

# Birth Control Bootcamp:

Conquering Contraception at Every Level!



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February 14, 2025



# Agenda

**1**

Contraception  
counseling

**2**

Contraception  
refreshers

**3**

Contraception  
updates

**4**

CDC  
MEC &  
SPR

**5**

How and  
when to  
refer

# Learning objectives

1. **Identify** indications for contraception counseling and best practices
2. **Review** currently available contraceptive technologies in the United States
3. **Sharpen** your knowledge of updates in contraception technology prescribing and counseling
4. **Utilize** the CDC Medical Eligibility Criteria to support patient-specific counseling and risk stratification
5. **Refer** to Complex Family Planning for counseling and management



# Disclosures

None

# Positionality

Cisgender, racialized white, woman

Former Catholic

OBGYN





**Which cat  
best represents  
your feelings on  
contraception  
counseling?**



**What are some of the  
barriers to discussing contraception  
for those who are eligible?**



# Section 1-3:



Contraception counseling

Contraception refreshers

Contraception updates



# Section 1:



**Contraception counseling**

Contraception refreshers

Contraception updates

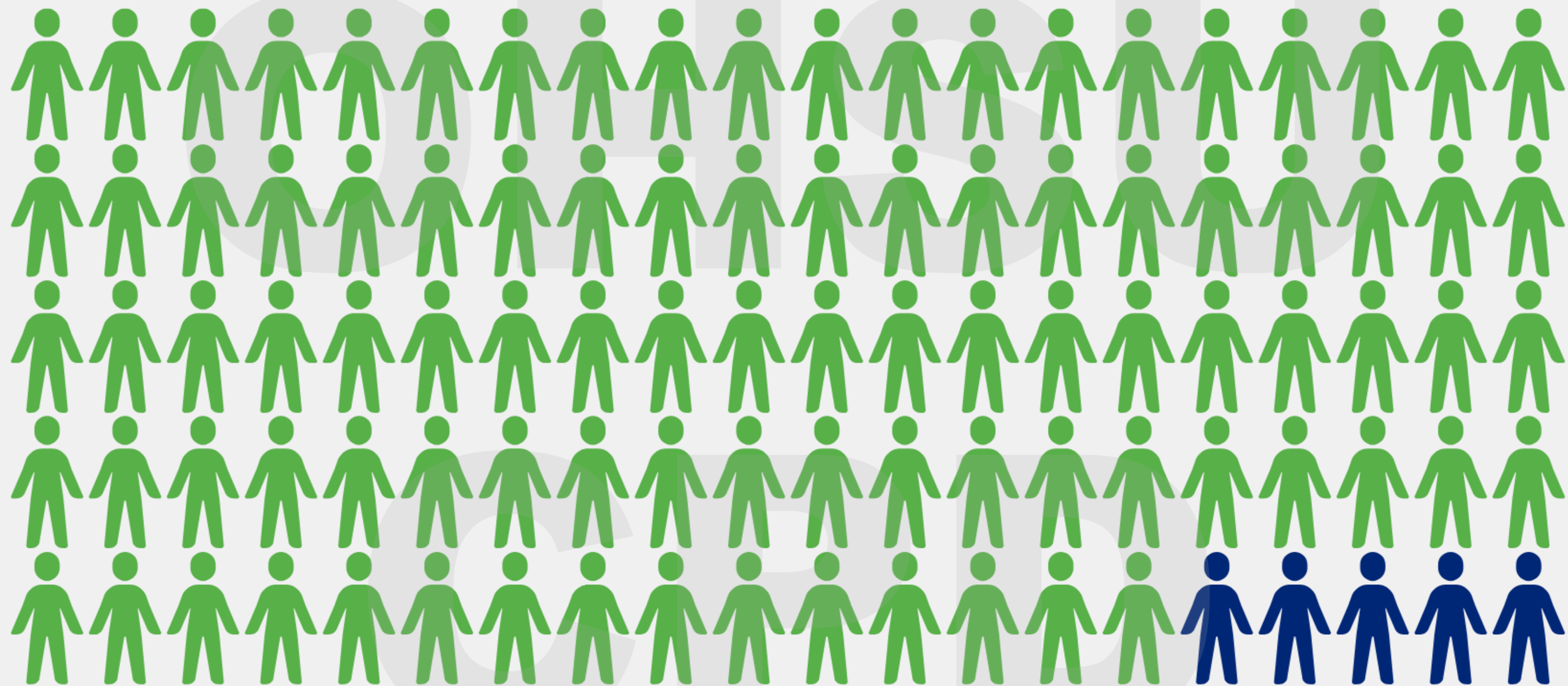
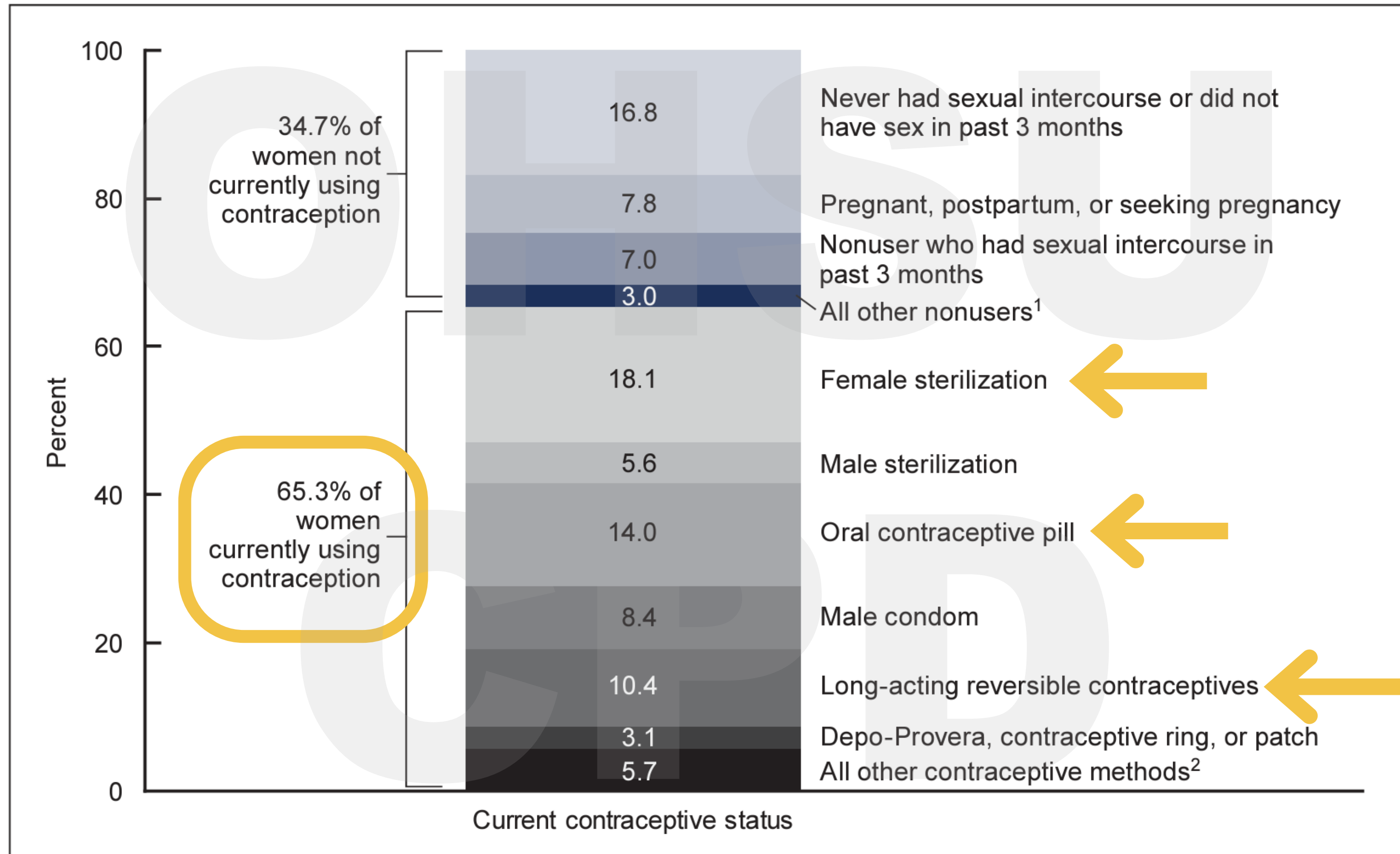




