CLINICAL REVIEW

Providing Quality Family Planning Services: Review of recommendations of the Centers for Disease Control (CDC) and the US Office of Population Affairs

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Over the last decade, the Center for Disease Control (CDC) has issued three guidelines to assist health care providers of family planning to better address the needs of reproductive age women: USMEC (United States Medical Eligibility Criteria for Contraceptive use), USSPR (US Selected Practice Recommendations for Contraceptive Use), and QFPR (Quality Family Planning Recommendations). The USMEC provides guidance on who can use various methods of contraception based on individual medical history and other factors. The USSPR provides guidance on how contraceptive methods can be used and how to remove barriers to successful use. The QFPR provides recommendations on how to provide quality family planning services (contraceptive services, pregnancy testing and counseling, helping women achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services). The QFPR report was developed collaboratively by the CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). This paper serves as a review of the QFP recommendations.

QFP recommendations for contraceptive services

Unintended pregnancy continues to be frequent in the U.S. population, where about half of the 6.6 million pregnancies each year are unintended.[1] The rates of unintended pregnancy are highest among the young, the poor, and minority women.[2] Only 5% of unintended pregnancies happen in women who use contraception consistently and correctly. Family planning services can help address this public health challenge by providing education, counseling, and medical services.[3]

To assist a woman who is initiating contraception or switching to a new method of contraception, the CDC recommends a systematic, step-wise approach where providers should follow five key steps, in accordance with the five principles of quality counseling.[4]

All patients should receive quality provision of contraceptive services in a non-judgemental manner, including those who identify as gay, lesbian, or transgender, as well as those with disabilities or English language barriers.

Steps in providing contraceptive services, including contraceptive counseling and education
• Establish and maintain rapport with the patient. • Obtain clinical and social information from the patient. • Work with the patient interactively to select the most effective and appropriate contraceptive method. • Conduct a physical assessment related to contraceptive use only when warranted. • Provide the contraceptive method along with instructions about correct and consistent use, help the patient develop a plan for using the selected method and for follow up, and confirm patient understanding.

Step 1: Establish and maintain rapport

Family planning is a sensitive issue for many patients; therefore, establishing and maintaining rapport between the patient and the provider is critical. The CDC recommends the following strategies: ask open-ended questions; demonstrate expertise, trustworthiness, and accessibility; ensure privacy and confidentiality; explain how personal information will be used; encourage the patient to ask questions and share information; listen to and observe the patient; be encouraging; and demonstrate empathy and acceptance.

Step 2: Obtain clinical and social information

Health care providers should use a patient-centered approach and personalize contraceptive recommendations. They should ask patients about their medical history in order to identify contraceptive methods that are safe for each individual patient. They should also ask the patients about specific pregnancy intentions/reproductive life plan, as well as about contraceptive experiences and preferences, and conduct a sexual health assessment.

Medical history: A medical history should be taken to ensure that methods of contraception being considered are safe according to the USMEC.[5]

For a female patient, the medical history should include menstrual history (last menstrual period, menstrual frequency, length and amount of bleeding, and other patterns of uterine/vaginal bleeding), gynecologic and obstetrical history, contraceptive use, allergies, recent intercourse, recent delivery, miscarriage, or termination, any relevant infectious or chronic health condition, and other characteristics and exposures (i.e., age, tobacco use, postpartum, breastfeeding, etc.) that might affect the medical eligibility criteria for contraceptive methods.

For a male patient, a medical history should include use of condoms; known allergies to condoms; partner use of contraception; recent intercourse; whether his partner is currently pregnant, has had a child, miscarriage, or termination; and the presence of any infectious or chronic health condition.

Pregnancy intention or reproductive life plan: Patients should be asked about their reproductive life plan: if they want to have any/more children and the desired timing and spacing of those children.

Contraceptive experiences and preferences: Method-specific experiences and preferences should be assessed by asking questions such as:

- What method(s) are you currently using, if any?
- What methods have you used in the past?
- Have you previously used emergency contraception?
- Did you use contraception at last sex?
- What difficulties did you experience with prior methods, if any?
- Do you have a specific method in mind?
- Have you discussed method options with your partner and does your partner have any preferences for which method you use?

Sexual health assessment: A sexual history and risk assessment is recommended using CDC guidelines. Correct and consistent condom use is recommended for those at-risk for STDs.[6]

Steps in conducting a sexual health assessment

- **Practices:** Ask about types of sexual activity in which the patient engages (vaginal, anal, or oral sex).
- **Pregnancy prevention:** Ask about current and future contraceptive options, previous use of methods, use of contraception at last sex, difficulties with contraception, and if patient has a particular method in mind.
- **Partners:** Ask questions to determine the number, gender (men, women, or both), and concurrency of the patient's sex partners. It might be necessary to define the term "partner" to the patient.
- **Protection from sexually transmitted diseases:** Ask about condom use, with whom they do or do not use condoms, and situations that make it harder or easier to use condoms. Discuss monogamy and abstinence.
- **Past STD history:** Ask about any personal history of STDs, and if their partners have ever had an STD. Explain that the likelihood of an STD is higher with a past history of an STD.

