MEDICAL STUDENTS FOR CHOICE

Case-Based Learning Guide

CONTRACEPTIVE COUNSELING

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MICROSOFT

MEDICAL STUDENTS FOR CHOICE

This collection of case-based learning exercises is meant to help you prepare for a variety of conversations with your future patients. Each exercise outlines the patient's case and includes a facilitator's guide, complete with a step-by-step breakdown of how to address the patient's concerns, as well as a student worksheet to pass out to all learners.

Many of these cases are advanced. If you do not have a facilitator who can give you background information on contraceptive options as you fill it out, you will want to lay that groundwork first. Please email MSFC at students@msfc.org for access to PowerPoints, charts, etc., to help you learn about contraceptive methods.

Once you've made your way through a case, feel free to practice the conversation you'd have with your patient. Role-playing exercises are a great way to both practice providing care and acknowledge any personal biases before seeing patients.

It's important to know how to discuss sexual and reproductive health issues in a way that is inclusive of all patients, including those who don't identify with their sex assigned at birth. That is why we have aimed to use gender-affirming language throughout these cases. You will notice that some cases involve a patient who uses they/them pronouns and gender-neutral terminology, such as "partner who produces sperm". Affirming patients' gender by using these terms and using gender neutral language is part of good patient-centered care – it demonstrates respect and fosters a safer environment for gender-nonconforming and transgender patients. Therefore, it's important to practice this language before seeing patients.

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Contraception Case #1- Facilitator's Guide

Jenna is a 33-year-old G1P1001 who would like to start the contraceptive patch today. She uses she/her pronouns and has told you that she has a history of hypertension. How would you determine if she is eligible to start the patch today? Would you recommend the patch as her contraceptive method, or would you suggest another method?

1. Explain what G1P1001 means.
    a. Jenna has been pregnancy 1 time (gravidity). She has had 1 pregnancy ending in a full term live birth. Parity can be broken down into four numbers, or TPAL (term, preterm, induced abortion/miscarriage, and live births).
2. Explain how you would determine her eligibility.
    a. You need more information about her hypertension history:
        i. Is patient on medication?
        ii. Is blood pressure controlled?
    b. History of hypertension is classified as category 3. This means the theoretical or proven risks generally outweigh the advantages of using the method. Therefore, it's important to determine if the history of hypertension was ongoing or based on one reading.
3. Patient reports that she had high blood pressure during her pregnancy with her son. She went for her postpartum visit and was told that her blood pressure was normal. She is not on any blood pressure medication. Her blood pressure today is 132/88. Can patient use the patch?
    a. Look up medical eligibility using the CDC's U.S. Medical Eligibility Criteria for Contraceptive Use (MEC) or the U.S. Medical Eligibility Criteria/U.S. Selected Practice Recommendations app. These guides give specific recommendations for patients with certain characteristics or medical conditions, based on a category system.
        i. History of high blood pressure during pregnancy with a current normal blood pressure (< 140/90) is classified as category 2. This means the advantages of using this method generally outweigh the theoretical or proven risks.
    b. More information from MEC: "Women with a history of high blood pressure in pregnancy, who also used COCs, had a higher risk for myocardial infarction and VTE [venous thromboembolism] than did COC [combined oral contraceptive] users who did not have a history of high blood pressure during pregnancy. The absolute risks for acute myocardial infarction and VTE in this population remained small."
4. Patient reports a history of high blood pressure during pregnancy and is not on blood pressure medication. Her blood pressure today is 150/96. Can the patient use the patch?
    a. Repeat the blood pressure yourself. A single reading of a blood pressure level is not sufficient to classify a woman as hypertensive.
    b. You need more information – when was her blood pressure last checked? Was the patient ever told that she had elevated blood pressure before? If so, when? Any other cardiovascular risk factors (e.g. smoking, diabetes)?
        i. From the CDC's MEC section on multiple risk factors for atherosclerotic cardiovascular disease: "When a woman has multiple major risk factors, any of which alone would substantially increase her risk for cardiovascular disease, use of CHCs [combined hormonal contraceptives] might increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of two category 2 risk factors might not necessarily warrant a higher category."

c. Depending on history, you might recommend a method without estrogen today, or you could have the patient come back for a repeat blood pressure reading to confirm the diagnosis of hypertension.

