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Canadian Contraception Consensus (Part 1 of 4)

This clinical practice guideline has been prepared by the Contraception Consensus Working Group, reviewed by the Family Physicians Advisory, Aboriginal Health Initiative, Clinical Practice – Gynaecology, and Canadian Paediatric and Adolescent Gynaecology and Obstetrics (CANPAGO) Committees, and approved by the Executive and Board of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To provide guidelines for health care providers on the use of contraceptive methods to prevent pregnancy and on the promotion of healthy sexuality.

Outcomes: Guidance for Canadian practitioners on overall effectiveness, mechanism of action, indications, contraindications, non-contraceptive benefits, side effects and risks, and initiation of cited contraceptive methods; family planning in the context of sexual health and general well-being; contraceptive counselling methods; and access to and availability of cited contraceptive methods in Canada.

Evidence: Published literature was retrieved through searches of Medline and The Cochrane Database from January 1994 to January 2015 using appropriate controlled vocabulary (e.g., contraception, sexuality, sexual health) and key words (e.g., contraception, family planning, hormonal contraception, emergency contraception). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies published in English from January 1994 to January 2015. Searches were updated on a regular basis and incorporated in the guideline to June 2015. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

Values: The quality of the evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table 1).

Key Words: contraception, family planning, hormonal contraception, emergency contraception, barrier contraceptive methods, contraceptive sponge, spermicide, natural family planning methods, tubal ligation, vasectomy, permanent contraception, intrauterine contraception, counselling, statistics, health policy, Canada, sexuality, sexual health, sexually transmitted infection (STI)

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Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207–8.

Chapter 1: Contraception in Canada

Summary Statements

1. Canadian women spend a significant portion of their lives at risk of an unintended pregnancy. (II-2)
2. Effective contraceptive methods are underutilized in Canada, particularly among vulnerable populations. (II-2)
3. Long-acting reversible contraceptive methods, including contraceptive implants and intrauterine contraception (copper-releasing and levonorgestrel-releasing devices/systems), are the most effective reversible contraceptive methods and have the highest continuation rates. (II-1)
4. Canada currently does not collect reliable data to determine the use of contraceptive methods, abortion rates, and the prevalence of unintended pregnancy among reproductive-age women. (II-2)
5. A universal subsidy for contraceptive methods as provided by many of Canada's peer nations and a few Canadian provinces may produce health system cost-savings. (II-2)
6. Health Canada approval processes for contraceptives have been less efficient than those of other drug approval agencies and Health Canada processes for other classes of pharmaceuticals. (II-2)
7. It is feasible and safe for contraceptives and family planning services to be provided by appropriately trained allied health professionals such as midwives, registered nurses, nurse practitioners, and pharmacists. (II-2)

Recommendations

1. Contraceptive counselling should include a discussion of typical use failure rates and the importance of using the contraceptive method consistently and correctly in order to avoid pregnancy. (II-2A)
2. Women seeking contraception should be counselled on the wide range of effective methods of contraception available, including long-acting reversible contraceptive methods (LARCs). LARCs are the most effective methods of reversible contraception, have high continuation rates, and should be considered when presenting contraceptive options to any woman of reproductive age. (II-2A)
3. Family planning counselling should include counselling on the decline of fertility associated with increasing female age. (III-A)
4. Health policy supporting a universal contraception subsidy and strategies to promote the uptake of highly effective methods as cost-saving measures that improve health and health equity should be considered by Canadian health decision makers. (III-B)
5. Canadian health jurisdictions should consider expanding the scope of practice of other trained professionals such as nurses, nurse practitioners, midwives, and pharmacists and promoting task-sharing in family planning. (II-2B)
6. The Canadian Community Health Survey should include adequate reproductive health indicators in order for health care providers and policy makers to make appropriate decisions regarding reproductive health policies and services in Canada. (III-B)
7. Health Canada processes and policies should be reviewed to ensure a wide range of modern contraceptive methods are available to Canadian women. (III-B)

Chapter 2: Contraceptive Care and Access

Summary Statements

8. Although there are many contraceptive options in Canada, only a narrow range of contraceptive methods are commonly used by those of reproductive age. (II-3)

9. Condom use decreases with longer relationship tenure and the perception of one sexual partner as primary, likely due to a lower perceived risk of sexually transmitted infection in that relationship. Condom use may also decrease markedly as an unintended consequence when an effective non-barrier method, such as hormonal contraception or intrauterine contraception, is initiated. (II-3)
10. Family planning counselling provides a natural segue into screening for concerns about sexual function or intimate partner violence. (III)
11. Well-informed and well-motivated individuals who have developed skills to practise safer sex behaviours are more likely to use contraceptive and safer sex methods effectively and consistently. (II-2)

