Person-Centered Approaches to Using Contraceptive Guidelines and Recommendations

Person-Centered Reproductive Health Program

UCSF

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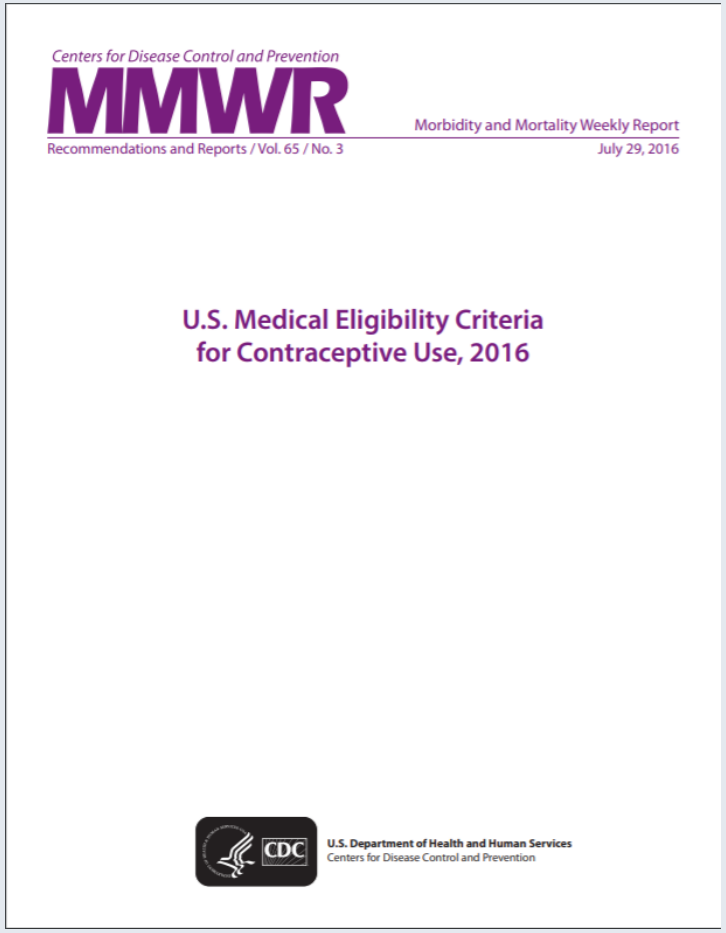
Learning objectives

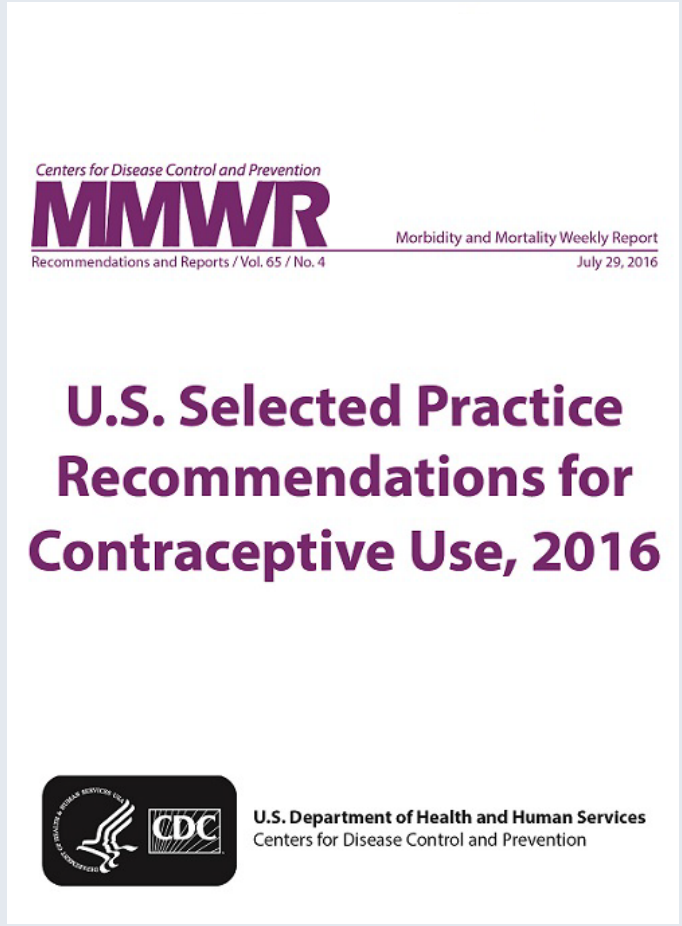
- Understand how to apply contraceptive clinical guidelines and recommendations in a person-centered manner
- Review person-centered educational approaches related to contraceptive eligibility and administration

Disclosures

- None to report

Contraceptive Guidelines





Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 63 / No. 4
April 25, 2014

Providing Quality Family Planning Services

Recommendations of CDC and the U.S. Office of Population Affairs



ACOG | Clinical
American College of Obstetricians & Gynecologists

Clinical Guidance Journals & Publications Patient Education

Practice Bulletin > Long-Acting Reversible Contraception Implants and Intrauterine Devices

Long-Acting Reversible Contraception Implants and Intrauterine Devices

Practice Bulletin | Number 186 | November 2017

What did the all the guidelines have in common?

- Prioritized effectiveness over other method characteristics
  - Recommended tiered effectiveness counseling (QFP, ACOG)
  - Conflated effectiveness as part of safety (CDC)

- No consideration of health equity
  - QFP included patient-centeredness, but equated this with tiered effectiveness counseling

Sea Change in Recommendations



- Explicit focus on person-centeredness and health equity
- Rejection of directive counseling and embrace of shared decision making
- Increased nuance and transparency

Guiding Principles for SRH Care

High-quality SRH care should be free from all forms of bias, including racism, classism, and bias based on disability status, weight, age, sexual orientation, and/or gender identity.

Six principles guide the delivery of quality SRH care:

1. Person-centered

Person-centered

Person-centeredness, defined as a focus on an individual person's needs, values, and preferences, is among the essential domains of health care quality.[29]

Advancing equity and minimizi
everyone's unique life context,
to use or not use contraceptio

BOX 2. Using the *U.S. Medical Eligibility Criteria for Contraceptive Use* and *U.S. Selected Practice Recommendations for Contraceptive Use* recommendations to support contraceptive decision-making

Return

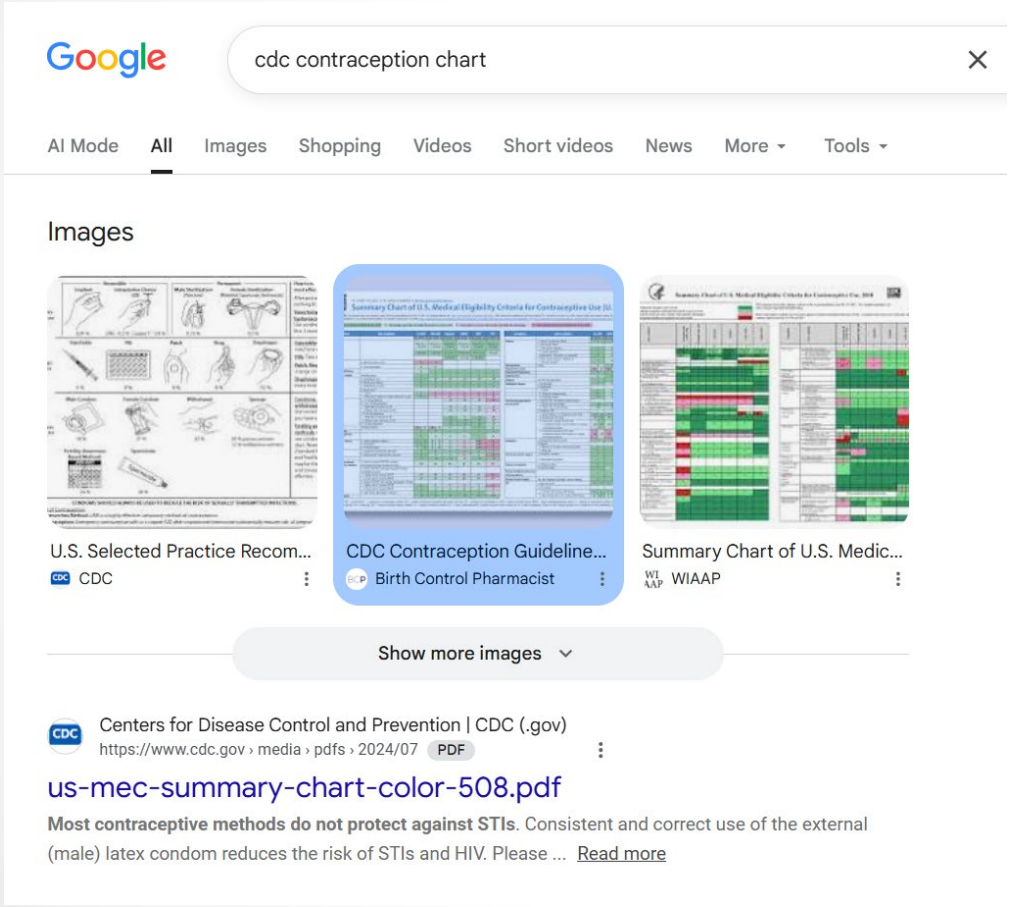
- CDC acknowledges the paramount importance of personal autonomy in contraceptive decision-making.
- Persons should have equitable access to the full range of contraceptive methods.
- Contraceptive services should be offered in a noncoercive manner that honors a person's values, goals, and reproductive autonomy.
- Shared decision-making and person-centered approaches recognize the expertise of both the health care provider and the person.
- A person-centered approach to contraceptive decision-making
    - prioritizes a person's preferences and reproductive autonomy rather than a singular focus on pregnancy prevention,
    - respects the person as the main decision-maker in contraceptive decisions, and
    - includes respecting the decision not to use contraception or to discontinue contraceptive method use.
- U.S. MEC and U.S. SPR recommendations can be used by health care providers to support persons in contraceptive decision-making.
- U.S. MEC and U.S. SPR recommendations can be used by health care providers to remove unnecessary medical barriers to accessing and using contraception.

