PARTICIPANT HANDOUTS

Family Planning Refresher Course

Thank you for attending today's training. By doing so you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, culturally competent, high-quality primary health care services.

Presented by

Jane Lose, APN, CNM, provider at STRIDE Community Health Center, and APN Medical Director for the State of Colorado's Family Planning Program

Target Audience

Clinical leadership, clinicians, and clinical support staff at health centers in Region VIII (CO, MT, ND, SD, UT, WY) including physicians, PAs, NPs, nurses, MAs, and other interested health care professionals.

Event Overview

This on-demand module will provide family medicine providers with an opportunity to refresh their family planning knowledge.

Learning Objectives

Upon completion of this session, participants should be able to:

1. Conduct a thorough sexual health history with your clients.
2. Identify all FDA approved contraceptive methods, effectiveness, risks and benefits of each.
3. Utilize this knowledge to use patient-centered methods to effectively counsel patients interested in contraception.
4. Effectively counsel adolescents, LGBTQIA folks and other specific populations about reproductive and sexual health.
5. Offer non-directive pregnancy options counseling.

CONTENTS

Page 2: CHAMPS Archives
Descriptions CHAMPS
Pages 2: Speaker Biography
Pages 3-52: Slides

CHAMPS On-Demand Modules and Courses
This event will be available on the CHAMPS On-Demand Modules and Courses Page. This online version will be available for at least one year from the live presentation date. For information about all CHAMPS On-Demand Trainings, please visit www.CHAMPSonline.org/events-trainings/on-demand-modules-and-courses.

Description of CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-designated Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, policy and funding communications, and the collection and dissemination of regional data. Staff and board members of CHAMPS Organizational Members receive targeted benefits in the areas of business intelligence, networking and peer support, recognition and awards, recruitment and retention, training discounts and reimbursement, and more.

For over 35 years, CHAMPS has been an essential resource for Community Health Center training and support! Be sure to take advantage of CHAMPS' programs, products, resources, and other services. For more information about CHAMPS, please visit www.CHAMPSonline.org. The Happenings box on the lower left side of the CHAMPS home page highlights the newest CHAMPS offerings, while the CHAMPS Membership box on the lower right side of the page lists current benefits for CHAMPS Organizational Members.

Description of RMPHTC
The Rocky Mountain Public Health Training Center (RMPHTC) is housed within the Center for Public Health Practice at the Colorado School of Public Health. We are one of the 10 Regional Public Health Training Centers designated by the Health Resources & Services Administration (HRSA) to provide training to professionals addressing public health issues. We serve Region VIII – which includes Colorado, Montana, North and South Dakota, Utah, and Wyoming.

RMPHTC works in partnership with subject matter experts to develop a skilled workforce, prepared to address public health needs in their communities. Our expertise in adult learning theory and instructional design ensures engaging, relevant trainings.

Speaker Biography
Jane Lose, ANP, CNM has spent her career in healthcare serving the underserved and has worked as both a clinician and an administrator in Federally Qualified Health Centers and the Indian Health Service. She is an expert in sexual and reproductive health and provides primary care, prenatal care, HIV care and transgender care as part of her clinical practice. She has been a part of national level policy work in sexual and reproductive health and quality, and has presented nationally on the topics of reproductive health and transgender care. Her most recent role is with the State of Colorado Department of Public Health and Environment, where she serves as the APN Medical Director for the Family Planning Program, and she maintains a clinical practice at STRIDE Community Health Center in the Denver Metro area.

Sexual and Reproductive Health Care

Jane Lose, RN, ANP, CNM
APN Medical Director, Family Planning Program
Colorado Department of Public Health and Environment
Primary Care Provider- STRIDE Community Health Center

Disclosures

Provider trainer for the Nexplanon Contraceptive Implant- Organon

Learning Objectives

- Learn how to take a sexual health history
- Develop skills for asking patients about reproductive life goals
- Identify the different methods of birth control and emergency contraception
- Have a simple counseling model you can use for sexual and reproductive health counseling

WHO Definition: Sexual Health

Sexual health is a "...state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity... For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled". *(World Health Organization, 2006)*

World Health Organization. Sexual and Reproductive Health and Research, 2022, WHO.int. Accessed 5 Dec. 2022.

- *"Speech has power. Words do not fade. What starts out as a sound, ends in a deed."*
  - *-Abraham Joshua Herschel*

General Communication Skills

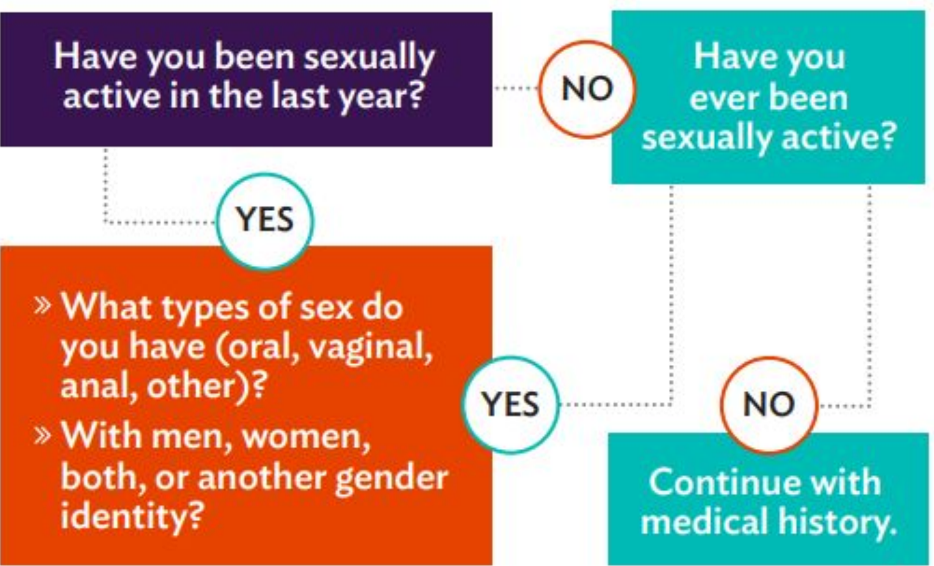
- Demonstrating empathy in response to patient cues: verbal and non-verbal
- Active listening: through body language and your verbal responses
- An appropriate level of eye contact
- Open, relaxed, yet professional body language (e.g. uncrossed legs and arms, leaning slightly forward in the chair)
- Establishing rapport
- Not interrupting the patient throughout the consultation
- Signposting: this involves explaining to the patient what you have discussed so far and what you plan to discuss next
- Summarizing at regular intervals

