations – explain recommendations by MEC
- Missed or late doses

38 year old G2P2 female with diabetes (no vascular disease) has been using condoms for contraception and is looking for a more effective method. What methods are safe for her to use?

A. IUD (copper or levonorgestrel)
B. Progestin-only methods (pill, injectable, implant)
C. Combined hormonal methods (pill, patch, ring)
D. Any of the above
A 27 year old with history of migraines with light sensitivity. No visual or other auras. Wants to start contraception. What methods are safe for her to use?

A. Combined hormonal methods  
B. Nexplanon implant  
C. Copper IUD  
D. Progesterone IUD  
E. Any of the above

Conclusion

- Support women through shared decision making  
- Use the many available resources  
- Contraception saves women's lives

Resources

- Many easily accessible resources exist to help solve contraception quandaries

TRUST WOMEN TO MAKE GOOD DECISIONS WHEN THEY HAVE GOOD INFORMATION

UCSF Family Planning Consult Service  
(415) 443-6318

Contact Us
Available at FPNTC.org

What methods are safe for her to use?