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Contraception Case #1- Student Worksheet

Jenna is a 33-year-old G1P1001 who would like to start the contraceptive patch today. She uses she/her pronouns and has told you that she has a history of hypertension. How would you determine if she is eligible to start the patch today? Would you recommend the patch as her contraceptive method, or would you suggest another method?

1. Explain what G1P1001 means.

2. Explain how you would determine her eligibility.

3. Patient reports that she had high blood pressure during her pregnancy with her son. She went for her postpartum visit and was told that her blood pressure was normal. She is not on any blood pressure medication. Her blood pressure today is 132/88. Can patient use the patch?

4. Patient reports a history of high blood pressure during pregnancy and is not on blood pressure medication. Her blood pressure today is 150/96. Can the patient use the patch?

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Contraception Case #2- Facilitator's Guide

Amy is a 22-year-old G0P0 who is interested in starting a combined oral contraceptive (COC). The patient uses they/them pronouns. They have a history of migraines. Is the patient eligible? If the patient is not eligible, what would you suggest instead?

1. What other piece of information do you need to determine if they are eligible to use COCs?
    a. You need to know if they have migraines with or without an aura.
    b. What is an aura?
        i. A reversible focal neurologic symptom that lasts for at least 5 minutes but no longer than 60 minutes. Neurologic symptoms consists of at least one of the following:
            1. Fully reversible dysphasic speech disturbance
            2. Sensory symptoms that are fully reversible, including positive features (pins and needles) and/or negative features (numbness)
            3. Visual symptoms that are fully reversible, including positive features (flickering lights, spots, lines) and/or negative features (loss of vision)
        ii. Refer to the International Headache Society's classification guide for more information.
2. How do you determine eligibility?
    a. Look up medical eligibility using the CDC's U.S. Medical Eligibility Criteria for Contraceptive Use (MEC) or the U.S. Medical Eligibility Criteria/U.S. Selected Practice Recommendations app. This guide gives specific recommendations for patients with certain characteristics or medical conditions, based on a category system.
    b. A patient's eligibility depends on their age and presence of an aura with migraines.
        i. COCs fall into category 2 for patients who experience migraines without an aura. In this category, "the advantages of using the method generally outweigh the theoretical or proven risks."
        ii. COCs fall into category 4 for a history of migraines with an aura at any age. In this category, the condition "represents an unacceptable health risk if the contraceptive method is used."
        iii. "**Evidence:** Among women with migraine, oral contraceptive use is associated with about a threefold risk for ischemic stroke compared with nonuse, although most studies did not specify migraine type or oral contraception formulation. The only study to examine migraine type found that the risk for ischemic stroke among women with migraine with aura was increased to a similar level among both oral contraceptive users and nonusers, compared with women without migraine. The risk for ischemic stroke is increased among women using COCs, compared with women not using COCs. The risk for ischemic stroke is also increased among women with migraine with aura, compared with women without migraine. One older meta-analysis found that migraine without aura was associated with an increased risk for ischemic stroke, while two more recent meta-analyses did not find such an association."
3. The patient's symptoms are consistent with migraines without an aura. However, they report that they used the pill in the past and noticed that they started seeing flickering lights before onset of headaches. You confirm that the patient developed aura with migraines when they were on the pill in the past. Are they still eligible for combined hormonal contraception?

   a. No. The development of migraines with aura on COCs is category 4.
4. What method(s) can the patient use?
   a. Any method without estrogen.
5. You discuss other contraceptive methods with your patient. They are interested in the copper IUD, but have concerns about insurance coverage. They heard that IUDs cost a lot of money. How do you approach this situation?
   a. You can reference the Obama Administration's health care law that requires insurance companies to cover every FDA-approved contraceptive method, with no copay or deductible. This includes emergency contraceptive pills, COC pills, progesterone-only pills, COC patch, COC ring, the contraceptive injection, the contraceptive implant, levonorgestrel IUD, and copper IUD.
   b. Some health plans have been grandfathered into the system, so check this guide by the National Women's Law Center if you're unsure. You can also refer to the website coverher.org.
   c. The ARCH Foundation provides assistance for patients who meet certain criteria.