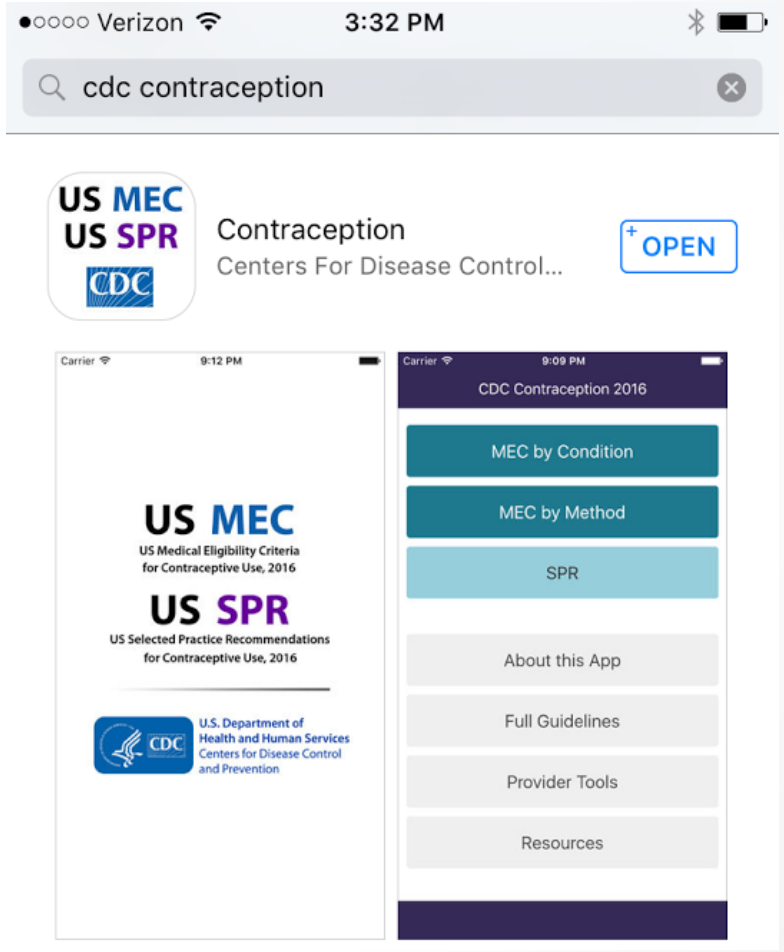
Abbreviations: U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use*; U.S. SPR = *U.S. Selected Practice Recommendations for Contraceptive Use*.

What we can learn from change in guidelines

- There has been an important shift in our field
- The old guidelines were not optimal
- There is always opportunity to improve things!
  - Don't be afraid to question guidelines and recommendations

Where do you find the US MEC and SPR?





What changed in the MEC?

- Made sickle cell guidelines more strict
- Tightened restrictions on DMPA, loosened on other progestin methods
- Reframed contraceptive decision making and counseling
  - Considered guidelines to be a tool to support informed decision making and remove unnecessary barriers
  - Acknowledged even those with potential for high risk pregnancy may not want to use most effective methods
  - Recognized that people may weigh different risks and benefits differently

A 36 year-old woman comes to you for contraception counseling.
She has a h/o of migraines with aura. Can she use an estrogen containing method?

Can a woman with migraines with aura use estrogen-containing contraceptives?

a. Yes
b. No
c. It depends



MEC and Headaches

Birth Control Methods

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
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*	

Medical Condition

MEC Category

Guidelines and Patient-Centered Care

- Guidelines help ensure people receive evidence-based care
- Can help avoid unnecessary barriers to care or use of specific methods
- HOWEVER, have potential to negatively impact patient experience if:
  - Are applied without attention to specific context
  - Are not explained in a patient-centered way

Case

- A 36 yo woman with migraines, but otherwise healthy, is establishing care with you. Her previous doctor had prescribed COCs for her and she would like a renewal. She tells you that since starting magnesium 2 years ago, she has not had any migraines, but prior to that had migraines with aura about 6 times a year. She really likes her method and does not want to switch.

What would you tell her?

Possible Responses

1. Review the benefits and risks of CHC in migraines with aura and renew her prescription if she still desires it
2. Tell her that CHC is absolutely contraindicated in patients with migraine with aura and you do not feel comfortable renewing her prescription
3. Refer her back to her previous doctor for her contraception prescription and tell her you will take care of her other health needs

What is the evidence?

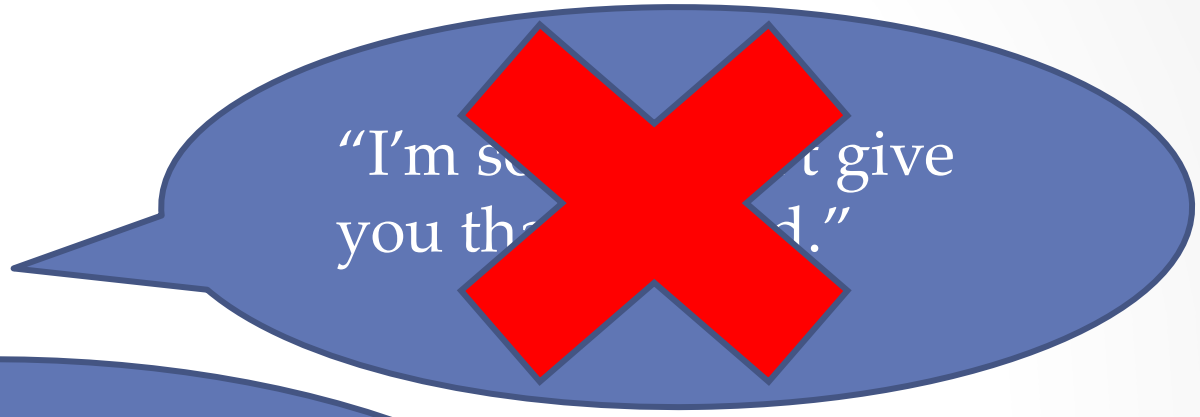
- Surprisingly limited data on the risks of migraine and CHCs
  - Especially with current formulations
- Baseline risk of ischemic stroke in young women 3–10 per 100,000 per year
  - Estimates of 2-3x increase with migraine with aura
  - Maximum risk of 30 per 100,000 per year, with attributable risk of 20/100,000
- Recent study from UK found no significant difference in stroke risk among patients with migraine with aura using POPs vs. COCs, with point estimate of excess risk of 10 per 100,000
- Risk of ischemic stroke in pregnancy ~10 per 100,000

Swartz, Int J Stroke, 2017
Tepper, Contraception, 2016; Sheikh, Headache, 2018, Gibbs Obstet Gyn 2026

There are no easy answers

- Understand both absolute and relative risks
- Balance risks of CHCs against the counterfactual: pregnancy
- Can be tricky to balance between patient preferences and established guidelines (and thus liability)
  - Documentation is key

Counseling about Contraindications



"Unfortunately, taking birth control with estrogen increases your risk of having a stroke, which we obviously really don't want to have happen to you."

Case

- A 25 year old woman who takes HCTZ for blood pressure control comes into your clinic asking about birth control. Her BP today is 136/89.

What can you tell her about her contraceptive options?

