Contraception: Counseling and selection

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Literature review current through: Apr 2021. | **This topic last updated:** Oct 19, 2020.

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 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]. These approaches are not ideally patient-centered in that they do not prioritize women's preferences for method characteristics and they 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 patients 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 patient's preferences around method efficacy, which is a high priority for many, is essential [34,35]. One data-supported strategy to improve patient knowledge is to review a tiered efficacy chart, such as that created by the United States Family Planning National Training Center (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"). While tiered efficacy charts are commonly used, they are not the only approach.

- **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: Optimizing time between pregnancies".)

- **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".)

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 [77-80]. To this end, many family planning programs and policies have prioritized use of the most highly effective methods [81,82]. 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 [83]. Rather, women have varying perspectives about whether, and to what degree, an unintended pregnancy would be a positive or negative experience in their lives [83-86]. In fact, some women embrace the lack of predictability of their fertility and consider unintended pregnancies to be welcome surprises [87].

- **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 [78,88]. This is consistent with the understanding that an unintended pregnancy does not result in the same negative reactions in all women [83]. In addition, it is likely that other confounders or mediators could impact pregnancy outcome when attempting to asses for the impact of pregnancy intention [88].

- **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 [34,35,89]. 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 [90]. Examples include nonconsensual sterilization and targeted marketing of the contraceptive injection Depo-Provera [91,92]. This history remains in the consciousness of the communities impacted, with one study reporting that over 40 percent of Black and Hispanic Americans 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 [93], and that Black women are more likely than White women to report having been pressured by a clinician to use contraception [94]. 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 Hispanic women than to low-income White women [95], and are more likely to agree to sterilize women of color and poor women than White women or non-poor women [96]. 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 [97]. (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 [90]. 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.)

ACKNOWLEDGMENT

The editorial staff at UpToDate would like to acknowledge Mimi Zieman, MD, and Andrew Kaunitz, MD, who contributed to earlier versions of this topic review.

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Topic 5459 Version 135.0

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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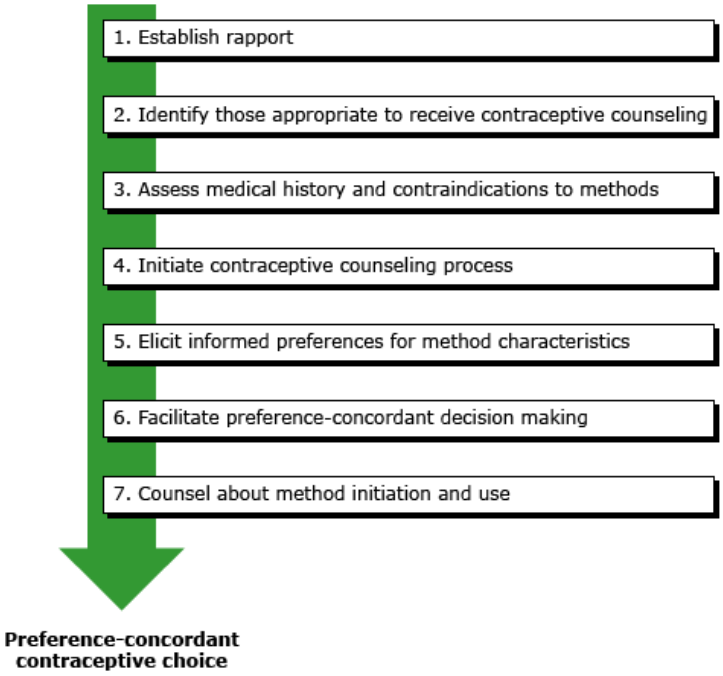
Graphic 120176 Version 1.0

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.

References:

1. *Johnson K, Posner SF, Biermann J, et al. Recommendations to improve preconception health and health care--United States. A report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR Recomm Rep 2006; 55:1.*
2. *Bellanca HK, Hunter MS. ONE KEY QUESTION: Preventive reproductive health is part of high quality primary care. Contraception 2013; 88:3.*
3. *Callegari LS, Aiken AR, Dehlendorf C, et al. Addressing potential pitfalls of reproductive life planning with patient-centered counseling. Am J Obstet Gynecol 2017; 216:129.*

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	"Yes, it would also be great if they could lower my risk of cancer like you	"As you can see on this chart, unfortunately, the methods you don't

	method and that you want something that makes your acne better. Are these the most important things to you?"	mentioned."	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 **CopperT:** 0.8 out of 100	Placement inside uterus	Lasts up to 3 to 12 years	**LNG:** Spotting, lighter or no periods **CopperT:** Heavier periods	Some pain with placement	**LNG:** No estrogen; may reduce menstrual cramps **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	
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	
Moderately 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	
Least effective							

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.

References:

1. *Trussell J. Contraceptive failure in the United States. Contraception 2011; 83:397.*
2. *Sundaram A, Vaughan B, Kost K, et al. Contraceptive failure in the United States. Perspect Sex Reprod Health 2017; 49:7.*

Reproduced with permission from: Family Planning National Training Center. Birth Control Methods Options Chart. Available at: www.fpntc.org/resources/birth-control-methods-options-chart (Accessed on January 24, 2019).

