It's a plan

Counselling Guide

Canadian women spend a significant portion of their lives at risk of an unintended pregnancy. The national average maternal age at first birth is currently over 30 years and Canadian women will typically spend 3 years or fewer pregnant, attempting to conceive, or immediately postpartum. This means that Canadian women require effective contraception over most of their reproductive lives.

The Contraceptive Landscape

In 2006, over 3,200 Canadian women of reproductive age responded to a survey about contraception use. The SOGC replicated the survey again in 2016. Looking back over 10 years, we find that there is still a lot of work to do to increase awareness and use of contraception among Canadians. The SOGC data on file show that 25% of women claim to be unsatisfied with their current form of birth control. There is a range of contraceptive options available in Canada, but Canadian women tend to use a narrow selection of contraceptive methods and are inconsistent in their use. Effective contraception use, a larger choice of contraceptive methods and wider access to them have the potential to decrease unplanned pregnancies.

- The rate of unintended pregnancies remains high at 61%.
- The most commonly used methods of contraception remain the same: Oral contraceptive pill, condoms, and withdrawal.
- Women are turning to the internet more for information about contraception, rather than to their doctors.
- Most women aren't aware of the range of contraception options that exist.
- Women over 30 are less likely to use contraception or condoms.
- There is a trend for increasing use of intrauterine contraceptives (IUCs).

Research in family planning has shown that wide access to contraceptive options and contraceptive counselling have an influence on women's family planning outcomes, but also that women are often dissatisfied with the counselling they receive. Health care providers play a critical role in educating patients about contraception and counselling them toward choosing the best options for their short-term, long-term goals, and their lifestyle.

The need for further optimization of counselling

Contraceptive counselling can occur during any visit and does not have to be time-consuming. The conversation should begin by identifying the patient's own individual contraceptive goals so that counselling, as best as possible, is matched to the patient needs.

Routine clinical events can serve as reminders (for the clinician) and natural segues (for the patient) for discussion of contraception:

Routine intake questions:

- Are you sexually active? (with men, or women, or both?)
- How many partners did you have in the last year?
- What kind of sexual practices do you engage in: Oral sex, vaginal sex, anal sex, other?
- What are you using for contraception?
- Are you planning a pregnancy in the near future?
- Are you using any method for STI prevention?

Questions at renewal of oral contraceptive prescription, periodic cervical screening or periodic general health assessment:

- Are you satisfied with your current contraception method?
- Are you sexually active? (with men, or women, or both?)
- How many partners did you have in the last year?
- What kind of sexual practices do you engage in: Oral sex, vaginal sex, anal sex, other?
- Are you planning a pregnancy in the near future?
- When, if ever, do you hope to have a pregnancy?
- If you got pregnant now, how would you feel about it?
- Are you using any method for STI prevention?

General queries:

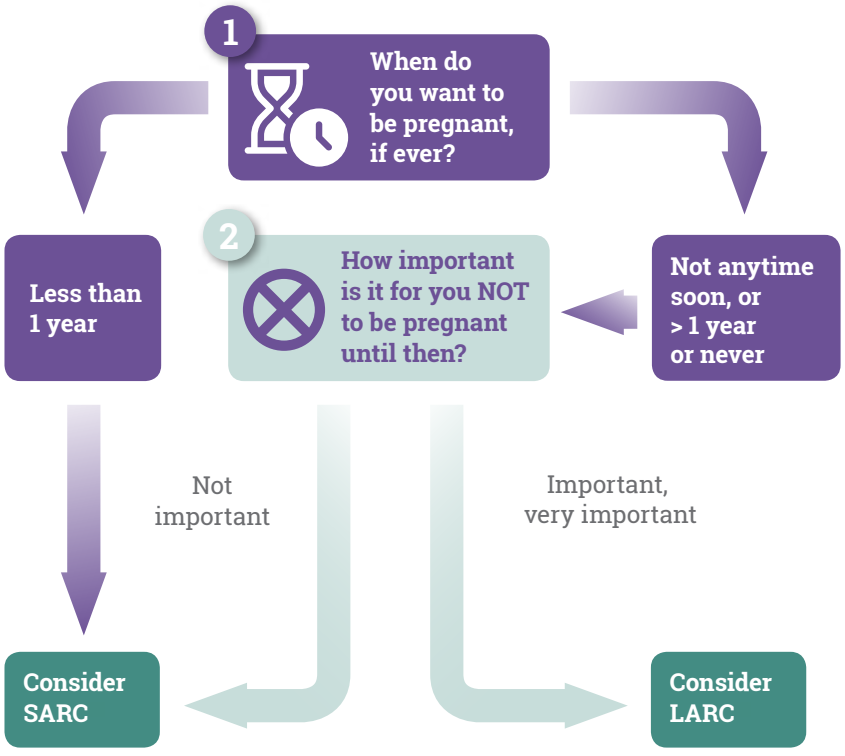
- How is your family? (or: How are the children?)
- Are you planning any additional pregnancies?