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

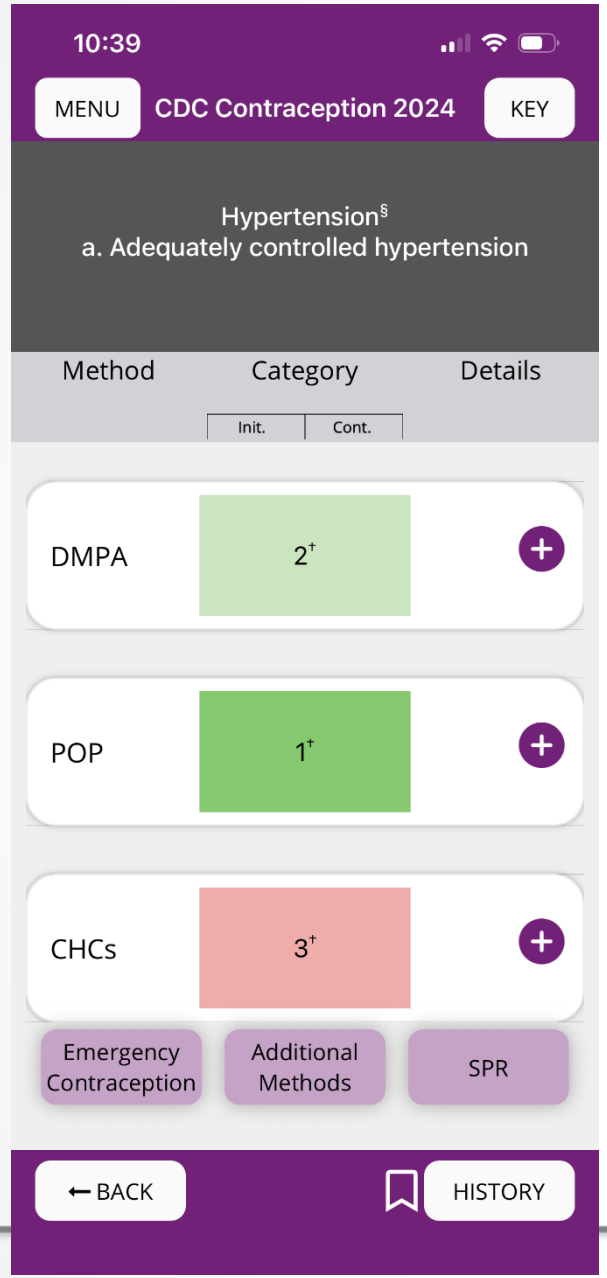


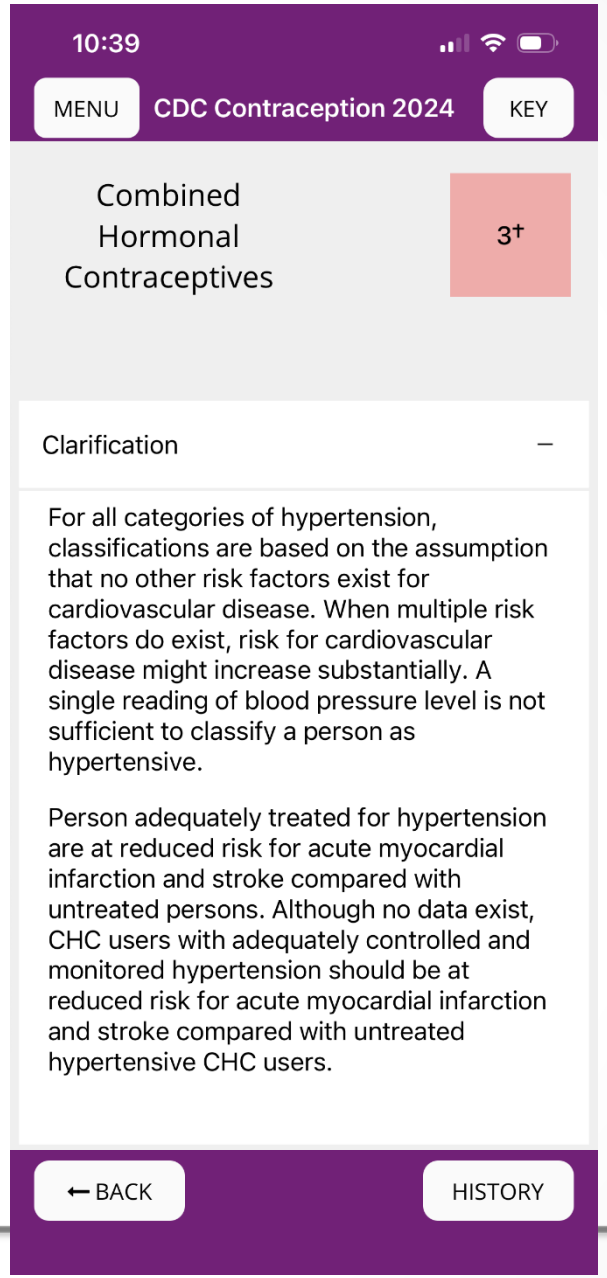
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	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[2]	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(including Crohn's disease, ulcerative colitis)	1		1		1		2		1		2/3	
Ischemic heart disease[2]	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations[2]		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma[2]	1		3		3		3		3		4	
	b) Malignant[2] (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[2]		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[2]	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 nonbreastfeeding 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									
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[2]	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[2]	a) Complicated	3	2	3	2	2		2		2		4	
	b) Uncomplicated	2		2		2		2		2		2*	
Stroke[2]	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[2]	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[2] (*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[2]	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													
Antiretroviral therapy All other ARV's are 1 or 2 for all methods.	Fosamprenavir (FPV)	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 2017. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

CS266008-A


10:39
MENU
CDC Contraception 2024
KEY
Hypertension§
a. Adequately controlled hypertension
Method
Category
Details
Init.
Cont.
DMPA
2+
POP
1+
CHCs
3+
Emergency Contraception
Additional Methods
SPR
BACK
HISTORY


10:39
MENU
CDC Contraception 2024
KEY
Combined Hormonal Contraceptives
3+
Clarification
For all categories of hypertension, classifications are based on the assumption that no other risk factors exist for cardiovascular disease. When multiple risk factors do exist, risk for cardiovascular disease might increase substantially. A single reading of blood pressure level is not sufficient to classify a person as hypertensive.
Person adequately treated for hypertension are at reduced risk for acute myocardial infarction and stroke compared with untreated persons. Although no data exist, CHC users with adequately controlled and monitored hypertension should be at reduced risk for acute myocardial infarction and stroke compared with untreated hypertensive CHC users.
BACK
HISTORY

Can my patient use this method?

US Medical Eligibility Criteria (MEC)



1	Can use the method	No restrictions
2	Can use the method	Advantages generally outweigh theoretical or proven risks.
3	Should not use method unless no other method is appropriate or acceptable	Theoretical or proven risks generally outweigh advantages
4	Should not use method	Unacceptable health risk

A patient-centered approach to category "3"

- Anything other than a 1 or a 4 represents a lack of certainty of recommendation
- A category 3 does NOT mean that the patient should be denied this method unless no other method is theoretically available
  - Whether another method is ACCEPTABLE to the patient is the critical question
- Requires a shared decision making approach with clear communication about risks and tradeoffs

How do you do shared decision making?

- Uncertainty is hard to communicate!
- Focus on how patient values and preferences relate to the reason for the category 3 rating
- When available, give data using absolute numbers and visual aids
- Help patients to understand how the information relates to their preferences

Supporting decision making

- Explain that both hypertension and hormonal methods increase risk for vascular events
  - Uncertainty about how much
  - As strokes and MIs are generally rare events in younger women, absolute excess risk is relatively small (<1 in 10,000 risk)
- Discuss her overall clinical situation with respect to vascular risk – e.g., is she otherwise low risk?
- Discuss use of LARC vs. progestin-only vs. barrier methods vs. category 3 methods, considering tradeoffs between
  - Bleeding patterns
  - Mechanism of use
  - Effectiveness
- Follow-up BP check if chooses hormonal method

Case

- A 32 year old G3P3 comes to see you for a two week post-partum check up. She is breastfeeding. She had her second baby almost exactly one year after her first, and she is very concerned about pregnancy prevention. After a patient-centered conversation, she decides she wishes to use pills. She asks you when she can start taking them.

  What do you tell her?

  Would her previous history of breastfeeding factor into your advice?

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/pregnancy-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.