Figure 2. Percent distribution of women aged 15–49, by current contraceptive status: United States, 2017–2019



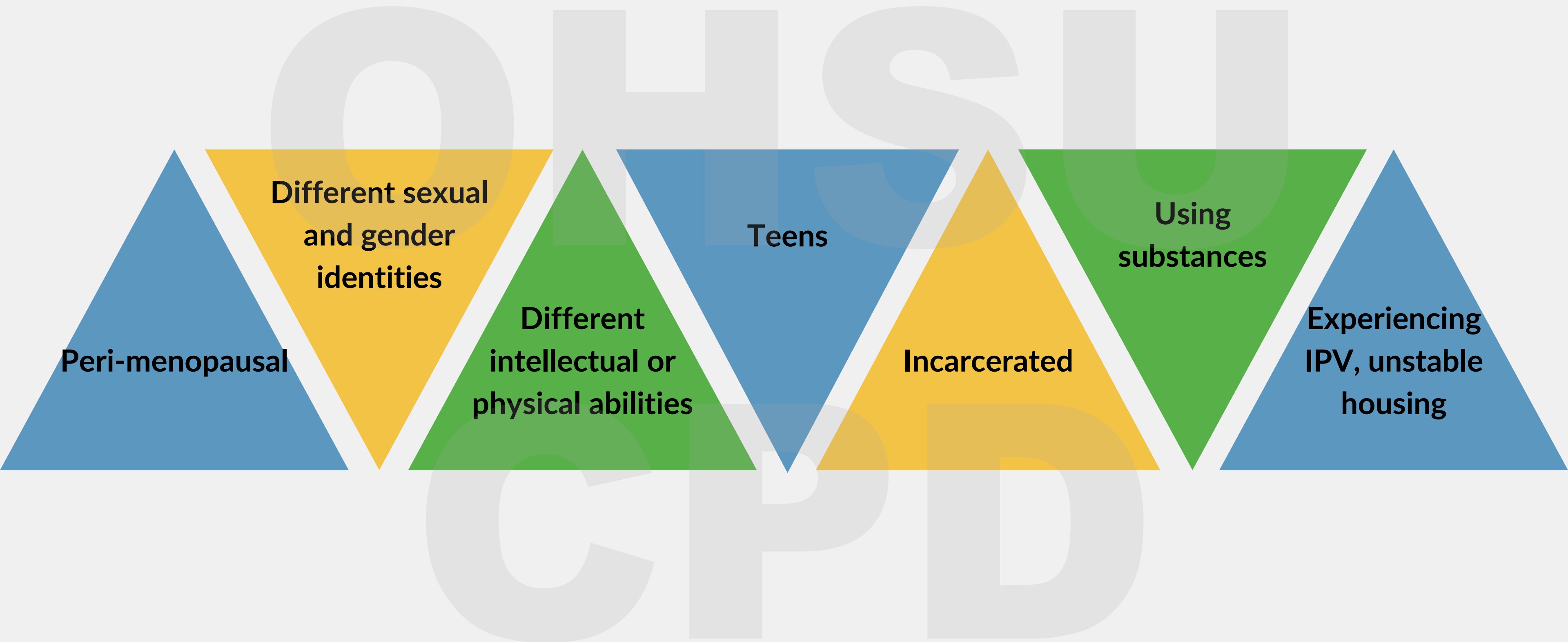
**Contraception  
disparities  
persist**

**Pregnancy is  
not health  
neutral**



*“In this part of the visit, I offer to talk with everyone about their needs for pregnancy prevention.”*

***Is there anything you’d like to explore today?”***







## COMMITTEE STATEMENT

NUMBER 1  
February 2022

# Patient-Centered Contraceptive Counseling

**Committee on Health Care for Underserved Women and Committee on Ethics.** This Committee Statement was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women, Contraceptive Equity Expert Work Group, and Committee on Ethics in collaboration with Melissa Kottke, MD, MPH, MBA; Lisa Goldthwaite, MD, MPH; Kavita Arora, MD, MBE, MS; and Jennifer Villavicencio, MD, MPP.

Contraception can be a fundamental part of an individual's health and wellness. Therefore, contraceptive counseling is an important interaction between patients and obstetrician-gynecologists and other health care practitioners. Counseling is an opportunity to solicit an individual's values, preferences, and insight into what matters most to them as it relates to contraception. However, contraceptive counseling may be subject to undue influence, such as a counselor's personal biases (implicit or explicit), pressure or coercion from a counselor or partner, or even the ideology of the institution at which someone is seeking contraceptive access. Intentional application of a patient-centered reproductive justice framework and use of a shared decision making model is the recommended approach for providing supportive contraceptive counseling and care to help patients to achieve their reproductive goals.



# Contraception (Birth Control) Guide

PICCK 2022


Partners in  
Contraceptive  
Knowledge  
and Choice

### Key

- Progestin hormone
- Progestin and estrogen hormones
- No hormones
- How often to use/take/change


### Start and stop on your own

#### Plan B® Emergency Contraception




Works best for BMI <26.  
May have spotting or period at new time.

#### Pulling Out




Requires partner control.  
No change to period.

#### Fertility Awareness



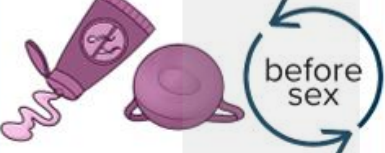
When fertile, use another contraceptive.  
No change to period.

#### Condoms External or Internal



Can prevent sexually transmitted infections.  
No change to period.


#### Spermicide or Vaginal Sponge



Spermicide comes in a cream, gel, foam, film, sponge, or suppository.  
No change to period.


### Prescription to start, stop on your own

#### Pills Progestin or Combined




Over 70 different formulations/types.  
May have lighter period or temporary spotting.

#### Patch




Works for BMI <30.  
May have lighter period or temporary spotting.

#### Vaginal Ring




Can be removed just before sex.  
May have lighter period or temporary spotting.

#### Ella® Emergency Contraception




Works best for BMI <35.  
May have spotting or period at new time.

#### Phexxi® Vaginal Gel



May act as lubricant to help with dryness.  
No change to period.