Long-acting reversible contraception (LARC) or Short-acting reversible contraception (SARC)?

Counselling women on the wide range of contraceptive options can help them make an informed choice that will best meet their needs. Asking key questions about when the patient is planning pregnancy and her tolerance for the risk of an unintended pregnancy until then can help her to choose the most appropriate method of contraception. Although both LARC and SARC may be suitable for women whatever their plan for pregnancy, the following standardized counselling questions may be used in order to identify patients best suited for long-acting versus short-acting reversible contraception:

- When do you want to be pregnant, if ever?
- How important is it for you NOT to be pregnant until then?

Counselling Algorithm (Toor Method)*



SARC: Short-acting reversible contraception
LARC: Long-acting reversible contraception
*Adapted from Dr. Rupinder Toor, NE Calgary Women's Clinic.
Provided as a guide; should not substitute clinical judgment.

It's a plan

Contraception questionnaire

Date: _____ Patient ID: _____

1. How old are you? _____

2. Have you experienced any of the following situations? Select all that apply:
   - ☐ Had a pregnancy scare from missing a pill
   - ☐ Forgot to use contraception
   - ☐ Did not use contraception because it was inconvenient
   - ☐ None of these have happened to me

3. Have you ever gotten pregnant while using a method of birth control? If yes, select all that applied:
   - ☐ No
   - ☐ Yes, while using a combined hormonal contraceptive (pill, patch, ring)
   - ☐ Yes, while using a progestin-only contraceptive (pill, needles)
   - ☐ Yes, while using a copper intrauterine contraceptive (copper IUC)
   - ☐ Yes, while using a hormonal intrauterine contraceptive (hormonal IUC)
   - ☐ Yes, while using a barrier method (condom, diaphragm)
   - ☐ Yes, while using natural family planning (withdrawal, calendar method)

4. Would an unintended or mistimed pregnancy be devastating for you?
   - ☐ Yes ☐ No

5. Are you planning to get pregnant soon?
   - ☐ No
   - ☐ Yes, within one year
   - ☐ Yes, in more than one year
   - ☐ Not sure

6. Are you looking for a permanent (non-reversible) birth control option?
   - ☐ Yes ☐ No

7. Are you comfortable with hormones as part of your contraception plan?
   - ☐ Yes ☐ No ☐ Not sure

8. With oral contraceptives, a pill must be taken every day at the same time in order to be at its maximum effectiveness. Are you able to take a pill at the same time every day?
   - ☐ Yes ☐ No

9. Do you need a contraception method that is easy to keep private?
   - ☐ Yes ☐ No

10. Injections are used to administer some forms of contraception. Would you be ok with receiving a needle four times a year?
    - ☐ Yes ☐ No

11. Do you have acne or excessive unwanted facial hair growth?
    - ☐ Yes ☐ No

12. Do you have heavy or painful periods?
    - ☐ Yes ☐ No

13. If it was possible to avoid having periods, would you want to avoid them?
    - ☐ Yes ☐ No

14. Do you chew/smoke/vape nicotine/tobacco?
    - ☐ Yes ☐ No

15. Have you ever been diagnosed by a physician or nurse practitioner with one or more of the following conditions? Select all that apply:
    - ☐ High blood pressure (treated or not)
    - ☐ Deep vein thrombosis/pulmonary embolism (blood clots in your veins or your lungs)
    - ☐ Stroke or heart attack
    - ☐ Migraine headache with aura
    - ☐ Breast cancer
    - ☐ I have not been diagnosed with any of these conditions

You can also invite your patients to visit **www.itsaplan.ca** to fill out this questionnaire on their own.