How to begin:

“I am going to ask you a few questions about your sexual history. I ask these questions at least once a year of all my patients because they are very important for your overall health. Everything you tell me is confidential. Do you have any questions before we start?”

But Why?

- Your sexual health is an important part your overall emotional and physical health.
- We ask these questions every year because it is common for people’s sexual behaviors and partners to change over time.
- These questions can lead to a conversation about your sexual and reproductive life goals, or other things that may concern you.



National Coalition for Sexual Health. *Sexual Health Questions to Ask All Patients.*
https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/asset/Sexual-Health-Questions-to-Ask-All-Patients.pdf

The Five "P"s

To further guide your dialogue with your patient, the 5 "Ps" may be a useful way to help you remember the major aspects of a sexual history.

1. Partners
2. Practices
3. Protection from STIs
4. Past History of STIs
5. Pregnancy Intention

Centers for Disease Control and Prevention (CDC). *A Guide to Taking a Sexual History.* https://www.cdc.gov/std/treatment/sexualhistory.pdf

DON'T
YUCK
MY
YUM

Best Practices:
Language Is Important

AVOID	USE INSTEAD
Are you married?	What is your current relationship status?
You’re married so you do not need STI testing, right?	Have you had any new sexual partners in the last year?
Do you think that your partner is cheating on you?	Does your partner have other partners?
Do you sleep with a lot of people?	How many sexual partners have you had?
Are you an IV drug user?	Have you ever injected drugs?

SHADES OF MEANING

"You're only using condoms half of the time? That's a pretty big risk to take. You could get STIs, including HIV, and you could get someone pregnant."

"That's great that you're using condoms. Would you be comfortable telling me about when you use them and when you don't?"

Trauma-informed Care

A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation- past and present- in order to provide effective health care services with a healing orientation.

https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

The 5th P: PREGNANCY

History of Reproductive Coercion

Historical and ongoing experiences of women of color include:

- Forced birth
- Forced sterilization
- Forced use of contraception
- Pressure to use particular birth control methods and limit family size
  - Providers are more likely to recommend IUDs to low SES black and Latina women
  - Difficulty removing IUD / implant
- As ‘guinea pigs’ to try out new birth control methods
- Race-based discrimination when receiving family planning care
- Minorities and women with less education, more likely to be dissatisfied with provider

18

Focus on Reproductive Justice

"The Reproductive Justice Framework and the Sexual and Reproductive Health Equity Framework guide Colorado's Family Planning Program. Reproductive Justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities (SisterSong). Sexual and reproductive health equity ensures that all people have what they need to reach their highest level of sexual and reproductive health, including self-determination and achieving personal reproductive goals *(CECA-Coalition to Expand Contraceptive Access)*."

[Repeal Hyde Art Project]

Starting the Conversation

One Key Question ™

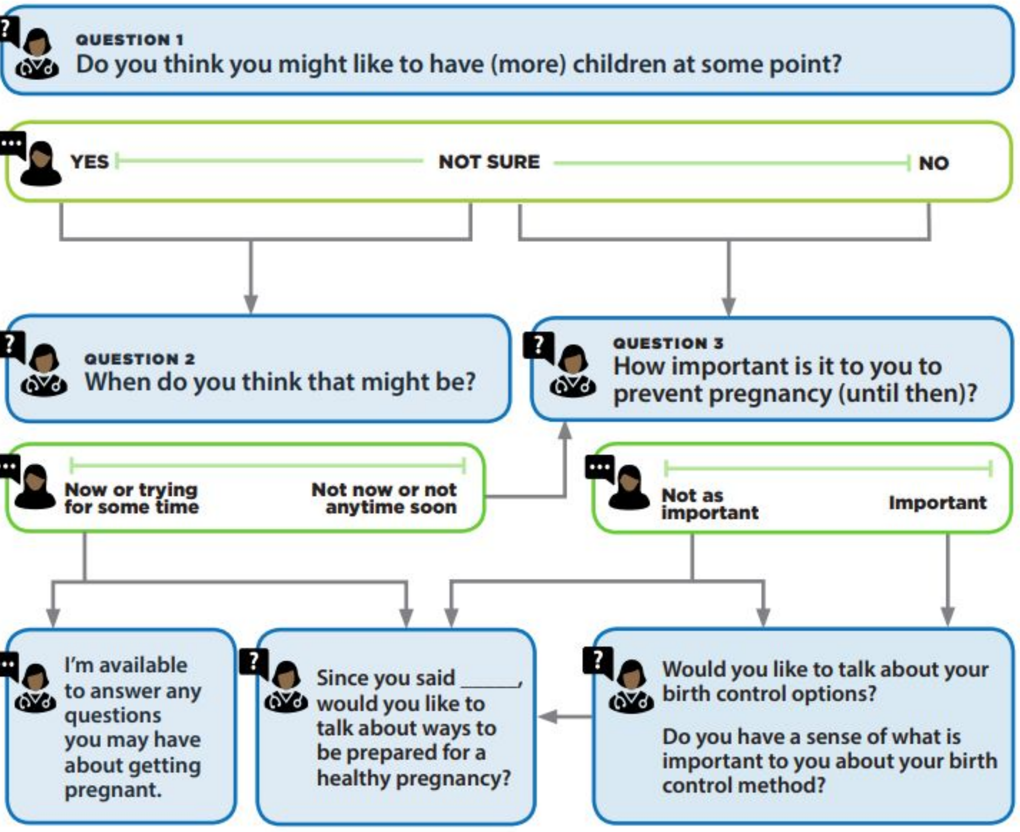
- "Would you like to become pregnant in the next year?"