Recommendations

8. Comprehensive family planning services, including abortion services, should be accessible to all Canadians regardless of geographic location. These services should be confidential, non-judgemental, and respectful of individuals' privacy and cultural contexts. (III-A)
9. A contraceptive visit should include history taking, screening for contraindications, dispensing or prescribing a method of contraception, and exploring contraceptive choice and adherence in the broader context of the individual's sexual behaviour, reproductive health risk, social circumstances, and relevant belief systems. (III-B)
10. Health care providers should provide practical information on the wide range of contraceptive options and their potential non-contraceptive benefits and assist women and their partners in determining the best user-method fit. (III-B)
11. Health care providers should assist women and men in developing the skills necessary to negotiate the use of contraception and the correct and consistent use of a chosen method. (III-B)
12. Contraceptive care should include discussion and management of the risk of sexually transmitted infection, including appropriate recommendations for condom use and dual protection, STI screening, post-exposure prophylaxis, and Hepatitis B and human papillomavirus vaccination. (III-B)

ABBREVIATIONS

BMI	body mass index
CCHS	Canadian Community Health Survey
EC	emergency contraception
IUD	intrauterine device
LARC	long-acting reversible contraceptive
LH	luteinizing hormone
LNG	levonorgestral
NIHB	non-insured health benefits
RCT	randomized control trial
STI	sexually transmitted infection
UPA	ulipristal acetate
UPI	unprotected intercourse
WHO	World Health Organization

13. Health care providers should emphasize the use of condoms not only for protection against sexually transmitted infection, but also as a back-up method when adherence to a hormonal contraceptive may be suboptimal. (I-A)
14. Health care providers should be aware of current media controversies in reproductive health and acquire relevant evidence-based information that can be briefly and directly communicated to their patients. (III-B)
15. Referral resources for intimate partner violence, sexually transmitted infections, sexual dysfunction, induced abortion services, and child protection services should be available to help clinicians provide contraceptive care in the broader context of women's health. (III-B)

Chapter 3: Emergency Contraception

Summary Statements

12. The copper intrauterine device is the most effective method of emergency contraception. (II-2)
13. A copper intrauterine device can be used for emergency contraception up to 7 days after unprotected intercourse provided that pregnancy has been ruled out and there are no other contraindications to its insertion. (II-2)
14. Levonorgestrel emergency contraception is effective up to 5 days (120 hours) after intercourse; its effectiveness decreases as the time between unprotected intercourse and ingestion increases. (II-2)
15. Ulipristal acetate for emergency contraception is more effective than levonorgestrel emergency contraception up to 5 days after unprotected intercourse. This difference in effectiveness is more pronounced as the time from unprotected intercourse increases, especially after 72 hours. (I)
16. Hormonal emergency contraception (levonorgestrel emergency contraception and ulipristal acetate for emergency contraception) is not effective if taken on the day of ovulation or after ovulation. (II-2)
17. Levonorgestrel emergency contraception may be less effective in women with a body mass index > 25 kg/m^2 and ulipristal acetate for emergency contraception may be less effective in women with a body mass index ≥ 35 kg/m^2. However, hormonal emergency contraception may still retain some effectiveness regardless of a woman's body weight or body mass index. (II-2)
18. Hormonal emergency contraception is associated with higher failure rates when women continue to have subsequent unprotected intercourse. (II-2)
19. Hormonal contraception can be initiated the day of or the day following the use of levonorgestrel emergency contraception, with back-up contraception used for the first 7 days. (III)
20. Hormonal contraception can be initiated 5 days following the use of ulipristal acetate for emergency contraception, with back-up contraception used for the first 14 days. (III)

Recommendations

16. All emergency contraception should be initiated as soon as possible after unprotected intercourse. (II-2A)
17. Women should be informed that the copper intrauterine device (IUD) is the most effective method of emergency contraception and can be used by any woman with no contraindications to IUD use. (II-3A)

18. Health care providers should not discourage the use of hormonal emergency contraception (EC) on the basis of a woman's body mass index (BMI). The copper intrauterine device for EC should be recommended for women with a BMI > 30 kg/m^2 who seek EC. If access and cost allow, ulipristal acetate for EC should be the first choice offered to women with a BMI ≥ 25 kg/m^2 who prefer hormonal EC. (II-2B)
19. Health care providers should discuss a plan for ongoing contraception with women who use pills for emergency contraception (EC) and should provide appropriate methods if desired. Hormonal contraception should be started within 24 hours of taking levonorgestrel for EC, and back-up contraception or abstinence should be used for the first 7 days after starting hormonal contraception. (III-B) Women who use UPA-EC should start hormonal contraception 5 days after using UPA-EC. UPA-EC users must use back-up contraception or abstinence for the first 5 days after taking UPA-EC and then for the first 14 days after starting hormonal contraception. (III-B)
20. Ulipristal acetate and levonorgestrel should not be used together for emergency contraception. (III-B)
21. A pregnancy test should be conducted if the woman has no menstrual period within 21 days of using pills or inserting a copper intrauterine device for emergency contraception. (III-A)
22. Health services should be developed to allow Canadian women to have timely access to all effective methods of emergency contraception. (III-B)

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