#### Diaphragm or Cervical Cap



Use with spermicide.  
No change to period.

### Visit to start, stop on your own


#### Shot



May cause weight gain and delayed return to fertility.  
May have spotting, heavier period, lighter period, or no period.


### In-person visit to start and stop

#### Arm Implant




Plastic rod placed just beneath the skin.  
May have spotting, lighter period, or no period.

#### Hormonal IUD



Can be emergency contraception.  
May have spotting, lighter period, or no period.


#### Copper IUD



Can be emergency contraception.  
May have spotting or heavier period.


### Permanent

#### Sterilization



Either partner can be sterilized.  
No change to period.

### Scan for



- This guide
- Information sheets on each method
- A postpartum contraception guide

[www.PICCK.org](http://www.PICCK.org)



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**NON HORMONAL**

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Fertility Awareness  
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Condoms External or Internal  
Can prevent sexually transmitted infections.  
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Spermicide or Vaginal Sponge  
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**PROGESTIN ONLY**

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**COMBINED ESTROGEN/ PROGESTIN**

Patch  
Can be removed just before sex.  
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Vaginal Ring  
Can be removed just before sex.  
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**NON HORMONAL**

Ella® Emergency Contraception  
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Phexxi® Vaginal Gel  
May act as lubricant to help with dryness.  
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Diaphragm or Cervical Cap  
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Copper IUD  
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May have spotting or heavier period.

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ON DEMAND

## Prescription to start, stop on your own

### Pills

Progestin or Combined



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### Patch



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SHORT (DAY-MON)

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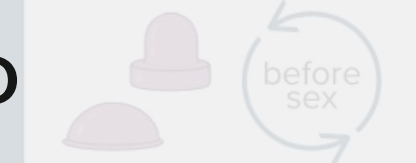
### Phexxi® Vaginal Gel



May act as lubricant to help with dryness.

No change to period.

### Diaphragm or Cervical Cap



Use with spermicide.

No change to period.

ON DEMAND

## Visit to start, stop on your own

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SHORT (DAY-MON)

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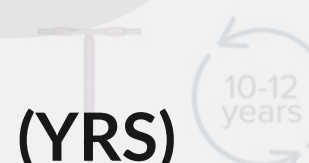


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LONG (YRS)

### Copper IUD



Can be emergency contraception.

May have spotting or heavier period.

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### Sterilization



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PATIENT-INITIATED

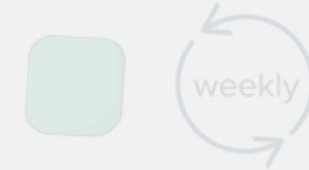
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PROVIDER-INITIATED

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PROVIDER-INITIATED

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### Hormonal IUD



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### Copper IUD



Can be emergency contraception.  
May have spotting or heavier period.

PROVIDER-ADMINISTERED/REMOVED

## Permanent

### Sterilization



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No change to period.

## Scan for



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- Information sheets on each method
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# Section 2:



Contraception counseling

**Contraception refreshers**

Contraception updates

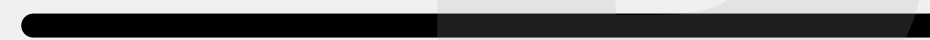


**Progestin**

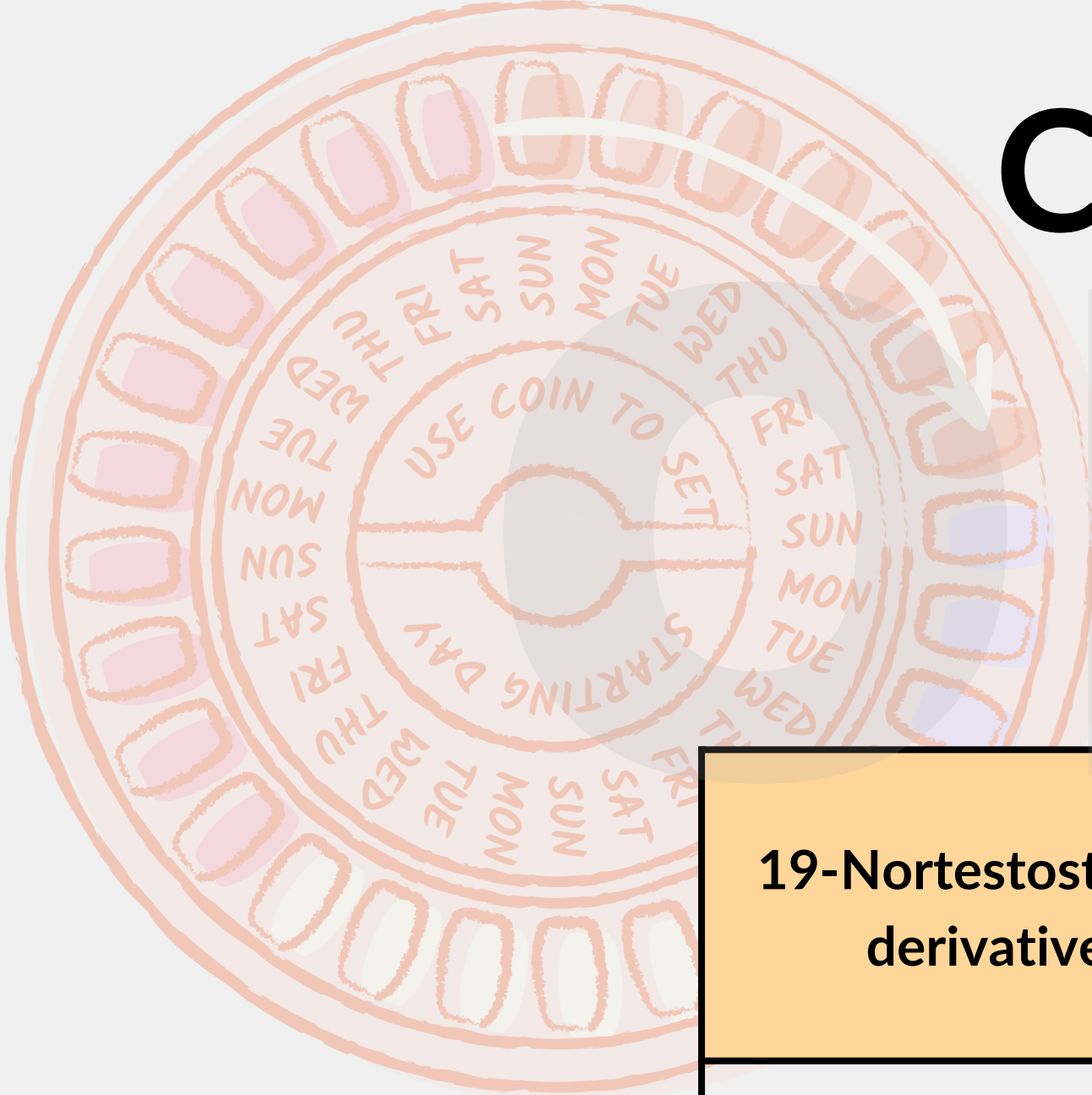


Thickens cervical mucus,  
slows tubal mobility, endometrial atrophy,  
sometimes blocks LH surge (high dose)

**Ethinyl  
estradiol**



FSH  
(ovulation  
suppression)