Canadian Contraception Consensus Recommendations

CHAPTER 1

Contraception in Canada

1. Contraceptive counselling should include a discussion of typical use failure rates and the importance of using the contraceptive method consistently and correctly in order to avoid pregnancy. (II-2A)

2. Women seeking contraception should be counselled on the wide range of effective methods of contraception available, including long-acting reversible contraceptive methods (LARCs). LARCs are the most effective methods of reversible contraception, have high continuation rates, and should be considered when presenting contraceptive options to any woman of reproductive age. (II-2A)

3. Family planning counselling should include counselling on the decline of fertility associated with increasing female age. (III-A)

4. Health policy supporting a universal contraception subsidy and strategies to promote the uptake of highly effective methods as cost-saving measures that improve health and health equity should be considered by Canadian health decision makers. (III-B)

5. Canadian health jurisdictions should consider expanding the scope of practice of other trained professionals such as nurses, nurse practitioners, midwives, and pharmacists and promoting task-sharing in family planning. (II-2B)

6. The Canadian Community Health Survey should include adequate reproductive health indicators in order for health care providers and policy makers to make appropriate decisions regarding reproductive health policies and services in Canada. (III-B)

7. Health Canada processes and policies should be reviewed to ensure a wide range of modern contraceptive methods are available to Canadian women. (III-B)

J Obstet Gynaecol Can 2015;37(10):936–938

CHAPTER 2

Contraceptive Care and Access

8. Comprehensive family planning services, including abortion services, should be accessible to all Canadians regardless of geographic location. These services should be confidential, non- judgemental, and respectful of individuals' privacy and cultural contexts. (III-A)

9. A contraceptive visit should include history taking, screening for contraindications, dispensing or prescribing a method of contraception, and exploring contraceptive choice and adherence in the broader context of the individual's sexual behaviour, reproductive health risk, social circumstances, and relevant belief systems. (III-B)

10. Health care providers should provide practical information on the wide range of contraceptive options and their potential non-contraceptive benefits and assist women and their partners in determining the best user-method fit. (III-B)

11. Health care providers should assist women and men in developing the skills necessary to negotiate the use of contraception and the correct and consistent use of a chosen method. (III-B)

12. Contraceptive care should include discussion and management of the risk of sexually transmitted infection, including appropriate recommendations for condom use and dual protection, STI screening, post-exposure prophylaxis, and Hepatitis B and human papillomavirus vaccination. (III-B)

13. Health care providers should emphasize the use of condoms not only for protection against sexually transmitted infection, but also as a back-up method when adherence to a hormonal contraceptive may be suboptimal. (I-A)

14. Health care providers should be aware of current media controversies in reproductive health and acquire relevant evidence-based information that can be briefly and directly communicated to their patients. (III-B)

15. Referral resources for intimate partner violence, sexually transmitted infections, sexual dysfunction, induced abortion services, and child protection services should be available to help clinicians provide contraceptive care in the broader context of women's health. (III-B)

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CHAPTER 3

Emergency Contraception

16. All emergency contraception should be initiated as soon as possible after unprotected intercourse. (II-2A)

17. Women should be informed that the copper intrauterine device (IUD) is the most effective method of emergency contraception and can be used by any woman with no contraindications to IUD use. (II-3A)

18. Health care providers should not discourage the use of hormonal emergency contraception (EC) on the basis of a woman's body mass index (BMI). The copper intrauterine device for EC should be recommended for women with a BMI >30 kg/m^2 who seek EC. If access and cost allow, ulipristal acetate for EC should be the first choice offered to women with a BMI > 25 kg/m^2 who prefer hormonal EC. (II-2B)

19. Health care providers should discuss a plan for ongoing contraception with women who use pills for emergency contraception (EC) and should provide appropriate methods if desired. Hormonal contraception should be started within 24 hours of taking levonorgestrel for EC, and back-up contraception or abstinence should be used for the first 7 days after starting hormonal contraception. (III-B) Women who use ulipristal acetate (UPA) for EC should start hormonal contraception 5 days after using UPA-EC. UPA-EC users must use back-up contraception or abstinence for the first 5 days after taking UPA-EC and then for the first 7 days after starting hormonal contraception. (III-B)

20. Ulipristal acetate and levonorgestrel should not be used together for emergency contraception. (III-B)

21. A pregnancy test should be conducted if the woman has no menstrual period within 21 days of using pills or inserting a copper intrauterine device for emergency contraception. (III-A)