PATH Questions

- **PA: Parenting/Pregnancy Attitudes:**
- Do you think you might like to have (more) children at some point?
- **T: Timing:** When do you think that might be?
- **H: How Important:** How important is it to you to prevent pregnancy (until then)?

(Murray, 2019; Envision SRH, 2022)

PATH Framework: Asking about Reproductive Goals



https://www.path-framework.com/_files/ugd/a919b3_9432f8666d7d460fa7dfb06dd1d53c47.pdf

Planning May Not Be Desirable

"I guess one of the reasons that I haven't gotten an IUD yet is like, I don't know, having one kid already and being in a long-term committed relationship, it takes the element of surprise out of when we would have our next kid, which I kind of want. I'm in that weird position. I just don't want to put too much thought and planning into when I have my next kid."

Gomez et al. Young Couples Study 2016

The American Congress of Obstetricians and Gynecologists (ACOG) offers guidance directing clinicians to “solicit an individual’s values, preferences, and insight into what matters most to them as it relates to contraception”.

What if the PATH answers are Yes, and NOW!!

- Advise prenatal vitamins, with folic acid
- Review medical conditions that may impact fertility or pregnancy and set health goals with the patient
- Review medications, and change ones that may be teratogenic
- Referrals as indicated

THE BASICS

How does contraception work to prevent pregnancy?