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 patient is not pregnant if the patient has no symptoms or signs of pregnancy and meets ANY of the following criteria:
☐ The patient has not had intercourse since last normal menses.
☐ The patient has been correctly and consistently using a reliable method of contraception.
☐ The patient is within 7 days from the first day of menstrual bleeding.
☐ The patient is within 4 weeks postpartum (for nonlactating patients).
☐ The patient is within the first 7 days postabortion or miscarriage.
☐ The patient is fully or nearly fully breastfeeding, amenorrheic, and less than 6 months postpartum.

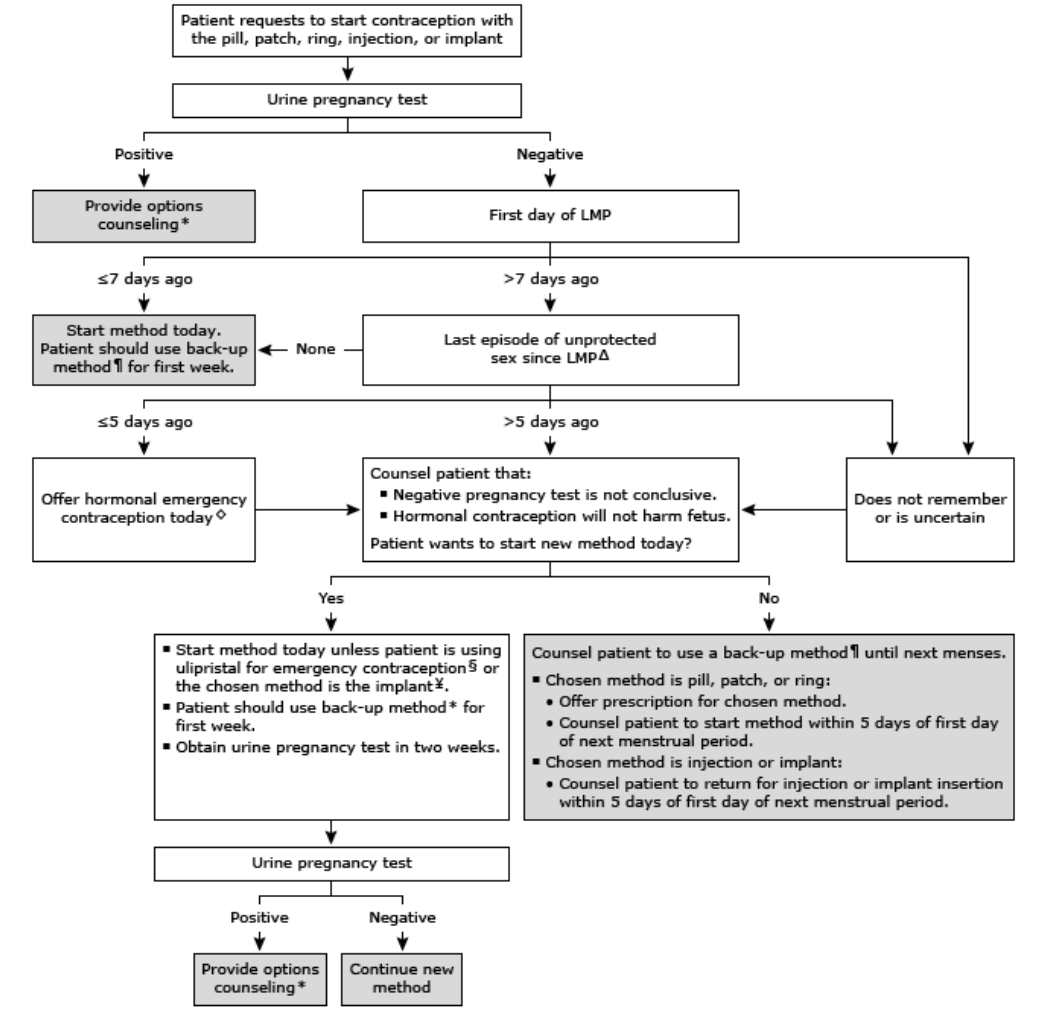
A systematic review of studies evaluating the performance of a pregnancy checklist compared with urine pregnancy test to rule out pregnancy concluded the negative predictive value of a checklist similar to the one above was 99 to 100%.

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 19.0

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

Contributor Disclosures

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]; Medicines360 [Consultant]. Other Financial Interest: American Board of Obstetrics and Gynecology. **Kristen Eckler, MD, FACOG** Nothing to disclose

Contributor disclosures are reviewed for conflicts of interest by the editorial group. When found, these are addressed by vetting through a multi-level review process, and through requirements for references to be provided to support the content. Appropriately referenced content is required of all authors and must conform to UpToDate standards of evidence.

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