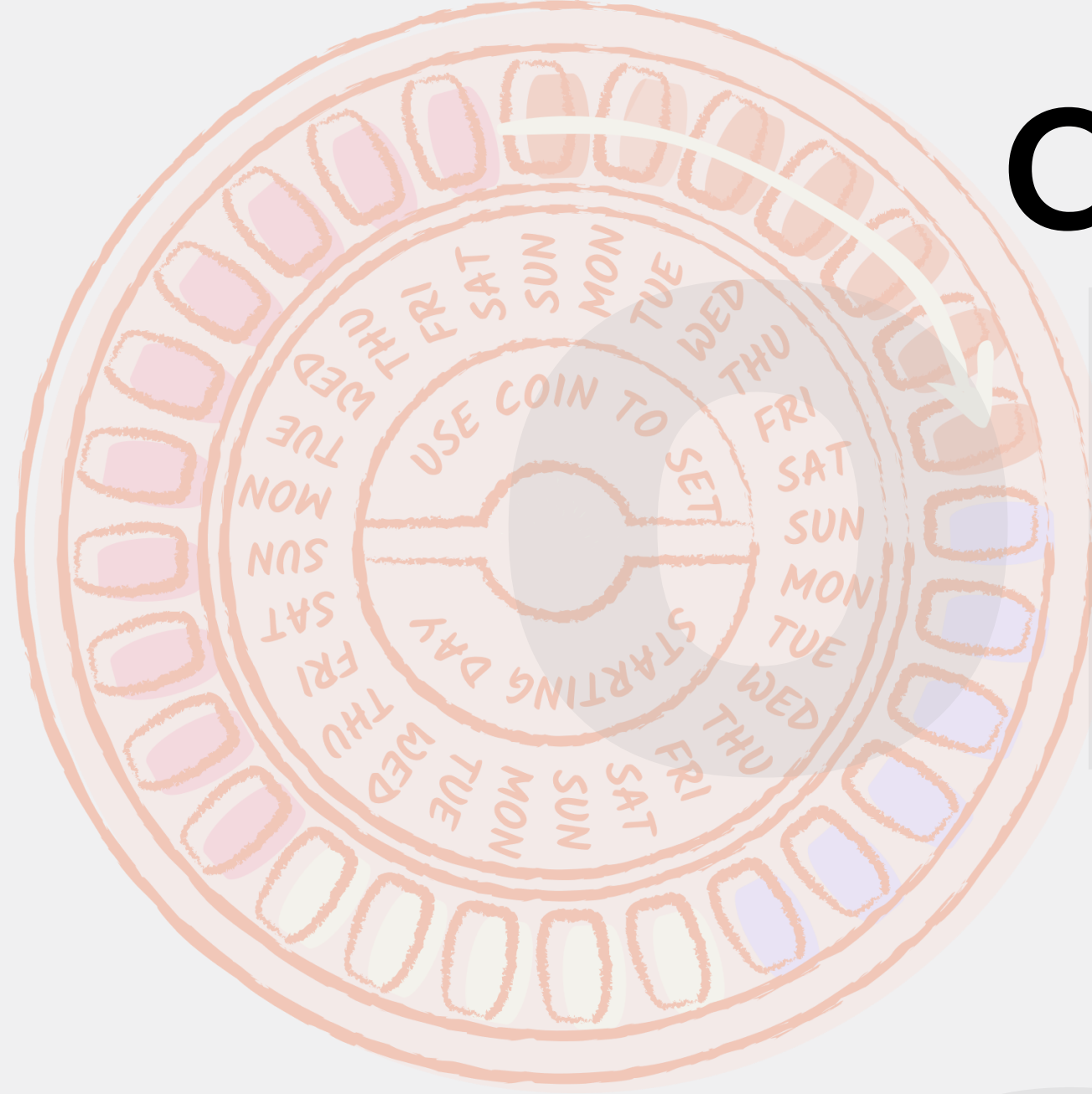


# COC

**10-35mcg ethinyl estradiol** (or estradiol valerate or estetrol)  
**+ progestin**

19-Nortestosterone derivatives	Pregnane derivatives	19-Norpregnane derivatives	Spironolactone derivative
Dienogest Norethindrone Levonorgestrel Gestodene Norgestimate Norgestrel	Chlormadinone acetate Cyproterone acetate Medrogestone Medroxyprogesterone acetate Megestrol acetate	Nomegestrol Promegestone Trimegestone Segesterone	Drospirenone





# COC

## 24 / 4

\*Reduced risk of escape ovulation if  
patient desires monthly bleed

## 21 / 7

Can be used  
continuously/extended

## Extended cycle

# Xulane

150mcg of norelgestromin  
& 35 mcg EE daily

# Twirla

120mcg levonorgestrel  
& 30 mcg EE daily

1 new patch every 7 days x3 weeks > 1 patch free week  
*Safety of extend cycle use unproven*

Patients weighing >90kg (198lbs) higher risk for pregnancy with patch due to decreased serum levels with increasing BMI

Rotate: buttocks, upper arm,  
lower abdomen, or upper torso (excluding  
breasts)



# Nuvaring

120 mcg/day of etonogestrel  
and 15 mcg/day of EE  
over 21 days of use

# Annovera

150 mcg/day of segesterone acetate  
and 13 mcg/day of EE  
over 21-days of use

Can use cyclically (3 weeks with ring, 1 week without then start a new ring), or continuously

If out for >48 hours, use backup x1 week

Refrigerated!

Cyclically for 13 cycles: 3 weeks with ring, 1 week then replace *same ring*

If out for 2 continuous or cumulative hours, back-up x1 week

# Depo-provera

IM: **150mg** medroxyprogesterone acetate q3 months IM (1mL vial, 22 gauge 1.5" needle)

SubQ: **104mg** medroxyprogesterone acetate q3 months SC (0.65mL in prefilled syringe, 26 gauge 3/8" needle)

- Black box warning: theoretical risks of bone loss
- Subpopulation with weight gain (1.9kg average)

60% amenorrhea at 1 year of use

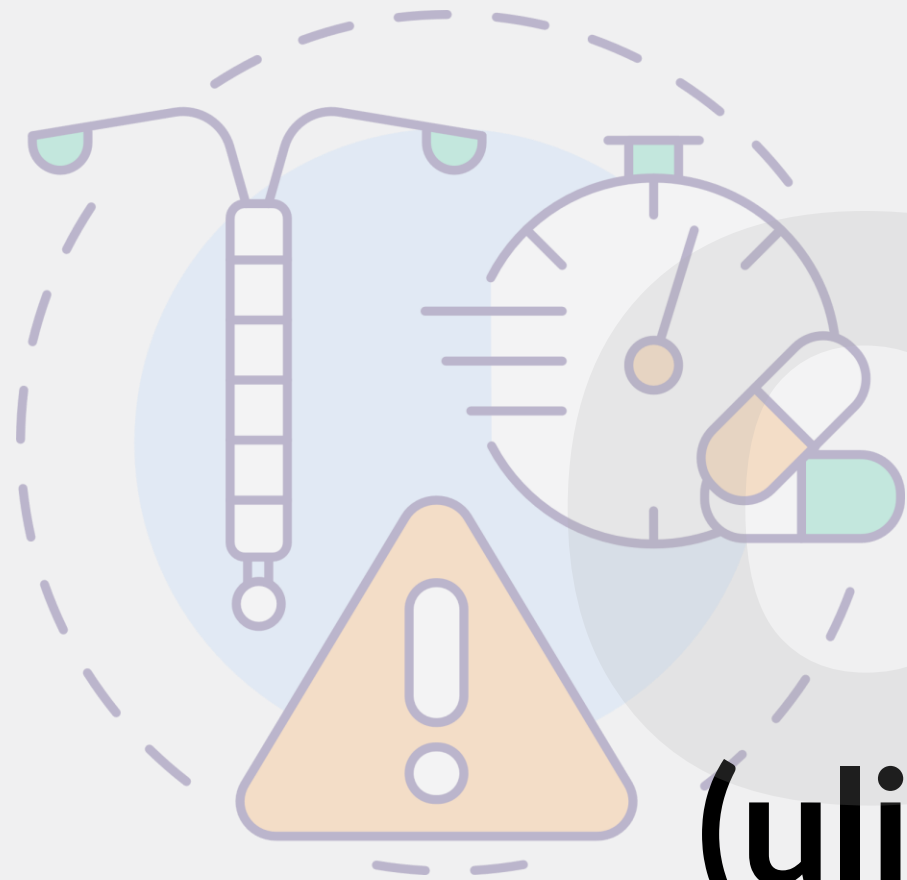
25% with irregular bleeding (due to glandular atrophy)