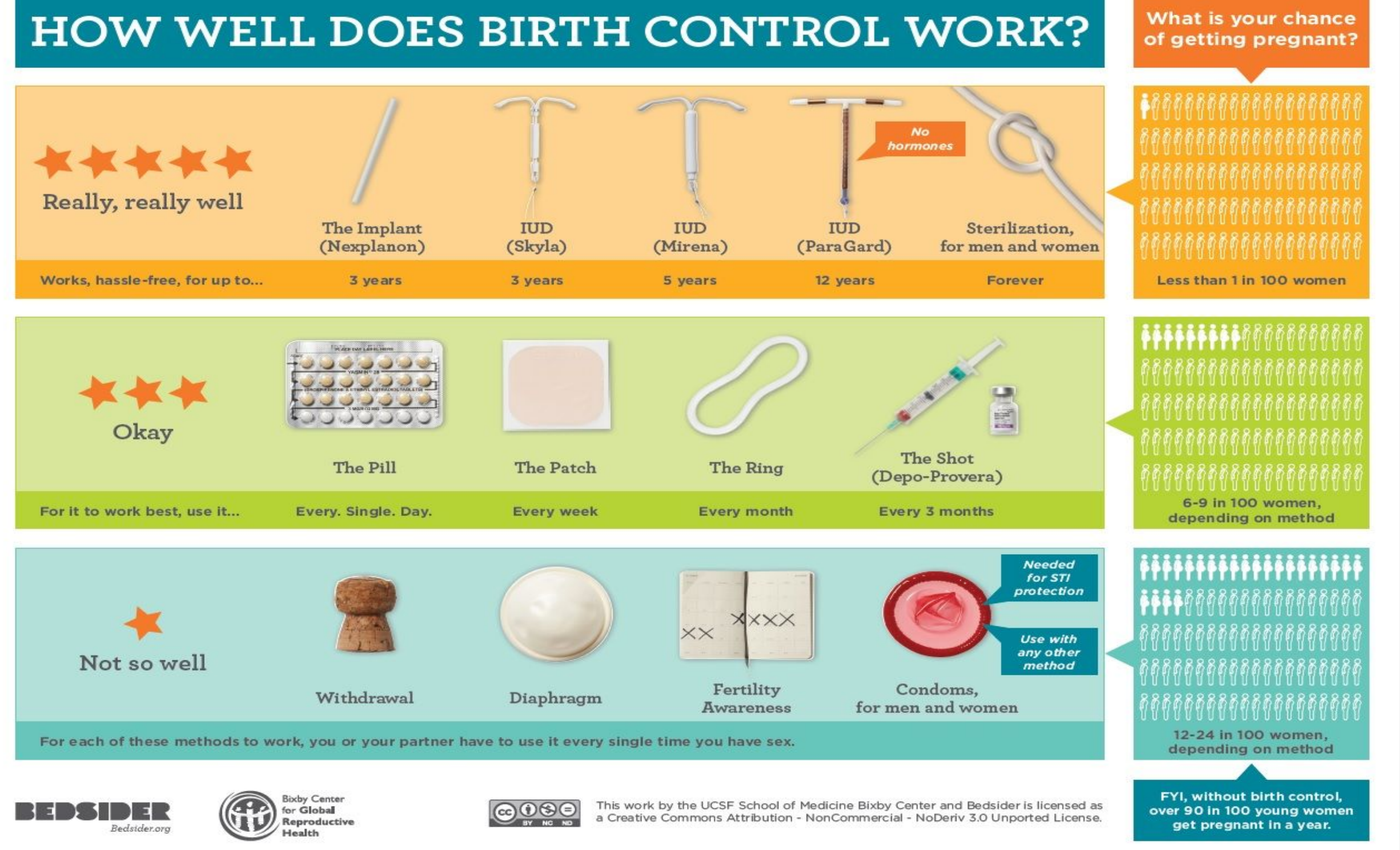
~~Sperm~~ + egg = no pregnancy

Sperm + ~~egg~~ = no pregnancy

~~Sperm~~ + ~~egg~~ = no pregnancy

Contraceptive Methods

Hormonal Methods	Non-Hormonal Methods
Oral Contraception (COCPs, POPs)	Abstinence, Fertility Awareness
Vaginal Rings	Withdrawal
Transdermal Patches	Spermicide, Vaginal Gel
Depo Provera (IM, SQ)	Barrier Methods (condoms, diaphragm)
Etonogestrel Implant	Sterilization (tubal, vasectomy)
Levonorgestrel Intrauterine Device	Copper Intrauterine Device



Bedsider.org

Abstinence

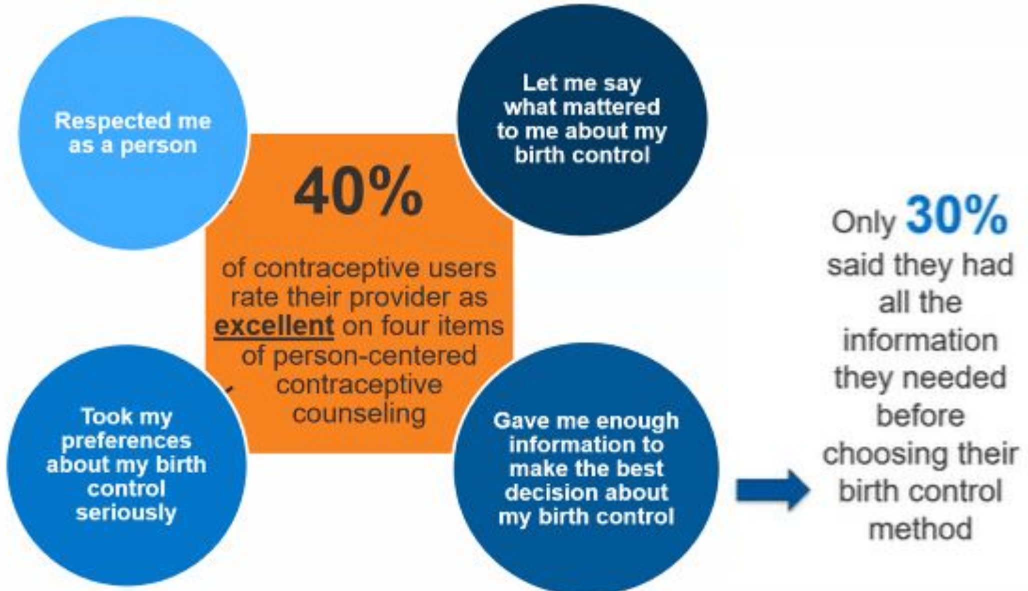
abstinence is 100% effective at preventing pregnancy and STIs

AAP Policy Statement
Contraception and Adolescents

Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners. In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to experience negative outcomes related to sexual activity.

PEDIATRICS Volume 120, Number 5, November 2007

Providing Enough Information to Choose a Method Is an Important Component of Contraceptive Counseling



SOURCE: KFF Women's Health Survey 2022; Person-Centered Contraceptive Counseling Measures, University of California San Francisco

KFF

Implant

- **Effectiveness**: 99.95% for both typical and perfect use
    - Approved for 3 years
    - Effective up to 5 years*
- **Adverse effects**: irregular bleeding, complications at insertion and removal
- **Effort:** Scheduling appointments for insertion and removal. Low effort in between
- **Value & Preference Alignment**: efficacy, convenience, discretion
- **Patient Population Considerations**: clients hoping for discreet, highly effective or low-effort birth control.

Hormonal IUDs

- **Effectiveness:** 99% for both typical and perfect use
- **Adverse Events**: irregular bleeding, expulsion
- **Effort:** scheduling appointments for insertion and removal, low effort in between
- **Value & Preference Alignment:** efficacy, convenience, discretion
- **Patient population considerations:** clients hoping for discreet, highly effective or low effort birth control

Levonorgestrel IUDs

Brand	Strength	Indication	Company
Mirena	levonorgestrel 52 mg (release rate of 21 mcg/day)	prevention of pregnancy for up to **8 years** treatment of heavy menstrual bleeding for up to 5 years	Bayer Health Care Pharmaceuticals Inc.
Skyla	levonorgestrel 13.5 mg (release rate of 14 mcg/day)	prevention of pregnancy for up to **3 years**	Bayer Health Care Pharmaceuticals Inc.
Liletta	levonorgestrel 52 mg (release rate of 20 mcg/day)	prevention of pregnancy for up to **8 years**	Allergan and Medicines360
Kyleena	levonorgestrel 19.5 mg (release rate of 17.5 mcg/day)	prevention of pregnancy for up to **5 years**	Bayer Health Care Pharmaceuticals Inc.