22. Health services should be developed to allow Canadian women to have timely access to all effective methods of emergency contraception. (III-B)

J Obstet Gynaecol Can 2015;37(10):936–938;
J Obstet Gynaecol Can 2016;38(12):1150–1151

Emergency Contraception (continued)

The most effective method of EC, which also provides quick start of regular contraception, remains the **copper IUD**:

- **EC:** Insert copper IUD if last unprotected sexual intercourse occurred within the previous 7 days if there are no contraindications (Refer to Chapter 7 Intrauterine Contraception) and you are reasonably certain the woman is not pregnant. **(See box 1, on page 9)**
- **On-going contraception**: copper IUD provides ongoing contraception for several years depending on the type. A follow-up visit should be planned 4-12 weeks after insertion to assess efficacy, satisfaction, and to check strings and signs of problems.
- **Back-up**: No back-up needed.

Given that the day of ovulation varies from cycle to cycle, EC pills are a valuable EC option whenever UPI occurs during the cycle. For women wanting **UPA-EC** (not recommended in the case of missed hormonal contraception):

- **EC**: Provide UPA-EC if last UPI occurred within the previous 5 days.
- **On-going contraception**: Pill, patch, ring, implant, or injection can be started 5 days after taking UPA-EC; LNG-IUS can be inserted 5 days after taking UPA-EC if there are no contraindications (Refer to Chapter 7 Intrauterine Contraception) and you are reasonably certain the woman is not pregnant. **(See box 2, on page 9)**
- **Back-up**: Use back-up (abstinence or barrier method) from the time of EC until hormonal contraception has been used for 7 days.

For women needing EC because of missed hormonal contraception (pill, patch, and ring) and those who prefer **LNG-EC**:

- **EC**: Provide LNG-EC if last UPI occurred within the previous 5 days.
- **On-going contraception**: Pill, patch, ring, implant or injection can be continued/started immediately or the day after taking LNG-EC; LNG-IUS can be inserted on the same day the LNG-EC was taken if there are no contraindications (Refer to Chapter 7 Intrauterine Contraception) and you are reasonably certain the woman is not pregnant. **(See box 2, on page 9)**
- **Back-up**: Use back-up (abstinence or barrier method) from the time of EC until hormonal contraception has been used for 7 days.

Condom use will protect against sexually transmitted infections.

After EC, if a woman's period is more than 7 days late, or she has not had one within 3-4 weeks of using EC, she should carry out a pregnancy test.

Emergency Contraception (continued)

BOX 1 Excluding pregnancy before inserting a copper IUD for EC	BOX 2 Excluding pregnancy before inserting an LNG-IUS after taking EC
You can be reasonably certain a woman is not pregnant if she has no signs and symptoms of pregnancy AND: 1. She has had no other UPI since her last menstrual period (normal in flow and timing) OR 2. Her urine pregnancy test is negative and the insertion of the emergency copper IUD occurs no later than 6 days after the expected date of ovulation (regular cycles and date of last menstrual period correctly identified) or no later than day 20 of a 28-day cycle.	You can be reasonably certain a woman is not pregnant if she has no signs or symptoms of pregnancy AND: 1. Her urine pregnancy test is negative AND • Any intercourse prior to UPI, for which the woman took the EC pill, occurred: + within the first 7 days of the onset of a normal menstrual period OR + within the first 7 days after an abortion or a miscarriage OR + within 4 weeks postpartum OR + while the woman was fully breastfeeding, amenorrheic, and within 6 months postpartum OR + while the woman was correctly and consistently using a reliable method of contraception until the UPI 2. AND She has had no UPI since taking EC

Abbreviations

CCC	Canadian Consensus on Contraception
Copper-IUD	Copper-containing intrauterine device
EC	Emergency contraception
IUD	Intrauterine device
IUS	Intrauterine system
LNG	Levonorgestrel
LNG-EC	Levonorgestrel-containing emergency contraception
LNG-IUS	Levonorgestrel-containing intrauterine system
UPA	Ulipristal acetate
UPA-EC	Ulipristal acetate-containing emergency contraception
UPI	Unprotected sexual intercourse

J Obstet Gynaecol Can 2016;38(12):1150–1151

CHAPTER 4

Natural Family Planning

23. Health care providers should respect the choice of a natural family planning (NFP) method, be aware of options for NFP, and be able to provide appropriate resources/ counselling on the correct use of a woman or couple's chosen method. (II-2B)