50% experience return of menstruation within 6 months but 25% might need up to 1 year after discontinuation





# Emergency contraception



**Ella  
(ulipristal)**

**Plan B  
(levonorgestrel)  
IUDs**

195 lbs	Delays or prolongs LH surge	ASAP / 5 days
165 lbs	Prevents LH surge	ASAP / 3 days
No weight effect	Contraceptive and contragestive effect	ASAP / 5 days

*Pills: "Only protects from the sex you've already had! Not any more sex you might have!"*

*\*Home/clinic UPT in 3 weeks for everyone (Pills or*

*IUDs)*

# Section 3:



Contraception counseling

Contraception refreshers

**Contraception updates**



Contraception

Progestin  
-only pills

Updates

	Norethindrone 0.35 mg 'Micronor' AKA Mini pill	Drosperinone 4 mg 'Slynd'	Norgestrel 0.075 mg 'Opill'
Access			
Dosing			
Pros			
Cons			

Contraception

Progestin  
-only pills

Updates

	Norethindrone 0.35 mg 'Micronor' AKA Mini pill	Drosperinone 4 mg 'Slynd'	Norgestrel 0.075 mg 'Opill'
Access	Prescription		
Dosing	28 active days, no hormone free interval		
Pros	Safe for almost everyone		
Cons	Irregular (usually light bleeding) Not ovulatory suppressive Need to be very adherent (within 3 hours)		



Contraception

Progestin  
-only pills

Updates

	Norethindrone 0.35 mg 'Micronor' AKA Mini pill	Drosperinone 4 mg 'Slynd'	Norgestrel 0.075 mg 'Opill'
Access	Prescription	Prescription	
Dosing	28 active days, no hormone free interval	24 active days, 4 days placebo	
Pros	Safe for almost everyone	Safe for almost everyone Suppresses ovulation More regular cycles	
Cons	Irregular (usually light bleeding) Not ovulatory suppressive Need to be very adherent (within 3 hours)	Expensive (prior auth) <b>Precaution for use if at high risk for hyperkalemia (rare)</b>	

Contraception

Progestin  
-only pills

Updates

	Norethindrone 0.35 mg 'Micronor' AKA Mini pill	Drosperinone 4 mg 'Slynd'	Norgestrel 0.075 mg 'Opill'
Access	Prescription	Prescription	OTC
Dosing	28 active days, no hormone free interval	24 active days, 4 days placebo	28 active days, no hormone free interval
Pros	Safe for almost everyone	Safe for almost everyone Suppresses ovulation More regular cycles	Safe for almost everyone <b>Suppresses ovulation</b> <b>Over the counter!</b>
Cons	Irregular (usually light bleeding) Not ovulatory suppressive Need to be very adherent (within 3 hours)	Expensive (prior auth) <b>Precaution for use if at high risk for hyperkalemia (rare)</b>	Irregular bleeding



Contraception

IUDs

Updates

Paragard	
Active agent	
Duration of use	
Side effect profile	

Contraception

IUDs

Updates

Paragard	
Active agent	176 mg of copper wire
Duration of use	10 years (12 years off label)
Side effect profile	Longer, heavier menses



Contraception

IUDs

Updates

	Paragard	Mirena	Liletta "Generic Mirena"
Active agent	176 mg of copper wire	52 mg levonorgestrel	52 mg levonorgestrel
Duration of use	10 years (12 years off label)	8 years (contraception) 5 years (HMB)	8 years (contraception) 5 years (HMB)
Side effect profile	Longer, heavier menses	Up to 90% reduction menstrual volume by 6 months  1 year: 20% amenorrhea	Significant reduction in menstrual volume  1 year: 19% amenorrhea

Contraception

IUDs

Updates

	Paragard	Mirena	Liletta "Generic Mirena"	Kyleena	Skyla
Active agent	176 mg of copper wire	52 mg levonorgestrel	52 mg levonorgestrel	19.5 mg levonorgestrel	13.5 mg levonorgestrel
Duration of use	10 years (12 years off label)	8 years (contraception) 5 years (HMB)	8 years (contraception) 5 years (HMB)	5 years	3 years
Side effect profile	Longer, heavier menses	Up to 90% reduction menstrual volume by 6 months  1 year: 20% amenorrhea	Significant reduction in menstrual volume  1 year: 19% amenorrhea	Regular menstrual bleeding decreases, but irregular bleeding and spotting may continue  1 year: 12% amenorrhea	Regular menstrual bleeding decreases, but irregular bleeding and spotting may continue  1 year: 6% amenorrhea

Contraception

Nonhormonal  
methods

Updates

	Fertility awareness	Vaginal pH modifier “Phexxi”	Tubal surgical contraception
Mechanism			
Requirements for use			
Other considerations			



Contraception

Nonhormonal methods

Updates

	Fertility awareness	Vaginal pH modifier “Phexxi”	Tubal surgical contraception
Mechanism	Cycle tracking “calendar method” Cervical mucus changes Basal body temperature Urinary LH		
Requirements for use	Regular cycles, attention to detail, daily follow up		
Other considerations	May be combined with condoms, cervical cap, or vaginal diaphragm		

Contraception

Nonhormonal methods

Updates

	Fertility awareness	Vaginal pH modifier “Phexxi”	Tubal surgical contraception
Mechanism	Cycle tracking “calendar method” Cervical mucus changes Basal body temperature Urinary LH	Inhibition sperm motility by acidifying vaginal vault	
Requirements for use	Regular cycles, attention to detail, daily follow up	Vaginal application 1h prior to sex	
Other considerations	May be combined with condoms, cervical cap, or vaginal diaphragm	May be combined with condoms, cervical cap, or vaginal diaphragm	

Contraception

Nonhormonal methods

Updates

	Fertility awareness	Vaginal pH modifier “Phexxi”	Tubal surgical contraception
Mechanism	Cycle tracking “calendar method” Cervical mucus changes Basal body temperature Urinary LH	Inhibition sperm motility by acidifying vaginal vault	Laparoscopic bilateral salpingectomy
Requirements for use	Regular cycles, attention to detail, daily follow up	Vaginal application 1h prior to sex	Secure in decision to never conceive again, aware procedure is not reversible Declines nonsurgical alternatives Medicaid/OHP requires 30 day waiting period (separate consent)
Other considerations	May be combined with condoms, cervical cap, or vaginal diaphragm	May be combined with condoms, cervical cap, or vaginal diaphragm	No minimum age or parity Ovarian cancer risk reduction No change in menses, menopause



# Section 4:



## Centers for Disease Control:

- Medical Eligibility Criteria (MEC)
- Selective Practice Recommendations (SPR)

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- Medical Eligibility Criteria (MEC)
- Selective Practice Recommendations (SPR)

# Contraception risk conceptualization

Impact of  
contraception  
use



Impact of  
contraception  
non use



# Contraception risk conceptualization

Impact of  
contraception  
use

Impact of  
pregnancy



For accessible version, please see the summary of classifications at <https://www.cdc.gov/contraception/hcp/usmec/>.

## Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)



**Category 4 - Risks outweigh  
benefits**

**Category 3 - Risks usually  
outweigh benefits**

**Category 2 - Benefits usually  
outweigh risks**

**Category 1 - Benefits outweigh  
risks**

*U.S. MEC recommendations comprise one aspect of contraceptive counseling...*

***Voluntary informed choice of contraceptive methods***  
*is an essential guiding principle of these recommendations, and*  
***person-centered contraceptive counseling*** *can help to ensure a*  
*person's contraceptive needs are met successfully.”*





For accessible version, please see the summary of classifications at <https://www.cdc.gov/contraception/hcp/usmec/>.

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)



**Updated in 2024.** This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: <https://www.cdc.gov/contraception/hcp/usmec/>. Most contraceptive methods do not protect against STIs. Consistent and correct use of the external (male) latex condom reduces the risk of STIs and HIV. Please see NIH guidelines for up to date recommendations on hormonal contraception and ARVs: <https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview?view=full#table-3> and <https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview?view=full>.

**KEY:** 1 = No restriction (method can be used) 2 = Advantages generally outweigh theoretical or proven risks 3 = Theoretical or proven risks usually outweigh the advantages 4 = Unacceptable health risk (method not to be used)

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age													
	Menarche to <20 yrs:	2		2		1		2		1		1	
	≥20 yrs:	1		1		1		1		1		2	
Anatomical abnormalities	a. Distorted uterine cavity	4		4									
	b. Other abnormalities	2		2									
Anemia, iron-deficiency		2		1		1		1		1		1	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a. Undiagnosed mass	1		2*		2*		2*		2*		2*	
	b. Benign breast disease	1		1		1		1		1		1	
	c. Family history of cancer	1		1		1		1		1		1	
	d. Breast cancer <sup>‡</sup>												
	i. Current	1		4		4		4		4		4	
	ii. Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a. <21 days postpartum					2*		2*		2*		4*	
	b. 21 to <30 days postpartum												
	i. With other risk factors for VTE					2*		2*		2*		3*	
	ii. Without other risk factors for VTE					2*		2*		2*		3*	
	c. 30-42 days postpartum												
	i. With other risk factors for VTE					1*		2*		1*		3*	
Cervical cancer	ii. Without other risk factors for VTE					1*		1*		1*		2*	
	d. >42 days postpartum					1*		1*		1*		2*	
Cervical ectropion	Awaiting treatment	4		2		4		2		1		2	
		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Chronic kidney disease <sup>‡</sup>	a. Current nephrotic syndrome	1		1		2		3		2/4*		4	
	b. Hemodialysis	1		1		2		3		2/4*		4	
	c. Peritoneal dialysis	2		1		2		3		2/4*		4	
Cirrhosis	a. Compensated (normal liver function)	1		1		1		1		1		1	
	b. Decompensated <sup>‡</sup> (impaired liver function)	1		2		2		3		2		4	
Cystic fibrosis <sup>‡</sup>		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE) <sup>‡</sup>	a. Current or history of DVT/PVE, receiving anticoagulant therapy (therapeutic dose)	2*		2*		2*		2*		2*		3*	
	b. History of DVT/PE, receiving anticoagulant therapy (prophylactic dose)												
	i. Higher risk for recurrent DVT/PE	2*		2*		2*		3*		2*		4*	
	ii. Lower risk for recurrent DVT/PE	2*		2*		2*		2*		2*		3*	
	c. History of DVT/PE, not receiving anticoagulant therapy												
	i. Higher risk for recurrent DVT/PE	1		2		2		3		2		4	
Depressive disorders	ii. Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	d. Family history (first-degree relatives)	1		1		1		1		1		2	
		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a. History of gestational disease	1		1		1		1		1		1	
	b. Nonvascular disease												
	i. Non-insulin dependent	1		2		2		2		2		2	
	ii. Insulin dependent <sup>‡</sup>	1		2		2		2		2		2	
	c. Nephropathy, retinopathy, or neuropathy <sup>‡</sup>	1		2		2		3		2		3/4*	
Dysmenorrhea	d. Other vascular disease or diabetes of >20 years' duration <sup>‡</sup>	1		2		2		3		2		3/4*	
	Severe	2		1		1		1		1		1	
Endometrial cancer <sup>‡</sup>		4		2		4		2		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy <sup>‡</sup>	(see also Drug Interactions)	1		1		1*		1*		1*		1*	
Gallbladder disease	a. Asymptomatic	1		2		2		2		2		2	
	b. Symptomatic												
	i. Current	1		2		2		2		2		3	
	ii. Treated by cholecystectomy	1		2		2		2		2		2	
	iii. Medically treated	1		2		2		2		2		3	
Gestational trophoblastic disease (GTD) <sup>‡</sup>	a. Suspected GTD (immediate postevacuation)												
	i. Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii. Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b. Confirmed GTD												
	i. Undetectable or non-pregnant β-hCG levels	1*		1*		1*		1*		1*		1*	
	ii. Decreasing β-hCG levels	2*		1*		2*		1*		1*		1*	
	iii. Persistently elevated β-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*		1*		2*		1*		1*		1*	
	iv. Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*		2*		4*		2*		1*		1*	
Headaches	a. Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b. Migraine												
	i. Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii. With aura	1		1		1		1		1		4*	
History of bariatric surgery <sup>‡</sup>	a. Restrictive procedures	1		1		1		1		1		1	
	b. Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a. Pregnancy related	1		1		1		1		1		2	
	b. Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of pelvic surgery	(see also Postpartum [including cesarean delivery])	1		1		1		1		1		1	
HIV	a. High risk for HIV	1*		1*		1*		1*					
	b. HIV infection							1*		1*		1*	
	i. Clinically well receiving ARV therapy	1		1		1		1		If on ARV, see also Drug Interactions.			
	ii. Not clinically well or not receiving ARV therapy <sup>‡</sup>	2		1		2		1		If on ARV, see also Drug Interactions.			

**Abbreviations:** ARV = antiretroviral; C = continuation of contraceptive method; CHC = combined hormonal contraceptive (pill, patch, and ring); COC = combined oral contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiation of contraceptive method; LNG-IUD = levonorgestrel intrauterine device; NA = not applicable; POP = progestin-only pill; P/R = patch/ring; SSRI = selective serotonin reuptake inhibitor; STI = sexually transmitted infection; VTE = venous thromboembolism. <sup>‡</sup>Condition associated with increased risk as a result of pregnancy. \*Please see the complete guidance for a clarification to this classification: <https://www.cdc.gov/contraception/hcp/usmec/>.