Copper IUD

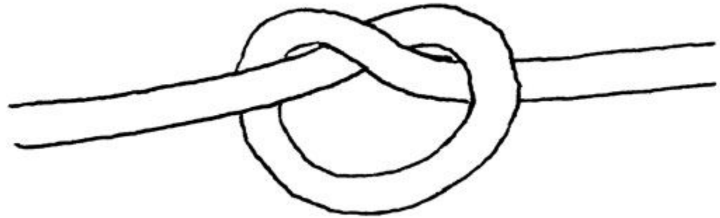
- **Effectiveness:** 99% for both typical and perfect use

    Approved for 10 years
- **Adverse Events**: Heavy bleeding, cramping, expulsion
- **Effort:** scheduling appointments for insertion and removal, low effort in between
- **Value & Preference Alignment:** efficacy, convenience, discretion, monthly periods
- **Patient population considerations:** clients hoping for discreet, monthly periods, non-hormonal method, highly effective or low effort birth control

Sterilization

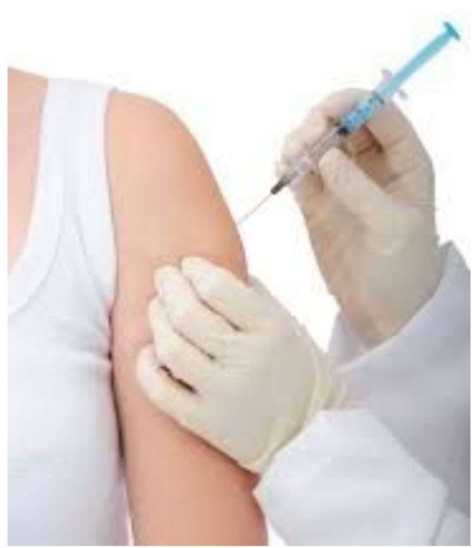
Vasectomy and Tubal Ligation

- **Permanent**
- **Effectiveness:** Over 99% for both typical and perfect use
- **Adverse Events**: surgical issues
- **Effort:** scheduling appointments for surgery, time for recovery, sperm testing after vasectomy
- **Value & Preference Alignment:** efficacy, convenience, discretion, permanence
- **Patient population considerations:** clients hoping for permanent, discreet, highly effective, low long term effort birth control



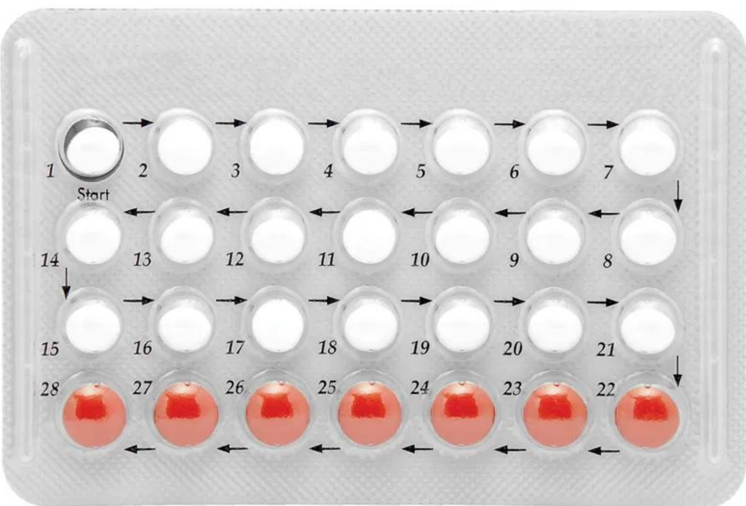
Depo Provera

- **Effectiveness**: typical- 95%, perfect- 98%
- **Adverse effects**: Weight gain, menstrual changes, bone density loss
- **Effort:** Scheduling appointments every 3 months for injection
- **Value & Preference Alignment**: Easy to use, discrete, high rate of amenorrhea
- **Patient Population Considerations**: Patients who cannot remember to take pills, or use patches or rings or do not want estrogen or LARC



Pills

- **Effectiveness**: 91%- typical use, 97%- perfect use
- **Adverse effects**: Increased blood clots, headaches, mood changes
- **Effort:** Scheduling appointments for prescription. Daily use
- **Value & Preference Alignment**: Easy to use, easy to stop, menstrual regulation
- **Patient Population Considerations**: Patients who do not want a procedure, patients who are able to remember to use it, patients who cannot afford other methods



Vaginal Ring

- **Effectiveness**: 91%- typical use, 97%- perfect use
- **Adverse effects**: Increased blood clots, headaches, mood changes
- **Effort:** Scheduling appointments for prescription. Monthly use
- **Value & Preference Alignment**: Easy to use, easy to stop, menstrual regulation
- **Patient Population Considerations**: Patients who do not want a procedure, patients who are able to remember to use it, patients who cannot afford other methods