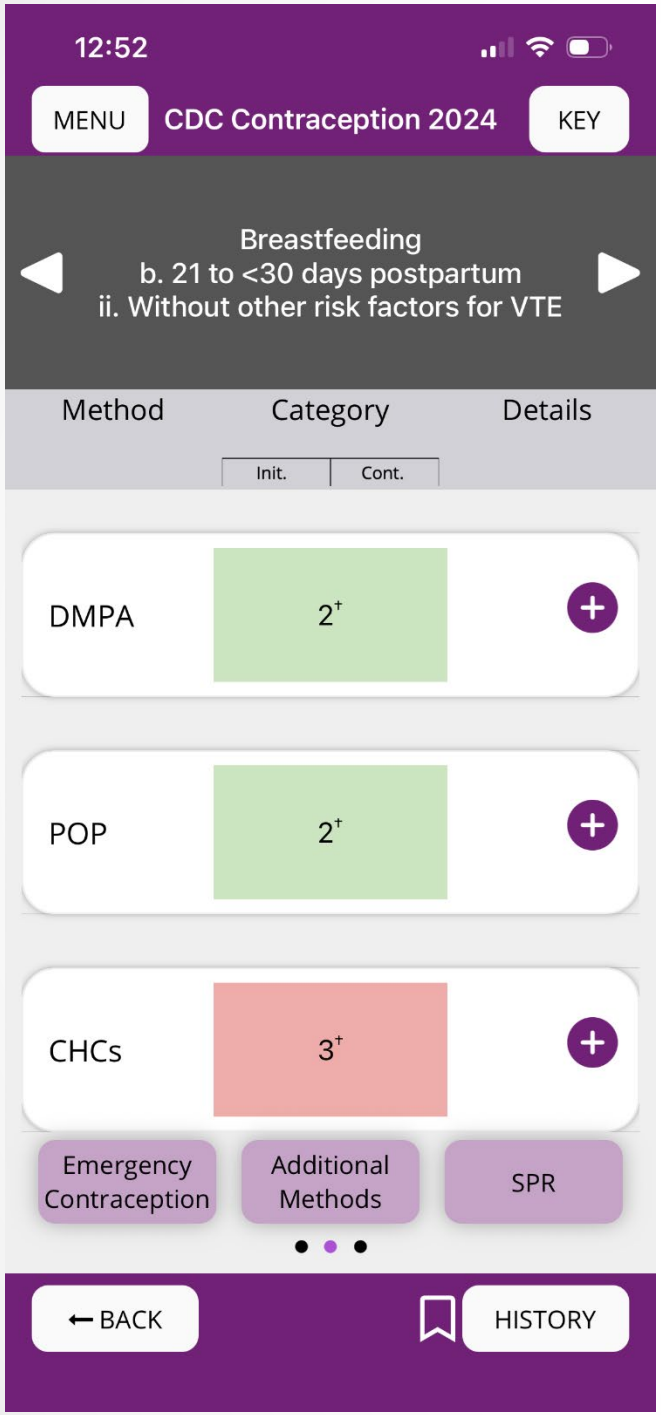
KEY: **1 = No restriction (method can be used)** | **2 = Advantages generally outweigh theoretical or proven risks** | **3 = Theoretical or proven risks usually outweigh the advantages** | **4 = Unacceptable health risk (method not to be used)**

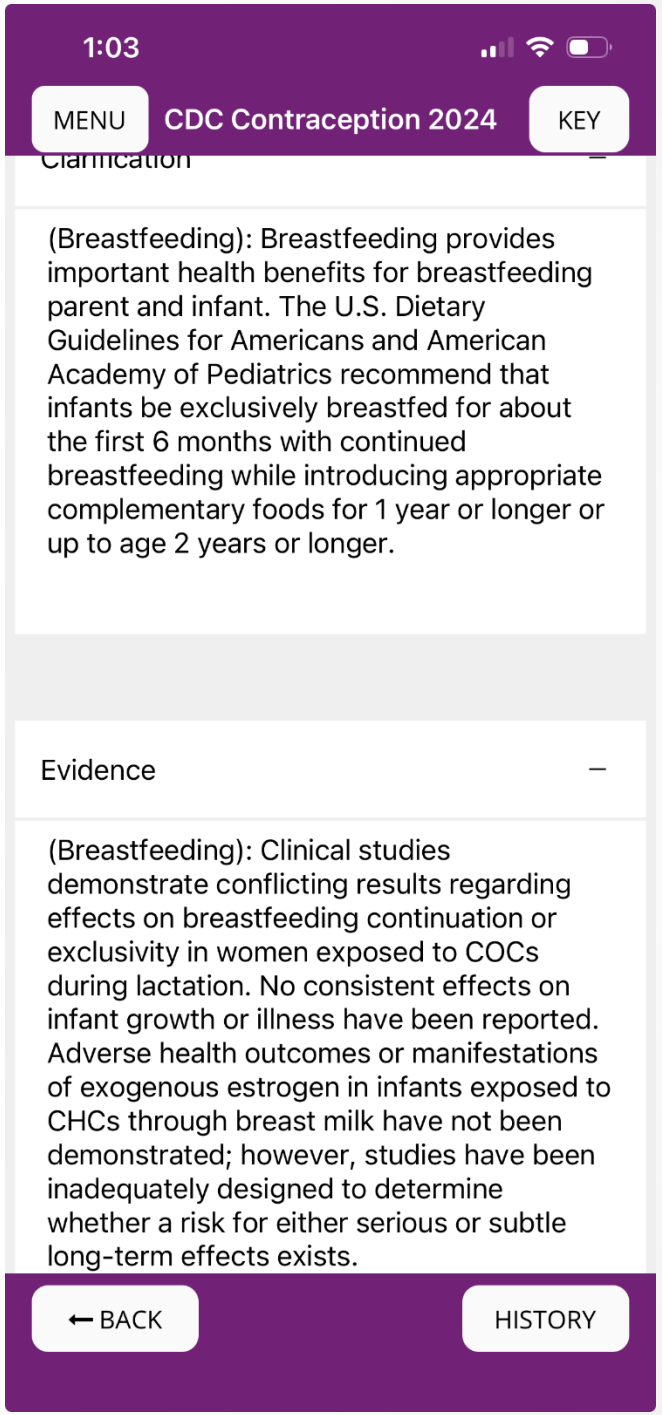
Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs:**2**		Menarche to <20 yrs:**2**		Menarche to <18 yrs:**1**		Menarche to <18 yrs:**2**		Menarche to <18 yrs:**1**		Menarche to <40 yrs:**1**	
		≥20 yrs:**1**		≥20 yrs:**1**		18–45 yrs:**1**		18–45 yrs:**1**		18–45 yrs:**1**		≥40 yrs:**2**	
						>45 yrs:**1**		>45 yrs:**2**		>45 yrs:**1**			
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[‡]												
	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***	
	ii. Without other risk factors for VTE					**1***		**1***		**1***		**2***	
	d. >42 days postpartum					**1***		**1***		**1***		**2***	
Cervical cancer	Awaiting treatment												
Cervical ectropion		**1**		**1**		**1**		**1**		**1**		**1**	
Cervical intraepithelial neoplasia		**1**		**2**		**2**		**2**		**1**		**2**	
Chronic kidney disease[§]	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**		**1**		**1**	
	b. Decompensated[¶] (*impaired liver function*)	**1**		**2**		**2**		**3**		**2**		**4**	
Cystic fibrosis[‡]		**1***		**1***		**1***		**2***		**1***		**1***	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)[¶]	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**	
	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**	
Depressive disorders		**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[‡]	**1**		**2**		**2**		**2**		**2**		**2**	
	c. Nephropathy, retinopathy, or 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[‡]		**4**	**2**	**4**	**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. 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)[‡]	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***		**1***		**1***	
	ii. Decreasing β-hCG levels	**2***	**1***	**2***	**1***	**1***		**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***		**1***		**1***	
	iv. Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	**4***	**2***	**4***	**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	(*see also Postpartum [including cesarean delivery]*)	**1**		**1**		**1**		**1**		**1**		**1**	
HIV	a. High risk for HIV	**1***	**1***	**1***	**1***	**1**		**1**		**1**		**1**	
	b. HIV infection					**1***		**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[¶]	**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. [‡]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/.

US SMEC 03


12:52
MENU
CDC Contraception 2024
KEY
Breastfeeding
b. 21 to <30 days postpartum
ii. Without other risk factors for VTE
Method
Category
Details
Init.
Cont.
DMPA
2+
POP
2+
CHCs
3+
Emergency Contraception
Additional Methods
SPR
BACK
HISTORY


1:03
MENU
CDC Contraception 2024
KEY
Clarification
(Breastfeeding): Breastfeeding provides important health benefits for breastfeeding parent and infant. The U.S. Dietary Guidelines for Americans and American Academy of Pediatrics recommend that infants be exclusively breastfed for about the first 6 months with continued breastfeeding while introducing appropriate complementary foods for 1 year or longer or up to age 2 years or longer.
Evidence
(Breastfeeding): Clinical studies demonstrate conflicting results regarding effects on breastfeeding continuation or exclusivity in women exposed to COCs during lactation. No consistent effects on infant growth or illness have been reported. Adverse health outcomes or manifestations of exogenous estrogen in infants exposed to CHCs through breast milk have not been demonstrated; however, studies have been inadequately designed to determine whether a risk for either serious or subtle long-term effects exists.
BACK
HISTORY

How does the rationale for the rating apply to THIS patient?

- How does this patient feel about the potential impact on breastfeeding in comparison to the risk of pregnancy?

- How would you support her decision making in this context?

Case

- A 36 yo woman with history of gastric bypass comes in for contraceptive care. She used oral contraceptive pills in the past and wants to use them again.

How would you counsel her?

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/pregnancy-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.