For accessible version, please see the summary of classifications at <https://www.cdc.gov/contraception/hcp/usmec/>.



## Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

**Updated in 2024.** This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: <https://www.cdc.gov/contraception/hcp/usmec/>. Most contraceptive methods do not protect against STIs. Consistent and correct use of the external (male) latex condom reduces the risk of STIs and HIV.

Please see NIH guidelines for up to date recommendations on hormonal contraception and ARVs: <https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview?view=full#table-3> and <https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview?view=full>.

**KEY:** 1 = No restriction (method can be used) 2 = Advantages generally outweigh theoretical or proven risks 3 = Theoretical or proven risks usually outweigh the advantages 4 = Unacceptable health risk (method not to be used)

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age	Menarche to <20 yrs:	2		2		1		2		1		1	
	≥20 yrs:	1		1		1		1		1		2	
Diabetes	a. History of gestational disease	1		1		1		1		1		1	
	b. Nonvascular disease												
	i. Non-insulin dependent	1		2		2		2		2		2	
	ii. Insulin dependent <sup>‡</sup>	1		2		2		2		2		2	
	c. Nephropathy, retinopathy, or neuropathy <sup>‡</sup>	1		2		2		3		2		3/4*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a. History of gestational disease	1		1		1		1		1		1	
	b. Nonvascular disease												
	i. Non-insulin dependent	1		2		2		2		2		2	
	ii. Insulin dependent <sup>‡</sup>	1		2		2		2		2		2	
	c. Nephropathy, retinopathy, or neuropathy <sup>‡</sup>	1		2		2		3		2		3/4*	
	d. Other vascular disease or diabetes of >20 years' duration <sup>‡</sup>	1		2		2		3		2		3/4*	

Chronic kidney disease <sup>a</sup>	a. Current nephrotic syndrome	1	1	2	2	2	3	2/4*	4
	b. Hemodialysis	1	1	2	2	2	3	2/4*	4
	c. Peritoneal dialysis	2	1	2	2	2	3	2/4*	4
Cirrhosis	a. Compensated (normal liver function)	1		1		1		1	
	b. Decompensated <sup>a</sup> (impaired liver function)	1		2		3		2	4
Cystic fibrosis <sup>‡</sup>		1*		1*		1*		2*	1*
Deep venous thrombosis (DVT)/Pulmonary embolism (PE) <sup>a</sup>	a. Current or history of DVT/PVE, receiving anticoagulant therapy (therapeutic dose)	2*		2*		2*		2*	3*
	b. History of DVT/PE, receiving anticoagulant therapy (prophylactic dose)								
	i. Higher risk for recurrent DVT/PE	2*		2*		2*	3*	2*	4*
	ii. Lower risk for recurrent DVT/PE	2*		2*		2*		2*	3*
	c. History of DVT/PE, not receiving anticoagulant therapy								
	i. Higher risk for recurrent DVT/PE	1		2		2	3	2	4
	ii. Lower risk for recurrent DVT/PE	1		2		2		2	3
	d. Family history (first-degree relatives)	1		1		1		1	2
Depressive disorders		1*		1*		1*		1*	1*
Headaches	a. Nonmigraine (mild or severe)	1		1		1		1	1*
	b. Migraine								
	i. Without aura (includes menstrual migraine)	1		1		1		1	2*
History of bariatric surgery <sup>‡</sup>	ii. With aura	1		1		1		1	4*
	a. Restrictive procedures	1		1		1		1	1
History of cholestasis	b. Malabsorptive procedures	1		1		1		1	3
	a. Pregnancy related	1		1		1		1	2
History of high blood pressure during pregnancy	b. Past COC related	1		2		2		2	3
		1		1		1		1	2
History of pelvic surgery	(see also Postpartum [including cesarean delivery])	1		1		1		1	1
		1		1		1		1	1
HIV	a. High risk for HIV	1*	1*	1*	1*	1		1	1
	b. HIV infection					1*		1*	1*
	i. Clinically well receiving ARV therapy	1	1	1	1	If on ARV, see also Drug Interactions.			
	ii. Not clinically well or not receiving ARV therapy <sup>a</sup>	2	1	2	1	If on ARV, see also Drug Interactions.			

**Abbreviations:** ARV = antiretroviral; C = continuation of contraceptive method; CHC = combined hormonal contraceptive (pill, patch, and ring); COC = combined oral contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiation of contraceptive method; LNG-IUD = levonorgestrel intrauterine device; NA = not applicable; POP = progestin-only pill; P/R = patch/ring; SSRI = selective serotonin reuptake inhibitor; STI = sexually transmitted infection; VTE = venous thromboembolism. <sup>a</sup>Condition associated with increased risk as a result of pregnancy. <sup>\*</sup>Please see the complete guidance for a clarification to this classification: <https://www.cdc.gov/contraception/hcp/usmec/>.



# Section 4



## Centers for Disease Control:

- Medical Eligibility Criteria (MEC)
- **Selective Practice Recommendations (SPR)**



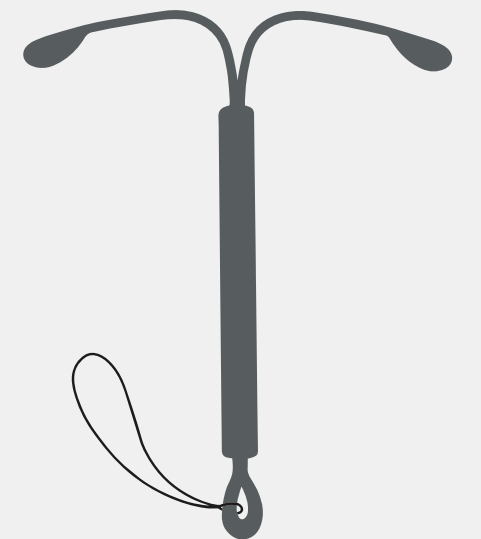
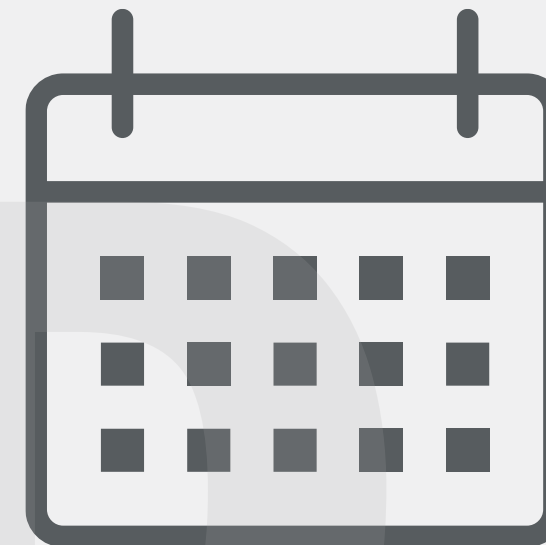
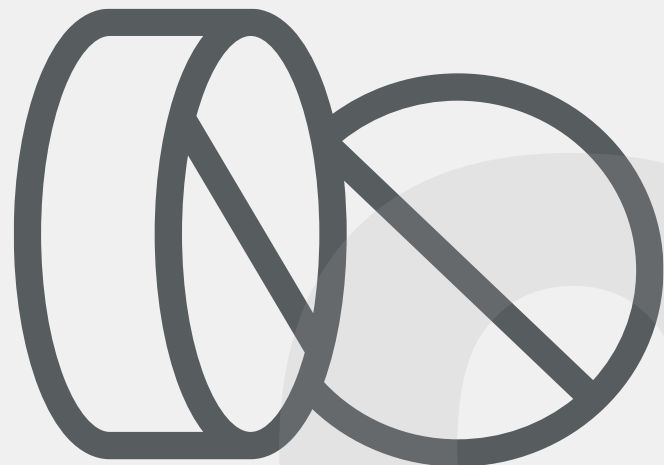
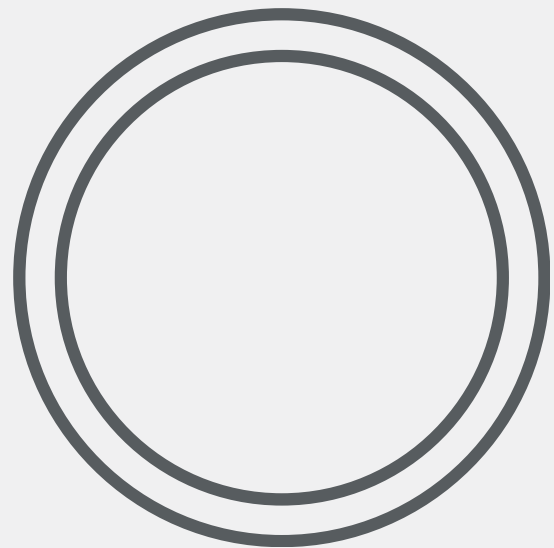
What to Do If Late,  
Missed, or Delayed  
Combined  
Hormonal  
Contraception