Transdermal Patch

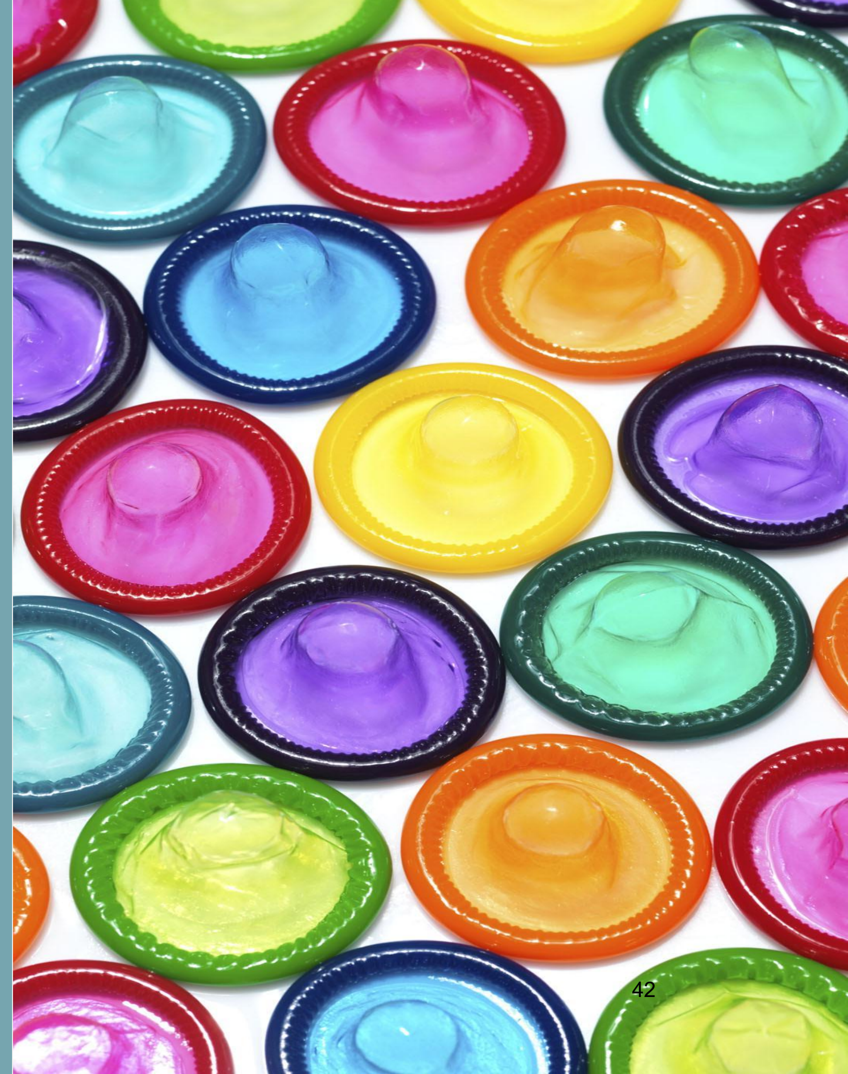
- **Effectiveness**: 91%- typical use, 97%- perfect use
- **Adverse effects**: Increased blood clots, headaches, mood changes
- **Effort:** Scheduling appointments for prescription. Weekly use
- **Value & Preference Alignment**: Easy to use, easy to stop, menstrual regulation
- **Patient Population Considerations**: Patients who do not want a procedure, patients who are able to remember to use it, patients who cannot afford other methods

Spermicide and Gel

- **Effectiveness**: 79-86%
- **Adverse effects**: vaginal irritation, UTIs, bacterial vaginosis and yeast
- **Effort:** Minimal, especially if easily available
- **Value & Preference Alignment**: OTC, easy to use
- **Patient Population Considerations**: Everyone, including everyone using another, more effective method

Condoms

- **Effectiveness**: typical- 82%
- **Adverse effects**: None
- **Effort:** Minimal, especially if easily available
- **Value & Preference Alignment**: Easy to use, discrete, protects against STDs
- **Patient Population Considerations**: Everyone, including everyone using another, more effective method



Providing Quality Family Planning Services

A report issued jointly by the CDC and OPA with recommendations outlining how to provide quality sexual and reproductive health care, including contraceptive services, pregnancy testing and counseling, achieving pregnancy, basic infertility, preconception health and sexually transmitted infection services.

https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

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

I = initiation, C = continuation (where a category differs between initiation and continuation it is shown as "I: x / C: y").

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
Age		Menarche to <20 yrs: **2**; ≥20 yrs: **1**	Menarche to <20 yrs: **2**; ≥20 yrs: **1**	Menarche to <18 yrs: **1**; 18-45 yrs: **1**; >45 yrs: **1**	Menarche to <18 yrs: **2**; 18-45 yrs: **1**; >45 yrs: **2**	Menarche to <18 yrs: **1**; 18-45 yrs: **1**; >45 yrs: **1**	Menarche to <40 yrs: **1**; ≥40 yrs: **2**
Anatomical abnormalities	a) Distorted uterine cavity	4	4				
	b) Other abnormalities	2	2				
Anemias	a) Thalassemia	2	1	1	1	1	1
	b) Sickle cell disease‡	2	1	1	1	1	2
	c) Iron-deficiency anemia	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‡						
	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*	1*	1*	3*
	ii) Without other risk factors for VTE			1*	1*	1*	2*
	d) >42 days postpartum			1*	1*	1*	2*
Cervical cancer	Awaiting treatment	I: 4 / C: 2	I: 4 / C: 2	2	2	1	2
Cervical ectropion		1	1	1	1	1	1
Cervical intraepithelial neoplasia		1	2	2	2	1	2
Cirrhosis	a) Mild *(compensated)*	1	1	1	1	1	1
	b) Severe‡ *(decompensated)*	1	3	3	3	3	4
Cystic fibrosis‡		1*	1*	1*	2*	1*	1*
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy						
	i) Higher risk for recurrent DVT/PE	1	2	2	2	2	4
	ii) Lower risk for recurrent DVT/PE	1	2	2	2	2	3
	b) Acute DVT/PE	2	2	2	2	2	4
	c) DVT/PE and established anticoagulant therapy for at least 3 months						
	i) Higher risk for recurrent DVT/PE	2	2	2	2	2	4*
	ii) Lower risk for recurrent DVT/PE	2	2	2	2	2	3*
	d) Family history *(first-degree relatives)*	1	1	1	1	1	2
	e) Major surgery						
	i) With prolonged immobilization	1	2	2	2	2	4
	ii) Without prolonged immobilization	1	1	1	1	1	2
	f) Minor surgery without immobilization	1	1	1	1	1	1
Depressive disorders		1*	1*	1*	1*	1*	1*