24. Natural family planning methods should not be proposed to women solely based on contraindications to another contraceptive method without a thorough review of other potentially safe and more effective methods. (II-2B)

25. Couples using natural family planning methods, including withdrawal and abstinence, should be provided with information about effective methods of emergency contraception and screening for sexually transmitted diseases. (III-B)

26. All pregnant or postpartum women should receive clear instructions on the lactational amenorrhea method of birth control and the criteria that must be met to achieve reliable contraception. (III-B)

J Obstet Gynaecol Can 2015;37(11):1033–1035

CHAPTER 5

Barrier Methods

27. Health care providers should promote the consistent and correct use of latex condoms to improve protection against pregnancy, human immunodeficiency virus infection, and other sexually transmitted infections. (II-2A)

28. Health care providers should educate women and men about the correct use of barrier methods. They should emphasize the need for dual protection against pregnancy and infections. (II-2B)

29. Women who use barrier methods of contraception should be counselled about emergency contraception. (III-B)

30. The use of spermicide-coated condoms should no longer be promoted. (I-A)

31. Diaphragms and cervical caps should continue to be available in Canada and appropriate training should be available for health care providers to become proficient in fitting diaphragms. (III-C)

32. Nonoxynol-9 products should not be used to reduce the risk of sexually transmitted infections and human immunodeficiency virus (HIV) infection and should not be used by women at high risk for HIV transmission. (I-A)

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CHAPTER 6

Permanent Contraception

33. Before providing permanent contraception, women should be counselled on the risks of the procedure, the risk of regret, and alternative contraceptive methods, including long-acting reversible contraceptives and male vasectomy. Informed consent must be obtained. (II-2A)

34. In a well-informed woman who understands her contraceptive options and the permanency of the procedure and who is capable of consent, age and parity should not be a barrier to permanent contraception. (III-B)

35. Women should be advised to use an effective method of contraception up until the day of their permanent contraception procedure. A pregnancy test should be performed on the day of the procedure. (III-A)

36. Women undergoing a laparoscopic procedure should continue to use an effective method of contraception for one week following the procedure. (III-B)

37. Women having a hysteroscopic tubal occlusion procedure should use an effective method of contraception up until the day of surgery and for at least 3 months afterward until imaging studies have confirmed bilateral tubal occlusion. (II-2A)

38. Isolation of the vas deferens should be performed using a minimally invasive vasectomy technique such as the no-scalpel vas occlusion technique. Vas occlusion should be performed by any 1 of 4 techniques that are associated with occlusive failure rates consistently below 1%. (III-B)

39. Patients who have had a vasectomy should be advised that they may stop using a second method of contraception when one uncentrifuged fresh semen specimen shows azoospermia or≤ 100 000 non-motile sperm/mL. (III-B)

J Obstet Gynaecol Can 2015;37(11):1033–1035

CHAPTER 7

Intrauterine Contraception

1. Health care professionals should be careful not to restrict access to intrauterine contraceptives (IUC) owing to theoretical or unproven risks. (III-A) Health care professionals should offer IUCs as a first-line method of contraception to both nulliparous and multiparous women. (II-2A)

2. In women seeking intrauterine contraception (IUC) and presenting with heavy menstrual bleeding and/or dysmenorrhea, health care professionals should consider the use of the levonorgestrel intrauterine system 52 mg over other IUCs. (I-A)

3. Patients with breast cancer taking tamoxifen may consider a levonorgestrel-releasing intrauterine system 52 mg after consultation with their oncologist. (I-A)

4. Women requesting a levonorgestrel-releasing intrauterine system or a copper-intrauterine device should be counseled regarding changes in bleeding patterns, sexually transmitted infection risk, and duration of use. (III-A)

5. A health care professional should be reasonably certain that the woman is not pregnant prior to inserting an intrauterine contraceptive at any time during the menstrual cycle. (III-A)

6. Health care providers should consider inserting an intrauterine contraceptive immediately after an induced abortion rather than waiting for an interval insertion. (I-B)

7. In women who conceive with an intrauterine contraceptive (IUC) in place, the diagnosis of ectopic pregnancy should be excluded as early as possible. (II-2A) Once an ectopic pregnancy has been excluded, the IUC should be removed without an invasive procedure. The IUC may be removed at the time of a surgical termination. (II-2B)