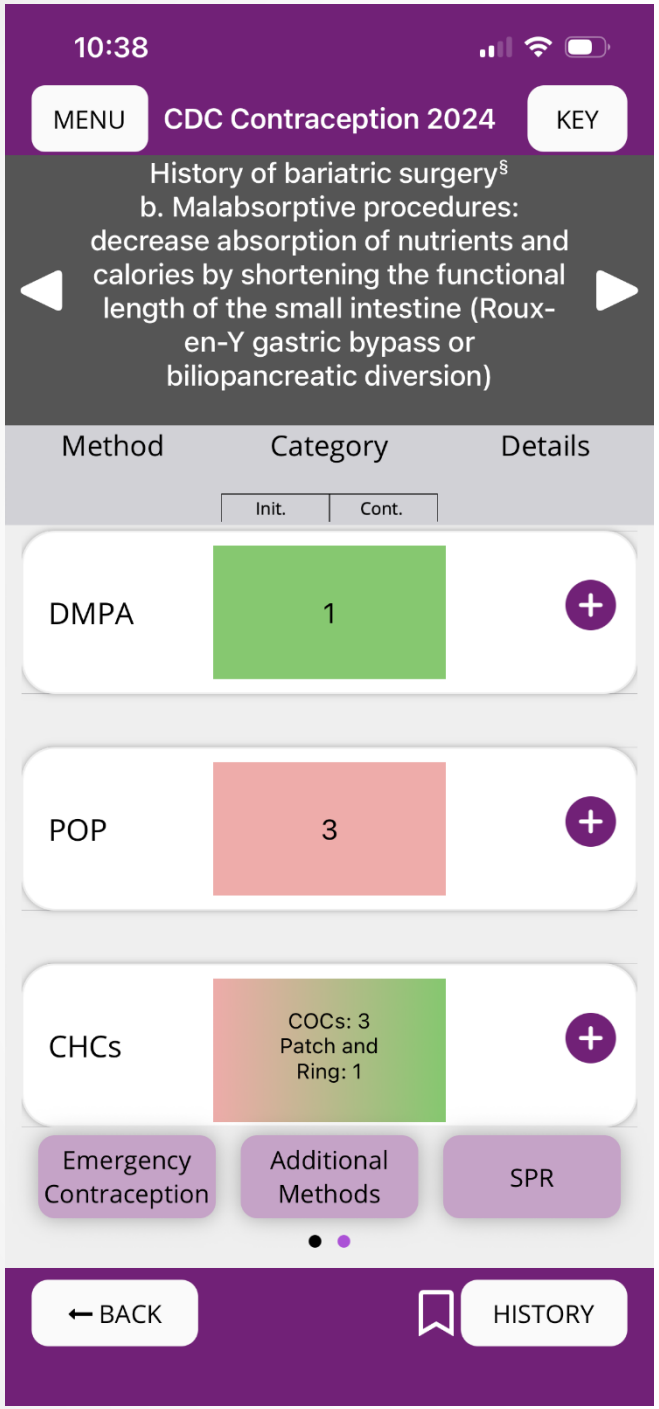
KEY: **1 = No restriction (method can be used)** | **2 = Advantages generally outweigh theoretical or proven risks** | **3 = Theoretical or proven risks usually outweigh the advantages** | **4 = Unacceptable health risk (method not to be used)**

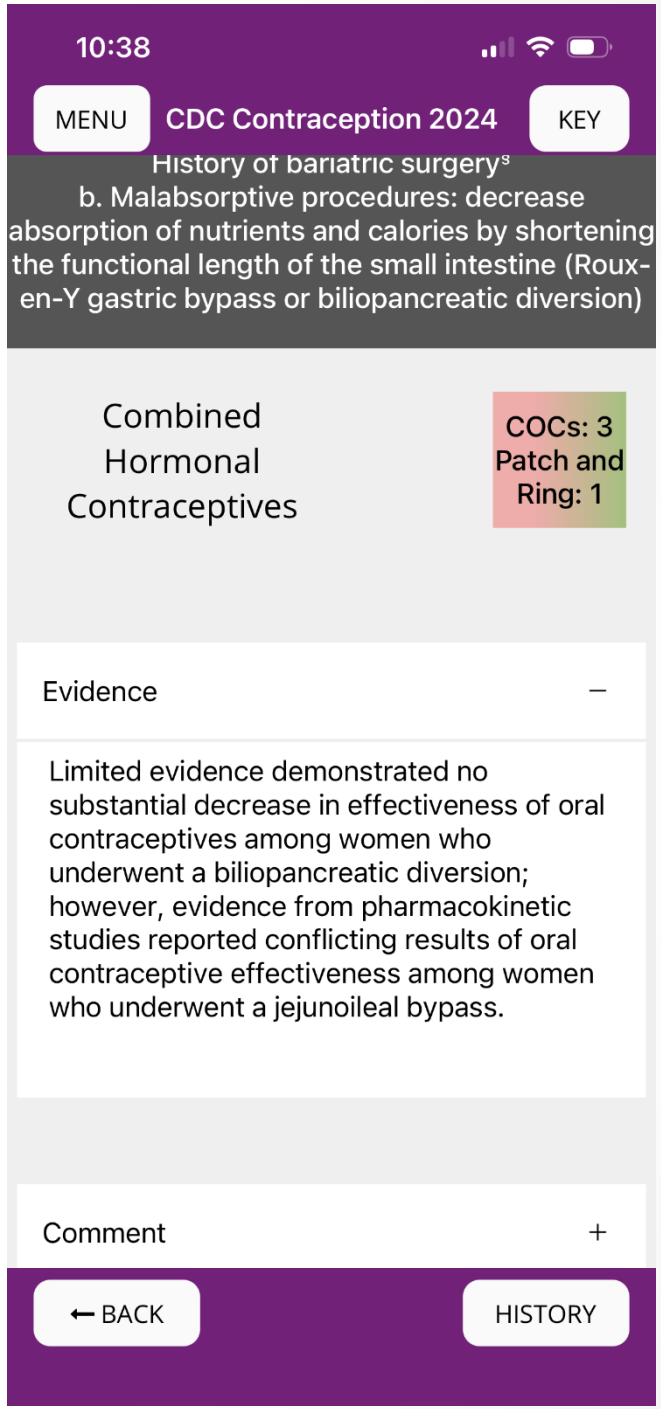
Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs:**2**		Menarche to <20 yrs:**2**		Menarche to <18 yrs:**1**		Menarche to <18 yrs:**2**		Menarche to <18 yrs:**1**		Menarche to <40 yrs:**1**	
		≥20 yrs:**1**		≥20 yrs:**1**		18–45 yrs:**1**		18–45 yrs:**1**		18–45 yrs:**1**		≥40 yrs:**2**	
						>45 yrs:**1**		>45 yrs:**2**		>45 yrs:**1**			
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[2]												
	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***	
	ii. Without other risk factors for VTE					**1***		**1***		**1***		**2***	
	d. >42 days postpartum					**1***		**1***		**1***		**2***	
Cervical cancer	Awaiting treatment	**4**	**2**	**4**	**2**	**2**		**2**		**1**		**2**	
Cervical ectropion		**1**		**1**		**1**		**1**		**1**		**1**	
Cervical intraepithelial neoplasia		**1**		**2**		**2**		**2**		**1**		**2**	
Chronic kidney disease[3]	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**		**1**		**1**	
	b. Decompensated[3] (*impaired liver function*)	**1**		**2**		**2**		**3**		**2**		**4**	
Cystic fibrosis[2]		**1***		**1***		**1***		**2***		**1***		**1***	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)[3]	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**	
	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**	
Depressive disorders		**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[2]	**1**		**2**		**2**		**2**		**2**		**2**	
	c. Nephropathy, retinopathy, or neuropathy[2]	**1**		**2**		**2**		**3**		**2**		**3/4***	
	d. Other vascular disease or diabetes of >20 years' duration[2]	**1**		**2**		**2**		**3**		**2**		**3/4***	
Dysmenorrhea	Severe	**2**		**1**		**1**		**1**		**1**		**1**	
Endometrial cancer[2]		**4**	**2**	**4**	**2**	**1**		**1**		**1**		**1**	
Endometrial hyperplasia		**1**		**1**		**1**		**1**		**1**		**1**	
Endometriosis		**2**		**1**		**1**		**1**		**1**		**1**	
Epilepsy[2]	(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)[2]	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***		**1***		**1***	
	ii. Decreasing β-hCG levels	**2***	**1***	**2***	**1***	**1***		**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***		**1***		**1***	
	iv. Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	**4***	**2***	**4***	**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[2]	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***	**1**		**1**		**1**		**1**	
	b. HIV infection					**1***		**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[1]	**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. [1]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/.

US SMEC-4


10:38
MENU
CDC Contraception 2024
KEY
History of bariatric surgery§
b. Malabsorptive procedures: decrease absorption of nutrients and calories by shortening the functional length of the small intestine (Roux-en-Y gastric bypass or biliopancreatic diversion)
Method
Category
Details
Init.
Cont.
DMPA
1
POP
3
CHCs
COCs: 3
Patch and
Ring: 1
Emergency Contraception
Additional Methods
SPR
BACK
HISTORY


10:38
MENU
CDC Contraception 2024
KEY
History of bariatric surgery§
b. Malabsorptive procedures: decrease absorption of nutrients and calories by shortening the functional length of the small intestine (Roux-en-Y gastric bypass or biliopancreatic diversion)
Combined Hormonal Contraceptives
COCs: 3
Patch and
Ring: 1
Evidence
Limited evidence demonstrated no substantial decrease in effectiveness of oral contraceptives among women who underwent a biliopancreatic diversion; however, evidence from pharmacokinetic studies reported conflicting results of oral contraceptive effectiveness among women who underwent a jejunoileal bypass.
Comment
BACK
HISTORY

How to support patient decision making

- Communicate concern, but lack of definitive evidence, for decreased effectiveness
  - "You already told me if was really important to you to use an effective method. Given this, are you concerned about this potential increased risk?"
  - "If there really was decreased effectiveness, would this affect how interested you are in using pills?"
  - "Given this uncertainty, do you want to talk again about other methods to see if they might be a better fit?