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
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	1	2	2	2	2	2
	c) Nephropathy/retinopathy/neuropathy‡	1	2	2	3	2	3/4*
	d) Other vascular disease or diabetes of >20 years' duration‡	1	2	2	3	2	3/4*
Dysmenorrhea	Severe	2	1	1	1	1	1
Endometrial cancer‡		I: 4 / C: 2	I: 4 / C: 2	1	1	1	1
Endometrial hyperplasia		1	1	1	1	1	1
Endometriosis		2	1	1	1	1	1
Epilepsy‡	*(see also Drug Interactions)*	1	1	1*	1*	1*	1*
Gallbladder disease	a) Symptomatic						
	i) Treated by cholecystectomy	1	2	2	2	2	2
	ii) Medically treated	1	2	2	2	2	3
	iii) Current	1	2	2	2	2	3
	b) Asymptomatic	1	2	2	2	2	2
Gestational trophoblastic disease‡	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/non-pregnant ß-hCG levels	I: 1* / C: 1*	I: 1* / C: 1*	1*	1*	1*	1*
	ii) Decreasing ß-hCG levels	I: 2* / C: 1*	I: 2* / C: 1*	1*	1*	1*	1*
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	I: 2* / C: 1*	I: 2* / C: 1*	1*	1*	1*	1*
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	I: 4* / C: 2*	I: 4* / C: 2*	1*	1*	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‡	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		1	1	1	1	1	1
HIV	a) High risk for HIV	I: 1* / C: 1*	I: 1* / C: 1*	1	1	1	1
	b) HIV infection			1*	1*	1*	1*
	i) Clinically well receiving ARV therapy	I: 1 / C: 1	I: 1 / C: 1	If on treatment, see Drug Interactions			
	ii) Not clinically well or not receiving ARV therapy‡	I: 2 / C: 1	I: 2 / C: 1	If on treatment, see Drug Interactions			

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

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100‡	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*Ulcerative colitis, Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease‡	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations‡		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma‡	1		3		3		3		3		4	
	b) Malignant‡ (hepatoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a) With prolonged immobility	1		1		1		2		1		3	
	b) Without prolonged immobility	1		1		1		2		1		1	
Obesity	a) Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m²	1		1		1		2		1		2	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	2		2		1		1		1		1	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a) Past												
	i) With subsequent pregnancy	1	1	1	1	1		1		1		1	
	ii) Without subsequent pregnancy	2	2	2	2	1		1		1		1	
	b) Current	4	2*	4	2*	1		1		1		1	
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function												
	i) <6 months	2		2		1		1		1		4	
	ii) ≥6 months	2		2		1		1		1		3	
	b) Moderately or severely impaired cardiac function	2		2		2		2		2		4	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	2*		2*		1*		1*		1*		1*	
	c) Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum (*nonbreastfeeding women*)	a) <21 days					1		1		1		4	
	b) 21 days to 42 days												
	i) With other risk factors for VTE					1		1		1		3*	
	ii) Without other risk factors for VTE					1		1		1		2	
	c) >42 days					1		1		1		1	
Postpartum (*in breastfeeding or non-breastfeeding women, including cesarean delivery*)	a) <10 minutes after delivery of the placenta												
	i) Breastfeeding	1*		2*									
	ii) Nonbreastfeeding	1*		1*									
	b) 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c) ≥4 weeks	1*		1*									
	d) Postpartum sepsis	4		4									

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
	b) Not on immunosuppressive therapy	1		1		1		2		1		2	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver‡	1		1		1		1		1		1	
Sexually transmitted diseases (STDs)	a) Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1		1		1		1	
	b) Vaginitis (*including trichomonas vaginalis and bacterial vaginosis*)	2	2	2	2	1		1		1		1	
	c) Other factors relating to STDs	2*	2	2*	2	1		1		1		1	
Smoking	a) Age <35	1		1		1		1		1		2	
	b) Age ≥35, <15 cigarettes/day	1		1		1		1		1		3	
	c) Age ≥35, ≥15 cigarettes/day	1		1		1		1		1		4	
Solid organ transplantation‡	a) Complicated	3	2	3	2	2		2		2		4	
	b) Uncomplicated	2		2		2		2		2		2*	
Stroke‡	History of cerebrovascular accident	1		2		2	3	3		2	3	4	
Superficial venous disorders	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial venous thrombosis (acute or history)	1		1		1		1		1		3*	
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	1*	1*	3*		3*		3*	3*	3*		4*	
	b) Severe thrombocytopenia	3*	2*	2*		2*		3*	2*	2*		2*	
	c) Immunosuppressive therapy	2*	1*	2*		2*		2*	2*	2*		2*	
	d) None of the above	1*	1*	2*		2*		2*	2*	2*		2*	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis‡ (*see also Drug Interactions*)	a) Nonpelvic	1	1	1	1	1*		1*		1*		1*	
	b) Pelvic	4	3	4	3	1*		1*		1*		1*	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*		3*		2*		2*	
Uterine fibroids		2		2		1		1		1		1	
Valvular heart disease	a) Uncomplicated	1		1		1		1		1		2	
	b) Complicated‡	1		1		1		1		1		4	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		1	1	2		2		2		1	
	b) Heavy or prolonged bleeding	2*		1*	2*	2*		2*		2*		1*	
Viral hepatitis	a) Acute or flare	1		1		1		1		1		3/4*	2
	b) Carrier/Chronic	1		1		1		1		1		1	1
Drug Interactions													
Antiretrovirals used for prevention (PrEP) or treatment of HIV	Fosamprenavir (FPV) All other ARVs are 1 or 2 for all methods.	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b) Lamotrigine	1		1		1		1		1		3*	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampin or rifabutin therapy	1		1		2*		1*		3*		3*	
SSRIs		1		1		1		1		1		1	
St. John's wort		1		1		2		1		2		2	

Updated in 2020. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condomreduces the risk of STDs and HIV.