8. In the case of pelvic inflammatory disease, it is not necessary to remove the intrauterine contraceptive unless there is no clinical improvement after 48 to 72 hours of appropriate antibiotic treatment. (II-2B)

9. Routine antibiotic prophylaxis for intrauterine contraceptive (IUC) insertion is not indicated. (I-B) Health care providers should perform sexually transmitted infection (STI) testing in women at high risk of STI at the time of IUC insertion. If the test is positive for chlamydia and/or gonorrhea, the woman should be appropriately treated post-insertion and the IUC can remain in situ. (II-2B)

10. Unscheduled bleeding in intrauterine contraception users, when persistent or associated with pelvic pain, should be investigated to rule out infection, pregnancy, gynecological pathology, expulsion or malposition. (III-A)

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CHAPTER 8

Progestin-Only Contraception

12. Progestin-only methods of contraception should be considered in women with medical conditions where estrogen is contraindicated or less appropriate, such as women who are recently postpartum, breastfeeding, or in smokers over age 35. (III-A)

13. There should be no restriction on the use of depot medroxy-progesterone acetate (DMPA), including duration of use, among women of reproductive age who are otherwise eligible to use the method. The overall risks and benefits of continuing DMPA use should be discussed with DMPA users at regular intervals throughout the course of treatment. (III-A)

14. Counselling regarding menstrual cycle disturbances should be done prior to initiating a progestin-only method of contraception. (I-A)

15. Health care providers should inform patients of the potential effects of depot medroxyprogesterone acetate on bone mineral density and counsel them on "bone health," including calcium and vitamin D supplementation, smoking cessation, weight-bearing exercise, and decreased alcohol and caffeine consumption. (III-A)

16. If prolonged and/or frequent bleeding occurs in users of progestin-only contraceptives, pregnancy, sexually transmitted infection, and genital pathology should be ruled out. (III-B)

17. Ectopic pregnancy should be ruled out if a pregnancy occurs in a woman using a progestin-only method of contraception. (III-A)

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CHAPTER 9

Combined Hormonal Contraception

1. Health care providers should give clear instructions for hormonal contraceptive use, including how to manage missed hormonal contraception, as part of contraceptive counselling. Women should be provided with resources to refer to in the event of missed and/or delayed hormonal contraceptives or if they develop any signs of a serious adverse event while using hormonal contraception (III-A).
2. Health care providers should consider advising women who are initiating contraception to start their combined hormonal contraception (CHC) immediately (Quick Start) provided that they are reasonably certain that the woman is not pregnant. Back-up contraception (barrier method) or abstinence should be used for the first 7 consecutive days of CHC use unless CHC was initiated on the first day of menses (I-A).
3. Health care providers should consider the possibility of irregular pill taking, concomitant medication use, malabsorption, uterine or cervical pathology, pregnancy, or chlamydial infection in women presenting with persistent unscheduled bleeding on the combined oral contraceptive pill (III-A).
4. If 1 combined oral contraceptive pill or other combined hormonal contraception (CHC) method is missed in the first week of use, backup contraception or abstinence should be used until the CHC method has been used for 7 consecutive days. In the case of missed CHC in the second or third week of hormones, the hormone-free interval should be eliminated for that cycle (III-A).
5. Back-up contraception should be used when 3 or more consecutive doses/days of combined hormonal contraception (CHC) have been missed in the second or third week of hormone use until the CHC has been used for 7 consecutive days. For practical reasons, the scheduled hormone-free interval should be eliminated in these cycles (I-A).
6. Health care providers should be aware of other medications being used by combined hormonal contraception users and the possibility of drug interactions that could affect serum levels and effectiveness of either medication (II-2A).
7. Health care professionals should be aware of the option of using continuous and/or extended combined hormonal contraception regimens and consider offering them to women for contraception, medical reasons, and personal preferences (III-A).
8. Women using continuous and/or extended combined hormonal contraception regimens should be counselled about expected bleeding patterns and how to manage unscheduled bleeding or spotting (III-A).
9. When a specific product has been prescribed to a woman, she should be informed if a generic substitution is being considered and her health care provider should be advised if a substitution is made. The woman should have the option to agree or disagree to the substitution and be informed about any difference in cost for a specific product (III-B).

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