Contraception and Depression

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Depressive disorders		1*		1*		1*		1*		1*		1*	

- Initial recommendation based on systematic review of six studies (1 RCT and 5 cohort studies) of women with bipolar disorder or depression
- Overall poor to fair quality studies

Pagano, *Contraception*, 2016.

Contraception and family planning

Opinion

The pill is linked to depression - and doctors can no longer ignore it

Holly Grigg-Spall

Hormonal contraceptives are used by 3.5 million women in the UK alone. The medical establishment must stop dismissing the risks they carry

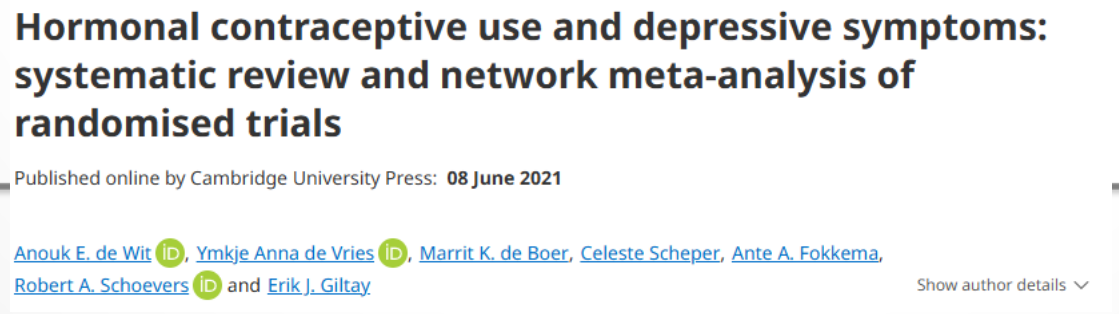
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Monday 3 October 2016 05.00 EDT



What do we know?

- Some biological evidence supporting progestin and estrogen influence on mood
- Danish study showed a relative risk of 1.1-1.3 for depression
  - However, was observational study and therefore prone to confounding
- Subsequent meta-analysis of RCT did not find a difference
- Some subsequent cohort studies have also been in conflict
  - Some indication may be more of a signal for adolescents



Hormonal contraceptive use and depressive symptoms: systematic review and network meta-analysis of randomised trials

Published online by Cambridge University Press: **08 June 2021**

Anouk E. de Wit, Ymkje Anna de Vries, Marrit K. de Boer, Celeste Scheper, Ante A. Fokkema, Robert A. Schoevers and Erik J. Giltay

Show author details

How do we put this all together?

- Data is not definitive. If it is real, the number needed to harm is around 200
- AND - We know that many patients are worried about effects on their mood some women report mood changes with methods
- AND - Research on patients' experiences during counseling documents that many feel their concerns are dismissed without due consideration

- **We need to honor patients' concerns/experiences around mood effects of contraception, acknowledging the lack of definitive data**
- **We can provide reassurance that at worst, few people are impacted**

Hall, AJOG, 2015; Dehlendorf, Contraception, 2013
Schaffir, Eur J Contracept Reprod Health Care, 2016

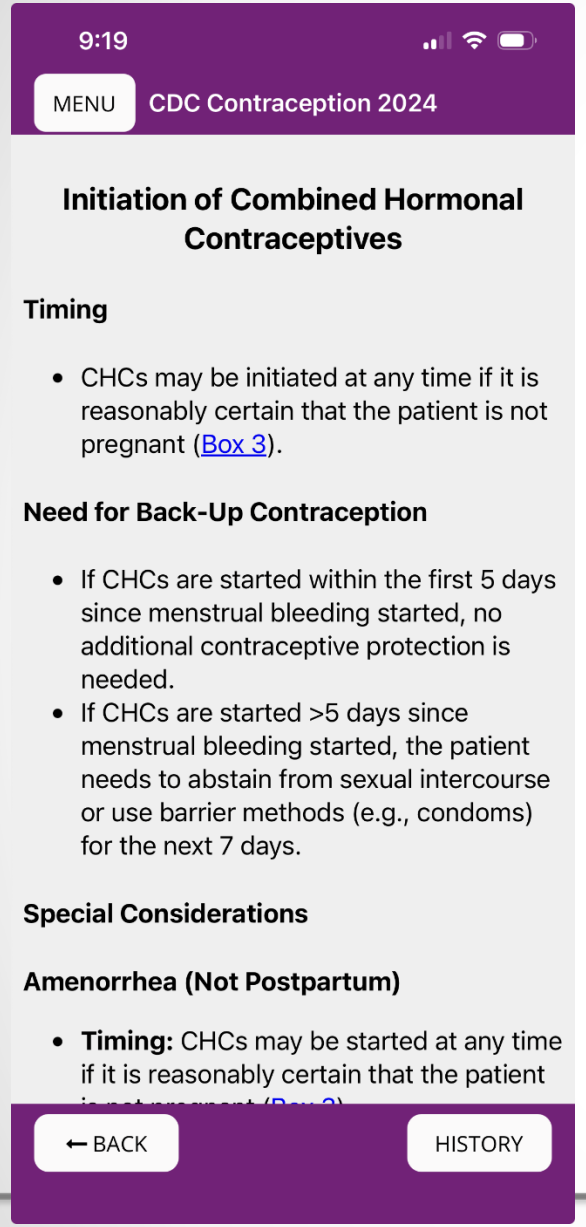
Selected Practice Recommendations

- Timing of method initiation
- How to be “reasonably sure” a patient is not pregnant
- Management of LARC-related bleeding

Case

- A patient comes in to see you requesting a new method of contraception. She had been using DMPA, but she stopped it because she hated the irregular bleeding. Her last shot was six months ago and she had her first normal period 2 weeks ago. She is currently using condoms. After counseling, she chooses to start oral contraceptive pills. She asks you when she should start.

What do you tell her?



Is "Quick Start" always the right answer?

- No data that "quick start" leads to better outcomes
- May increase risk of irregular bleeding
- Need to ensure patient-centered counseling