CS314239-A

OOPS! EMERGENCY CONTRACEPTION: BIRTH CONTROL THAT WORKS AFTER SEX

Types of Emergency Contraception	How well does it work?	How soon do I have to use it?	How do I use it?	How can I get it?
Copper IUD	Almost 100% effective (1st)	Within 5 days	It's placed in the uterus by a health care provider. Keeps working as super effective birth control.	Go visit a health care provider. Say it's for EC so you are scheduled quickly.
ella (ella ulipristal acetate tablet 30 mg)	(2nd) May be less effective if over 195 pounds. Try an IUD.	ASAP. Works better the sooner you take it, up to 5 days.	Take the pill as soon as you get it. Remember to use it every time you have unprotected sex.	Get a prescription. Find it online or at a clinic.
Plan B One-Step or a generic	(3rd) May be less effective if over 165 pounds. Try ella or an IUD.	ASAP. Works better the sooner you take it, up to 5 days.	Take the pill(s) as soon as you get it. Remember to use it every time you have unprotected sex.	No prescription needed. Find it at a pharmacy, clinic, or online.

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Starting the Conversation

One Key Question ™

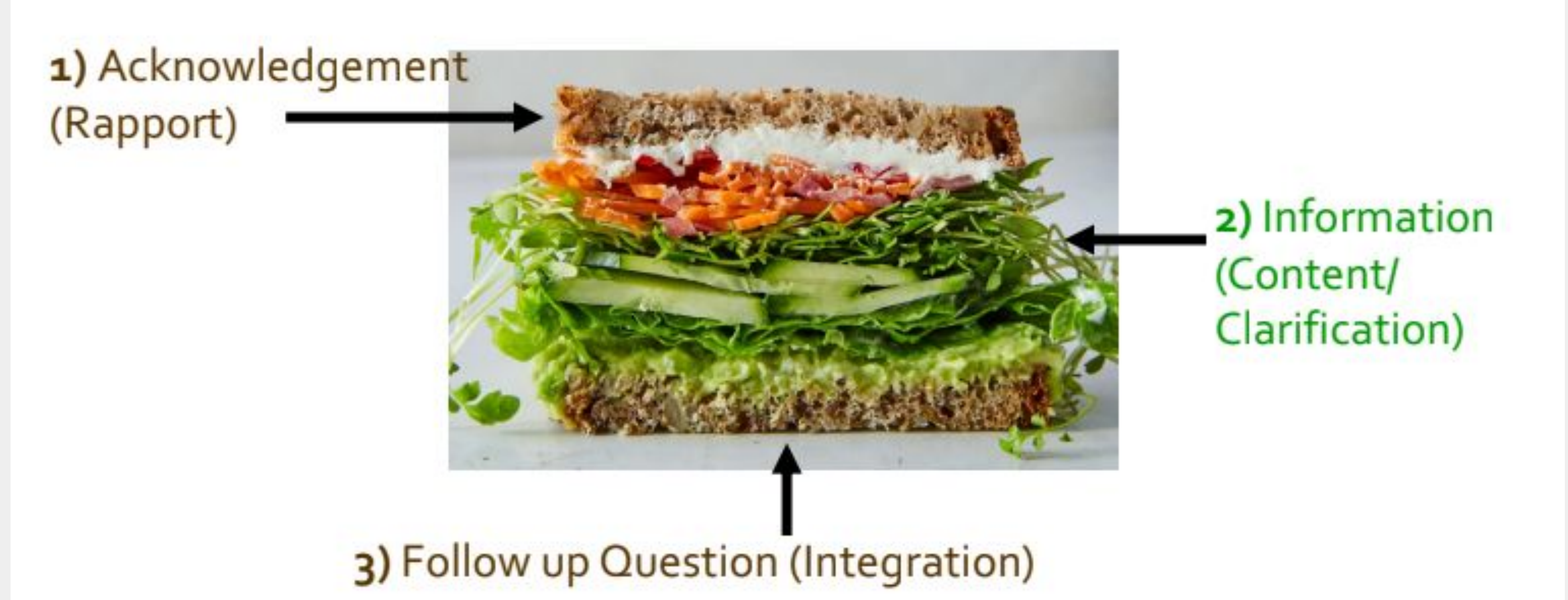
- "Would you like to become pregnant in the next year?"

PATH Questions

- **PA: Parenting/Pregnancy Attitudes:**
- Do you think you might like to have (more) children at some point?
- **T: Timing:** When do you think that might be?
- **H: How Important:** How important is it to you to prevent pregnancy (until then)?

(Murray, 2019; Envision SRH, 2022)

Counseling: The Information Sandwich



(Contraceptive Technology, 2021)

First Step: Acknowledgement

Start with a Positive

Second Step: Information the Content

Third Step: Ask a Follow Up Question Relevant to Content

Resources

- QFP- Providing Quality Family Planning
- US MEC- US Medical Eligibility Criteria
- Bedsider
- Planned Parenthood Birth Control
- Beyond the Pill
- PICCK- Partners in Contraception Choice and Knowledge
- A Guide to Taking a Sexual Health History- CDC
- Taking a Sexual Health History- NYCgov
- TAKING ROUTINE HISTORIES OF SEXUAL HEALTH: A System-Wide Approach for Health Centers- National LGBT Health Education Center and NACHC
- FDA Birth Control Guide
- Reproductive Health Access Project contraceptive choices guide
- AAFP Sexual Health History
- RHNTC, CTC-SRH