What to Do If Late  
or Missed Progestin-  
Only Pills

Management of  
Bleeding Irregularities  
While Using  
Contraception


When to Start  
Contraceptive  
Methods and Routine  
Follow-Up

Management of  
IUDs When Pelvic  
Inflammatory  
Disease (PID) Is  
Found



## Health Officials Urge Doctors to Address IUD Insertion Pain

As videos describing the procedure as agonizing spread on social media, new guidelines advise physicians to consider various anesthetics.

 Share full article



 304



Less than 5 percent of doctors offered an injection of a local anesthetic during insertion of an intrauterine device, or IUD, many instead prescribing over-the-counter painkillers, which have been shown to be less effective. Valentine Chapuis/Agence France-Presse — Getty Images

By Teddy Rosenbluth

Aug. 7, 2024

# How to be reasonably certain that a patient is not pregnant

**NB: If not meeting criteria...consider prescribing with counseling about possible luteal phase pregnancy, and recommend home UPT in 3-4 weeks!**

is  $\leq 7$  days after start of normal menses

has not had sexual intercourse

has been correctly and consistently using a reliable method of contraception *\*Including nonhormonal methods!*

is  $\leq 7$  days after spontaneous or induced abortion

is within 4 weeks postpartum

is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [ $\geq 85\%$ ] of feeds are breastfeeds), amenorrheic, and  $< 6$  months postpartum





# Section 5:



## Referrals to Complex Family Planning

CPD



# What is Complex Family Planning?





# What is Complex Family Planning?

*Nationally:*

- *One of five ABOG recognized subspecialties*



# What is Complex Family Planning?

*Nationally:*

- *One of five ABOG recognized subspecialties*
- *Clinical and research expertise in contraception, abortion, complications of early pregnancy, and often, trauma-informed gynecologic care*



# What is Complex Family Planning?

At OHSU:

- 12 clinical faculty, 1 research faculty, 2 FNP, 2 fellows






# What is Complex Family Planning?

*At OHSU:*

- *12 clinical faculty, 1 research faculty, 2 FNP, 2 fellows*
- *Women's Health Research Unit, ONPRC*



The background image shows a modern, multi-story building with a glass facade. A curved walkway with a metal railing runs along the side of the building. In the foreground, there are several small round tables and metal chairs, suggesting an outdoor seating area. The sky is overcast with grey clouds.

# What is Complex Family Planning?

*At OHSU:*

- *12 clinical faculty, 1 research faculty, 2 FNP, 2 fellows*
- *Women's Health Research Unit, ONPRC*
- *Center for Women's Health, HMC, CHH/SOR, as well as Planned Parenthood Columbia Wilamette and Lillith Clinic*



# *Who should be referred to CFP?*

Medical or social complexity impacting contraception decision making

Poor prior experiences with hormonal contraception or seeking alternatives

Interested in permanent contraceptive procedures, esp those previously denied care

Pregnancy ambivalence or seeking abortion care

Needing sedation or anxiolysis for gynecologic care, coordination of multidisciplinary care



CONSULT TO CWH - CENTER FOR WOMEN'S HEALTH

✓ Accept

✗ Cancel

Process Instructions:

To schedule your appointment, please call 503-418-4500

Priority:

Routine

Urgent

Class:

Internal referral

External Order

Preferred Location:

Oregon Health & Science ...

Oregon Health & Science Univ

External Order

Comments:

+

abc

↶

↷

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Insert SmartText

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⌵

90%

Referral to Complex Family Planning...

Referral:

To Location/POS:

By Provider:

JULIA TASSET

3181 SW Sam Jackson Park Road Portland OR 97239-3011

To Provider:

Number of Visits:

1

Expiration Date:

Dept Specialty:

Obstetrics & Gynecology

Ref to Department:

⌵ Additional Order Details

ⓘ Next Required

✓ Accept

✗ Cancel

# Learning outcomes

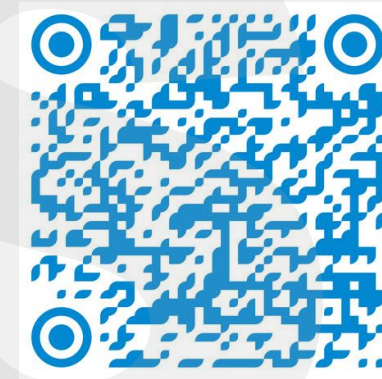


*Hormonal content, frequency of administration, efficacy, and patient control*

*Sharing information and supporting choices*

*CDC's Medical Eligibility Criteria (MEC) for Contraceptive Use and Selective Practice Recommendations (SPR)*





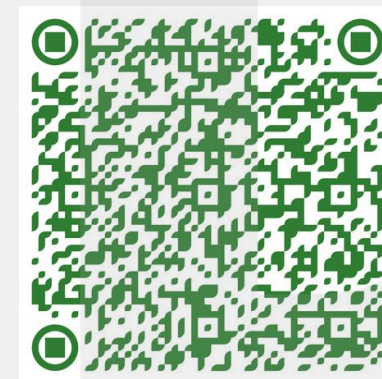
### Slides:

<https://ohsucfp.my.canva.site/primary-care-review-contraception-021424>



### **CDC Resources:**

<https://www.cdc.gov/contraception/hcp/provider-tools/index.html>



### **PICCK Resources:**

<https://picck.org/practice-resources/>

# Thank You

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