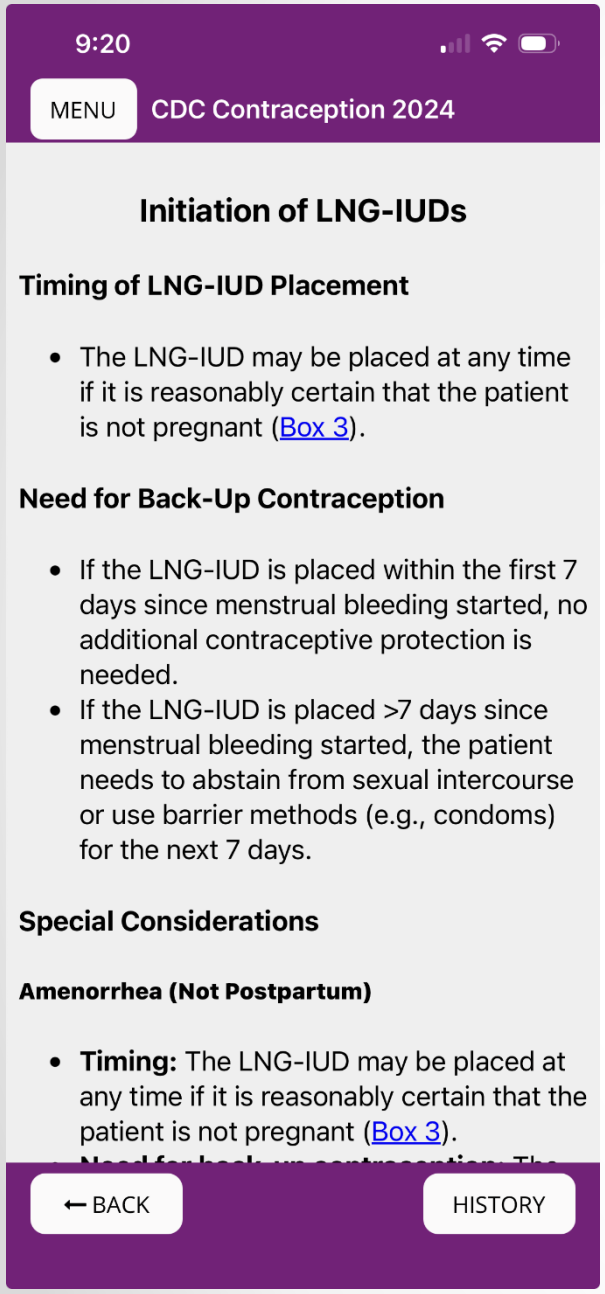
Brahmi, Contraception, 2013

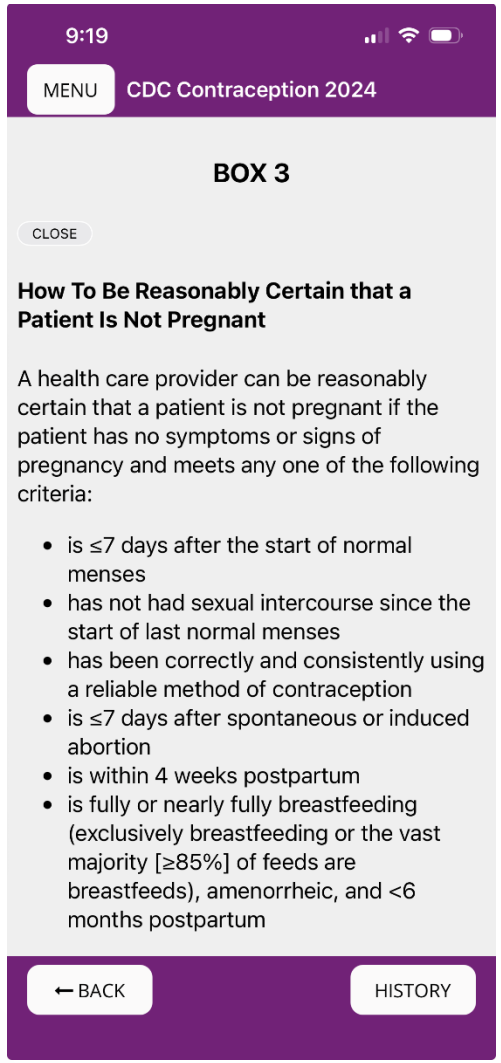
Case

- A 22 year old patient comes in to see you requesting an IUD. Her last period was 3 weeks ago, and she has been using condoms with multiple male partners. Her last STI test was negative six months ago.

Would you put in her IUD today?

What is “Reasonably Certain”?





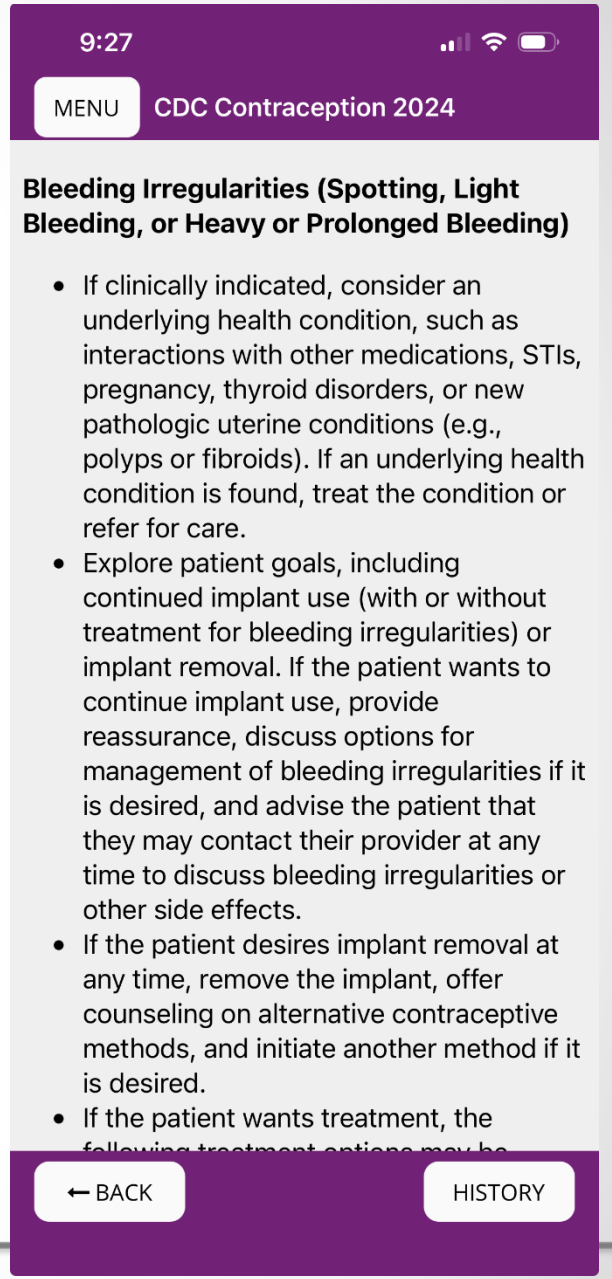
- What is a reliable method?
- Can patients be trusted to report consistency?
- What are the implications of starting contraception in the luteal phase?

Case

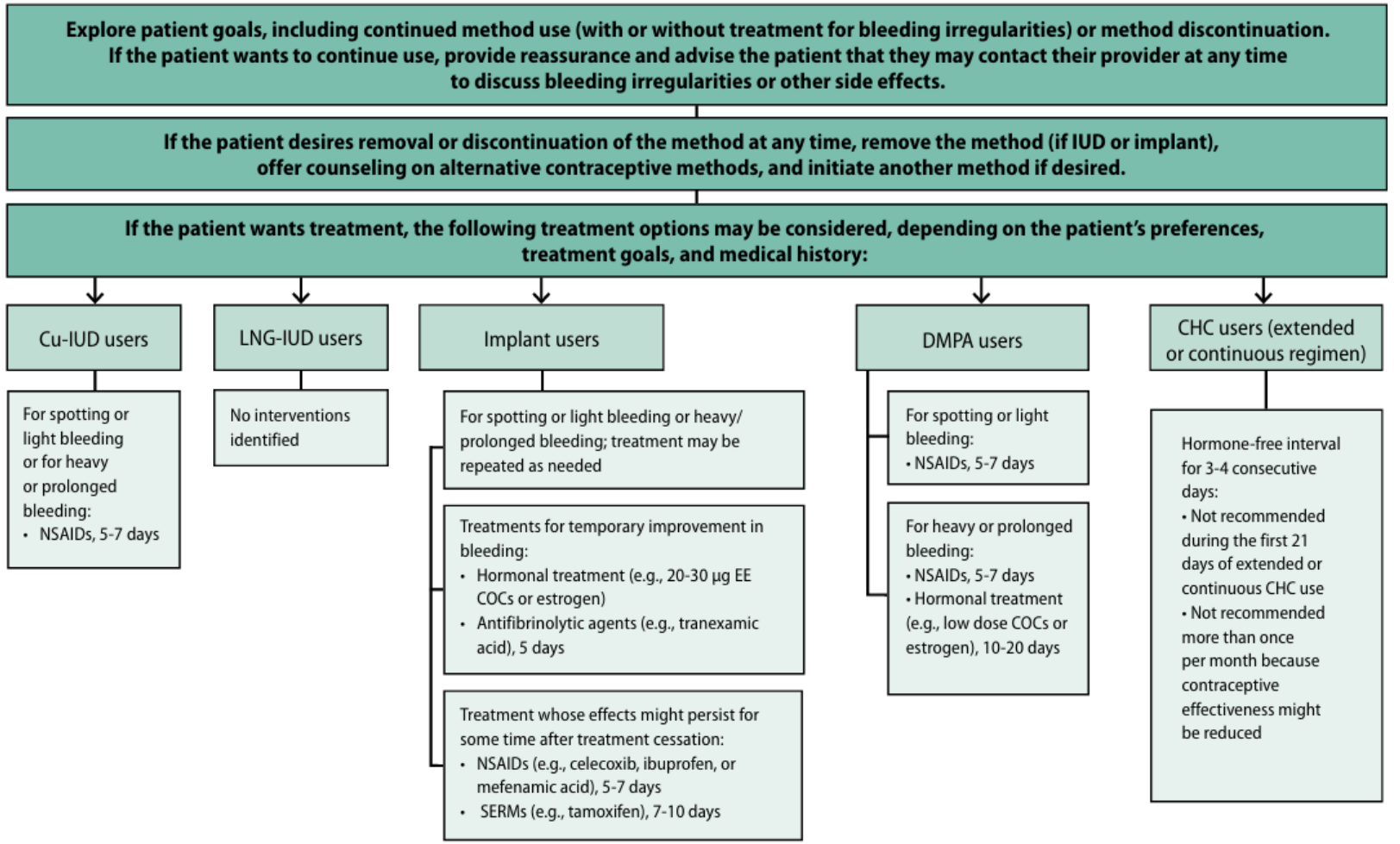
- A 19 yo patient comes back in 4 months after having a contraceptive implant placed. She is dissatisfied with the bleeding and asks to have her implant removed. What would you do?

Points to Consider

- It is ESSENTIAL to ensure patient can have LARC removed when requested. Doing otherwise is a violation of reproductive autonomy.
- Can offer management of bleeding if she is interested.



Management of Bleeding Irregularities While Using Contraception*



Case

- A 27 year old woman comes in for her postpartum visit. She is not breastfeeding because she has to get back to her job at Wendy's. She is not interested in any contraception at this visit either and says she would be open to another pregnancy "if it is meant to happen."