<u>Step 3</u>: Work interactively with the patient to select the most effective and appropriate contraceptive method.

Providers should educate the patient about contraceptive methods and help the patient consider potential barriers to using the methods. The CDC recommends a tiered approach, presenting information on the most effective methods first, before presenting information on less effective methods, including an explanation that long-acting reversible contraceptive methods are safe and effective for most women, including those who have never given birth and adolescents. Information should be tailored and presented to ensure a patient-centered approach. If not all methods are available at the service site, it is important to have referral links in place to maximize opportunities for patients to obtain their preferred method.

For patients who have completed childbearing or do not plan to have children, permanent sterilization (female or male) should be discussed. Women and men should be counseled that these procedures are not intended to be reversible and that other highly effective, reversible methods of contraception like implants or IUDs might be an alternative if they are unsure about future childbearing.

When educating patients about contraceptive methods, providers should ensure that patients understand the following:

Method effectiveness: Percentage of women experiencing an unintended pregnancy during the first year of typical use.

Correct use of the method. The mode of administration and understanding how to use the method correctly are important considerations for the patient when choosing a method. For example, receiving a contraceptive injection every 3 months might not be acceptable to a woman who fears injections.

Noncontraceptive benefits. Many contraceptives have noncontraceptive benefits, in addition to preventing pregnancy, such as reducing heavy menstrual bleeding. Although the noncontraceptive benefits are not the major determinant for selecting a method, awareness of these benefits can help patients decide between methods and may make it more likely to use the method correctly and consistently.

Side effects. Providers should inform the patient about risks and side effects of contraceptive methods and help the patient understand that certain side effects might disappear over time. They should encourage the patient to weigh the experience of coping with side effects against the experience of an unintended pregnancy. Providers should discuss and correct misperceptions about side effects and should educate about warning signs for rare but serious adverse events with specific contraceptive methods (such as venous thromboembolism with use of combined hormonal methods).

Protection from STDs. Patients should be informed that contraceptive methods, other than condoms, offer no protection

against STDs, including HIV. Dual protection from both pregnancy and STDs can be achieved through correct and consistent use of condoms with every act of sexual intercourse, or correct and consistent use of a condom, to prevent infection plus another form of contraception to prevent pregnancy.

Providers should relay information that is medically accurate, balanced, and provided in a nonjudgmental manner that can be readily understood and retained. Providers should encourage partner communication about contraception, as well as understanding partner barriers (such as misperceptions about side effects) of contraceptive use.

When working with male patients, when appropriate, providers should discuss information about female-controlled methods (including emergency contraception), encourage discussion of contraception with partners, and provide information about how partners can access contraceptive services. They should also be reminded that condoms should be used correctly and consistently to reduce risk of STDs, including HIV.

Social-behavioral factors. Social-behavioral factors influence the likelihood of correct and consistent use of contraception. Providers should help the patient consider the advantages and disadvantages of the method(s) being considered, the patient's feelings about using the method(s), how her/his partner is likely to respond, their peers' perceptions of the method(s), and their confidence in being able to use the method correctly and consistently, like using a condom during every act of intercourse or remembering to take a pill every day.

Intimate partner violence and sexual violence. Current and past intimate partner sexual or domestic violence might impede the correct and consistent use of contraception and might be a consideration when choosing a method. For example, an IUD might be preferred because it does not require the partner's participation. The medical history might provide information on signs of current or past violence, and providers should ask about relationship issues that might be potential barriers to contraceptive use. Patients experiencing intimate partner domestic violence or sexual violence should be referred for appropriate care.

Mental health and substance use behaviors. Mental health disorders (depression, anxiety, etc.) and substance use (alcohol, prescription drug abuse, and illicit drug use) might affect a patient's ability to correctly and consistently use contraception. Providers should ask patients about substance use behaviors or mental health disorders that might interfere with their motivation or ability to follow through with contraceptive use. Patients with mental health disorders or substance use behaviors should be referred for appropriate care.

***Step 4:* Conduct a physical assessment related to contraceptive use, when warranted.**

Most women will need no or few examinations or laboratory tests before starting a method of contraception. Guidance on necessary examinations and tests related to initiation of contraception is available in the CDC's Selective Practice Recommendations (SPR),[7] which recommends specific assessments that need to be conducted when providing contraceptive services to females seeking reversible contraception. Clinical evaluation of a patient electing permanent sterilization should be guided by the clinician who performs the procedure.

