Person-Centered Contraception Counseling for Family PACT Clients Webinar Q&A October 19, 2022

Wording and Explanations

1. **I do contraceptive counseling with teenagers, and I do not think they would understand "Are you having sex that could get you pregnant?" Is there another way to phrase that question? Or do you recommend asking the sex of their partners?**

   Answer: Especially with teens, you may already know the answer to the partner(s) question, especially if you have done a **strengths, school, home, activities, drugs, emotions/eating, sexuality, safety (SSHADDESS)** and **home, education/employment, peer group activities, drugs, sexuality, and suicide/depression (HEADSS)** assessment prior to asking the **parenting/pregnancy attitudes, timing, how important (PATH)** questions. Some alternative language from the CDC 5Ps (partners, practices, protection from sexually transmitted infections (STIs), past history of STIs, pregnancy intention) for asking about sexual partner/practices:

   "Are you currently having sex of any kind—oral, vaginal, or anal— with anyone? (Are you having sex?)"

   "What parts of your body (and your partner's body) are involved when you have sex?"

   Some youth will also use the term "PIV" for penis in vagina as a way to indicate they have having penetrative vaginal sex.

2. **How would you explain using withdrawal correctly?**

   Answer: Please review the webinar/transcript, as this was discussed during the webinar.

3. **How do you start this conversation with preteens?**

   Answer: Even though most preteens are not sexually active, many have questions about their bodies and/or sexuality. Open ended language like *"I'm available to talk about changes happening with your body."* Also, modeling consent during physical exams is important. A discussion about confidentiality, its limits, and mandated reporting is critical.

4. **How do you suggest we discuss family planning with the trans population we care for?**

   Answer: The PATH questions and the contraceptive counseling framework discussed are recommended for trans and non-binary clients. For specific resources on family planning services for trans and gender diverse clients, see the following Society for Family Planning recommendations: https://www.contraceptionjournal.org/article/S0010-7824(20)30104-9/fulltext

5. **What recommendations would you offer to a parent of a 10-year-old who disclosed that they are sexually active? How can a parent have the contraception option conversation?**

   Answer: As a health care professional, this situation would warrant a mandated report given the age of the client. A conversation about contraception options should be deferred until the safety of the client can be established.

6. **What is recommended if a person expresses that a pregnancy is totally unacceptable to them (especially in a state that has banned abortion, with a patient who likely could not afford to travel for one), but they are very afraid of IUD and implant side effects and would prefer to rely on condoms only, or the birth control pill only, when those methods have very high failure rates?**

   Answer: In these scenarios, it is essential to remember that the patient is the expert in their own life and as providers we need to respect their bodily autonomy to decide the best contraceptive option for them. It is important to query about their contraceptive preferences to determine why the method they want to use is preferable to them (i.e., something they can control, non-hormonal, on demand, etc.). For clients who indicated pregnancy prevention is very important and live in states where abortion is less available, a respectful conversation about method effectiveness is certainly relevant. Sample language could be:

   "Since you have said it's really important to you to prevent pregnancy at this time, I just wanted to check in about the birth control you want to use. Condoms can work well to prevent pregnancy, but do not work as well as other methods. How do you feel about that?"

   "I hear that you want to use condoms are your primary method. You have also said that not getting pregnant is very important. Would you like to discuss ways to help condoms be as effective as possible?"

   "Sometimes people like to combine methods to increase how well they work to prevent pregnancy. Would you like to talk about any other methods you could use with condoms?"

Teach Back

7. **What role does the teach back method play in all of your approaches? The goal should be care; not how efficient questions are. What about engagement with your patients especially if cultures and language are different?**

   Answer: The "ask" portion of the affirm, share, ask (ASA) cycle incorporates questions to help clients integrate new information and help providers assess for understanding. When using teach back, our recommendation is to use language that is not patronizing or condescending. Sample language includes:

   "Just to be sure I did not forget to tell you something..."
   "We have just gone over a ton of information and I'm not always as clear as I would like to be..."

Methods

8. **Is there a limit to the Depo shot only being used for 2 years or less?**

   Answer: No. Please see the following guidance from the American College of Obstetricians and Gynecologists (ACOG): https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/06/depot-medroxyprogesterone-acetate-and-bone-effects

9. **If you do give someone a Depo injection and it does increase depression, would you be able to provide another type of contraception to counter effect?**

   Answer: Other contraception would not directly counter depression, though the client could certainly switch to another method moving forward to avoid that side effect. Anti-depression medication and therapy can also be considered for clients.

10. **Will there be discussion on ambivalence with methods? I have many clients that are certain that they are not wanting pregnancy at this time, but they don't want to use a more effective form of birth control - like an IUD, or hormonal contraception, or don't even want to use condoms.**

    Answer: "On the one hand, on the other hand" is a useful tool for working with ambivalence and can sometimes help clients gain some clarity. *"On the one hand, you really do not want to have a kid/get pregnancy now. On the other hand, you are not particularly interested in using a birth control method. Do I have that right?"* Such statements allow clients to clarify their feelings. For some, this might lead them to realize that they perhaps do want to use something for pregnancy prevention. For others, it merely clarifies that pregnancy prevention is not a priority at this time. It is not our job as providers to resolve ambivalence, but rather to provide a space for people to explore their ambivalence and provide relevant information, if appropriate.

11. **Regarding birth control methods, particularly condoms, is there updated evidence with how effective those are at preventing pregnancy as a non-hormonal method?**

    Answer: From the upcoming 22nd edition of Contraceptive Technology, condom failure rates are the following: perfect use 2%, typical use 13%.

12. **As far as higher or lower sexual drive (with impact on sexual life) what is evidence around that with hormonal methods? How to inform patient on that?**

    Answer: People use contraception in sexual contexts, and the most important part of the discussion about sexuality and contraception is to ask patients about their contraceptive needs in the context of their sexuality and sexual expressions. Historically, a company bringing a birth control method to market did not ask participants in the clinical trials about the impact of the contraceptive on their sexuality. The data is still sparse; however, the recent medical literature demonstrates that the sexual acceptability of contraception including physiological, psychological, and relationship considerations can influence pleasure, contraceptive preferences, satisfaction, and use over time. Contraceptive methods often lead to improvements in users' sex lives, and a smaller percentage of users report a negative effect on their sexual experience. Individual methods can positively or negatively affect sexual

acceptability; this may be due to the particular mechanism of action (estrogen suppressing endogenous androgen may decrease desire), or side effects (menstrual suppression may have a good impact on sexuality). In general, the data show that estrogen-containing contraceptives have the potential to increase sex hormone-binding globulin (SHBG), which decreases androgens. While lower androgen levels can be correlated to decreased sexual desire, the studies do not show that users of estrogen containing contraceptives consistently have lower sexual desire.

13. **How about the patch for people with high/borderline blood pressure?**

    Answer: Per USMEC, it is a category 3. Note that the 35mcg patch (Xulane/OrthoEvra) has approximately 60% higher estrogen levels when compared to a 35mcg oral contraceptive pill.