How does your concern about short interpregnancy intervals influence your counseling ?

Would it be different if she was 37?

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

Obstetric Care Consensus | #8

smfm.org

Interpregnancy Care

Check for updates

This document is endorsed by the American College of Nurse-Midwives and the National Association of Nurse Practitioners in Women's Health. This document was developed by the American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine in collaboration with Judette Marie Louis, MD, MPH; Allison Bryant, MD, MPH; Diana Ramos, MD, MPH; Alison Stuebe, MD, MSc; and Sean C. Blackwell, MD

TABLE 1
Interpregnancy Care Recommendations

Recommendation	Grade of Recommendation
Interpregnancy Interval	
Women should be advised to avoid interpregnancy intervals shorter than 6 months.	1B Strong recommendation, moderate-quality evidence
Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months.	2B Weak recommendation, moderate-quality evidence

Possible Responses

1. It wouldn't impact my counseling because the data are not compelling. It's more about socioeconomic confounders (just look at Kate Middleton)
2. I would inform her about the potential risks of short IPI and let her decide
3. I would strongly recommend that she use contraception to avoid pregnancy for at least a year especially since she's young

Points to Consider

- Be aware of the tendency to judge people's reproductive decisions, with particular attention to judgment that may be applied differentially by women's socio-demographic characteristics
- Reproductive autonomy requires that each person receives information about risks and can make her own decision
- Allow patients to balance desire to use or avoid contraception with their feelings/ thoughts about pregnancy (even if not entirely planned)

Conclusion

- Guidelines are essential means to standardize and optimize care
- However, they are not always developed with patient-centeredness in mind, and even when they are the evidence can mean different things to different people
- Providers can use guidelines in a patient-centered way by understanding areas of uncertainty, educating patients, and individualizing their advice

qfpguide.org

Required Filings an... | Strategic Science CT... | Household Employer | UCSF | New Tab | Farmers HOA | The Quality Of Heal... | LARC-Statement-of... | Home - Netflix | mydesktop.sfdph.org | Halogen Software | Jacquie Lawson Gar...

QFP Guide

Explore the QFP | Download the QFP | About the QFP



Providing Quality Family Planning (QFP) Services in the United States

Recommendations of the U.S. Office of Population Affairs (Revised 2024)

Get Started ›

Search the QFP for key topics...

The **QFP** is for any and **all health care providers** who care for patients of reproductive age. QFP provides information on the following topics:

- Fundamentals of Sexual and Reproductive Health Care Delivery
- Determining an Individual's Need and Desire for Services
- Person-Centered Contraceptive Care Delivery
- STI and HIV Services
- Family Building

Considering Other Guidelines

- A 21 yo G0P0 presents to the family planning clinic requesting a DMPA shot. She has been on this method for five years.

How would you counsel this patient?

FDA 2004 Black Box Warning

WARNING: LOSS OF BONE MINERAL DENSITY

See full prescribing information for complete boxed warning.

- **Women who use Depo-Provera Contraceptive Injection may lose significant bone mineral density. Bone loss is greater with increasing duration of use and may not be completely reversible. (5.1)**
- **It is unknown if use of Depo-Provera Contraceptive Injection during adolescence or early adulthood, a critical period of bone accretion, will reduce peak bone mass and increase the risk for osteoporotic fracture in later life. (5.1)**
- **Depo-Provera Contraceptive Injection should not be used as a long-term birth control method (i.e., longer than 2 years) unless other birth control methods are considered inadequate. (5.1)**

Should you limit Depo use to 2 years?

- No evidence of increased future fracture or osteoporosis risk
- BMD loss temporary, recovers after discontinuation
- May want to consider not continuing into menopause, to allow time for bone to recover

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 602 • June 2014
(Reaffirmed 2019)

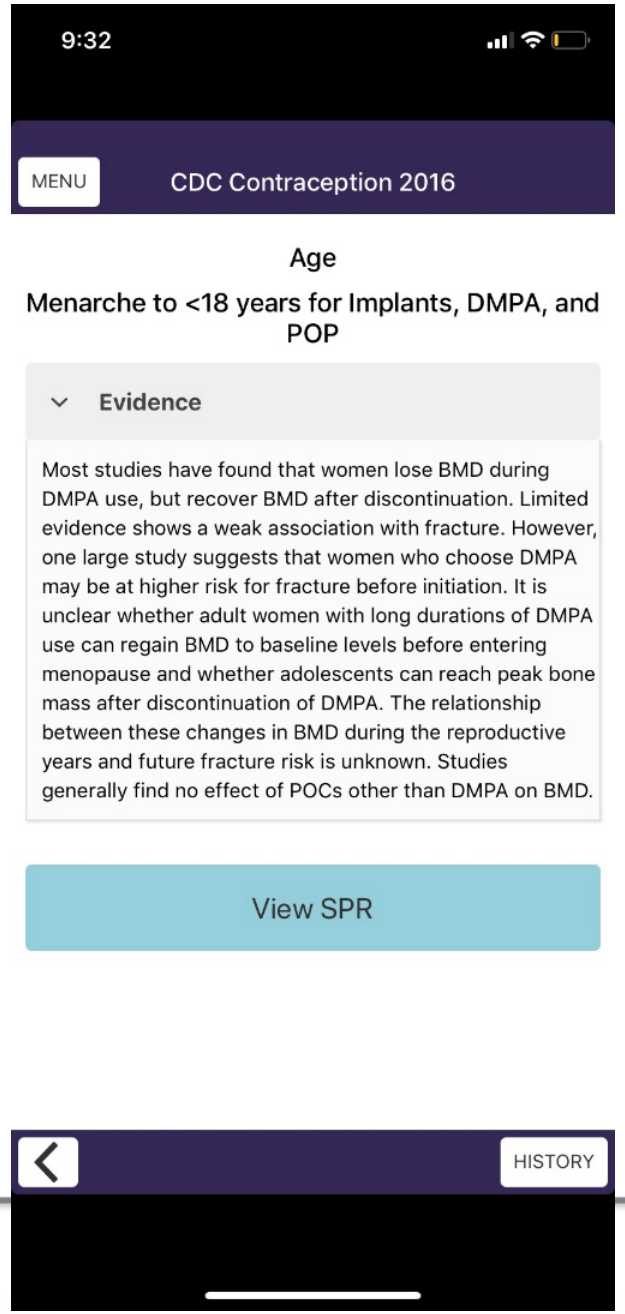
(Replaces Committee Opinion Number 415, September 2008)

ABSTRACT: Depot medroxyprogesterone acetate (DMPA) is a highly effective injectable contraceptive that affords privacy and has a convenient dose schedule of four times per year, making it appealing to many users, especially adolescents. Although the use of DMPA is associated with loss of bone mineral density (BMD), current

The effect of DMPA on BMD and potential fracture risk should not prevent practitioners from prescribing DMPA or continuing use beyond two years.

prescribing DMPA or continuing use beyond 2 years. The potential health risks associated with the bone effects of DMPA must be balanced against a woman's likelihood of pregnancy using other methods or no method, and the known negative health and social consequences associated with unintended pregnancy, particularly among

Health care providers should inform women and adolescents….about the benefits and risk of DMPA and use clinical judgment to assess appropriateness of use.


9:32
MENU
CDC Contraception 2016
Age
Menarche to <18 years for Implants, DMPA, and POP
Evidence
Most studies have found that women lose BMD during DMPA use, but recover BMD after discontinuation. Limited evidence shows a weak association with fracture. However, one large study suggests that women who choose DMPA may be at higher risk for fracture before initiation. It is unclear whether adult women with long durations of DMPA use can regain BMD to baseline levels before entering menopause and whether adolescents can reach peak bone mass after discontinuation of DMPA. The relationship between these changes in BMD during the reproductive years and future fracture risk is unknown. Studies generally find no effect of POCs other than DMPA on BMD.
View SPR
HISTORY

Case

- A 24 yo G2P2 single woman is requesting an interval sterilization procedure. She says that she "has her boy and her girl" and does not want any more children.

How would you respond?

Possible Responses

1. Warn her that young women often regret getting sterilized once they're older, so a reversible method would probably be better for her
2. Tell her that she might find a new male partner and want to have children with him, so a reversible method would probably be better for her
3. Encourage her to think about how sterilization fits into the context of her own life compared to other methods
4. Options 1 & 2

Points to Consider

- Provider concern about future regret may drive counseling around sterilization
  - Tendency to use demographic characteristics to predict long-term regret ("statistical risk counseling")
  - Divert conversation to LARC methods instead

- Women often perceive that providers try to dissuade them from sterilization and feel that this undermines their autonomy and their choices

Lawrence: *Human Reprod*, 2011
Borrero: *J Gen Intern Med*, 2009

Points to Consider

- Goal is to ensure that women are knowledgeable and informed of risks and benefits *at the time of her decision*, with the understanding that eliminating entirely the risk of regret is not possible

- Clear understanding about the permanence of sterilization and alternative options has been linked to less future regret

Allyn: *J Reprod Med*, 1986
Moseman: *Contraception*, 2006