Blood pressure should be taken before initiating the use of combined hormonal contraception.

Providers should assess the current pregnancy status of a patient receiving contraception by using the following criteria to rule out pregnancy:[7]

- The patient is ≤7 days after the start of normal menses or after spontaneous/induced abortion;
- The patient has not had sexual intercourse since the start of last normal menses or has been using a reliable method of contraception correctly and consistently;
- The patient is within 4 weeks postpartum; and
- The patient is fully or nearly fully breastfeeding (exclusively breastfeeding or ≥85% of feeds are breastfeeds), amenorrheic, and <6 months postpartum.

Weight measurement is **not** needed to determine medical eligibility for any method of contraception. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

Unnecessary medical procedures and tests might create logistical, emotional, or economic barriers to contraceptive access for some women, particularly adolescents and low-income women who have the highest rates of unintended pregnancies. For both adolescent and adult women, the following examinations and tests are **not** needed routinely to provide contraception safely to a healthy patient (although they might be needed to address other non-contraceptive health needs): pelvic examinations, unless inserting an intrauterine device (IUD) or fitting a diaphragm; and cervical cytology or other cancer screening, including clinical breast exam, HIV screening and laboratory tests (lipids, glucose, liver enzyme, hemoglobin levels, or thrombogenic mutations).

For male patients, no physical examination needs to be performed before distributing condoms.

***Step 5:* Provide the contraceptive method along with instructions about correct and consistent use, help the patient develop a plan for using the selected method and for follow-up, and confirm patient understanding.**

Onsite dispensing is ideal. Contraception should be initiated right away rather than waiting for the next menses (also known as "quick start") if the provider can reasonably be certain that the woman is not pregnant by using the criteria described above. Ideally, a full year's supply should be dispensed/prescribed in order to minimize the number of times a patient has to return to the service site. If a patient chooses a method that is not available on-site or the same day, the provider should counsel the use of another method until the chosen method can be started. Advance provision of emergency contraception is recommended.

Providers should help the patient develop a plan for using the selected method. They should help patients anticipate reasons why they might not use their chosen method(s) correctly or consistently and help them develop strategies to deal with these possibilities. For example, for a patient selecting oral contraceptives who might forget to take the pill, the provider can counsel the use of reminder systems such as daily text messages or cell phone alarms.

Side effects are the primary reason for method discontinuation, so providers should discuss ways to deal with potential side effects to increase satisfaction with the method and improve continuation.

Providers should discuss an appropriate follow-up plan, which will reinforce the perceived accessibility of the provider and increase rapport. Alternative modes of follow-up other than visits to the service site, such as telephone, e-mail, or text messaging should be considered, if needed.

Providers should assess whether the patient understands the information that was presented and then document it in the medical record. The teach-back method may be used by asking the patient to repeat back messages about typical method effectiveness: how to use the method correctly; protection from STDs; warning signs for rare, but serious, adverse events; what to do if they experience a warning sign; and when to return for follow-up.

Counseling returning patients

Providers should ask if there are any concerns with the method and assess its use. They should also assess any changes in the medical history, including changes in risk factors and medications that might affect safe use of the contraceptive method. If the patient is using the method correctly and consistently and there are no concerns about continued use, an appropriate follow-up plan should be discussed and more contraceptive supplies given/prescribed. If there are concerns about the patient's correct or consistent use of the method, the provider should present alternative methods of contraception.

Counseling adolescents

Providers should give comprehensive information to adolescents about how to prevent pregnancy. This information should clarify that abstinence is an effective way to prevent pregnancy and STDs. If the adolescent indicates that she or he will be sexually active, providers should give information about contraception and help her or him to choose a method that best meets her or his individual needs, including the use of condoms to reduce the risk of STDs. Long-acting reversible contraception is a safe and effective option for many adolescents, including those who have not been pregnant or given birth.

Providers should offer confidential services to adolescents and observe all relevant state laws and any legal obligations, such as notification or reporting of child abuse; child molestation; sexual abuse, rape, or incest; as well as human trafficking. Confidentiality is critical for adolescents and can greatly influence their willingness to access and use contraceptive services. Providers should encourage and promote communication between the adolescent and his/her parents or guardians about sexual and reproductive health. Educational materials and programs can be provided and joint discussions can address family values and expectations about dating, relationships, and sexual behavior. Services for adolescents should be provided in a "youth-friendly" manner, making sure they are accessible, acceptable, age-appropriate, and comprehensive.

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Submitted July 6, 2016