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Contraception Case #2- Student Worksheet

Amy is a 22-year-old G0P0 who is interested in starting a combined oral contraceptive (COC). The patient uses they/them pronouns. They have a history of migraines. Is the patient eligible? If the patient is not eligible, what would you suggest instead?

1. What other piece of information do you need to determine if they are eligible to use COCs?

2. How do you determine eligibility?

3. The patient's symptoms are consistent with migraines without an aura. However, they report that they used the pill in the past and noticed that they started seeing flickering lights before onset of headaches. You confirm that the patient developed aura with migraines when they were on the pill in the past. Are they still eligible for combined hormonal contraception?

4. What method(s) can the patient use?

5. You discuss other contraceptive methods with your patient. They are interested in the copper IUD, but have concerns about insurance coverage. They heard that IUDs cost a lot of money. How do you approach this situation?

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Contraception Case #3- Facilitator's Guide

Continuation of Case #2.

Amy decides that they want to start COCs, and you determine from using the MEC that Amy has no contraindications to COC use. Can they start taking the pills today?

1. What is quick start?
    a. Quick start is starting a contraceptive method on any day during the menstrual cycle. This is in contrast to conventional start – starting a method on the Sunday after menses (Sunday start) or on day 1 of the cycle (first day start). For more information, read this guide from ARHP.
2. What are the benefits of quick start?
    a. Waiting until menses means that pregnancy prevention may be delayed for weeks. This may result in pregnancy, forgetting the instructions, or not filling the prescription. For patients who desire the contraceptive implant or IUD, the delay also means that the patient has to reschedule, which means additional travel and time off work, as well as possible additional childcare costs.
    b. No significant differences in bleeding patterns, pregnancy rates, or method continuation have been found among patients who quick start the contraceptive pill, patch, ring, or injection when compared to those who waited until menses. One study found that quick start of the contraceptive injection resulted in fewer pregnancies than patients who were prescribed the pill, patch or ring to start prior to the first injection.
        i. Lopez, LM, Newmann SJ, Grimes DA, Nanda KA, Schulz KF. Immediate start of hormonal contraceptives for contraception. *Cochrane Database Systematic Review*. 2012 Dec 12;12:CD006260.
3. What do you need to know before recommending quick start?
    a. Use this Quick Start algorithm from RHEDI to help you ask the right questions and determine eligibility.
    b. Has the patient been sexually active since her LMP? If so, was it with a partner who produces sperm? When did sexual activity occur? Was the patient using contraception, including condoms? (*Practice role playing this case with varying medical histories. Use this Quick Start algorithm from RHEDI to help students ask the right questions and determine eligibility.)*

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Contraception Case #3- Student's Guide

Continuation of Case #2.

Amy decides that they want to start COCs, and you determine from using the MEC that Amy has no contraindications to COC use. Can they start taking the pills today?

1. What is quick start?

2. What are the benefits of quick start?

3. What do you need to know before recommending quick start?

Practice role playing this case with varying medical histories. Use this Quick Start algorithm from RHEDI to help you ask the right questions and determine eligibility.

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Contraception Case #4- Facilitator's Guide

Alex is a 32-year-old G4P2022 who is seeing you for 2 weeks after an aspiration abortion at 8 weeks gestational age. Alex uses they/them pronouns. At the time of the abortion visit, they were unsure about starting contraception, but since then, they have decided on the contraceptive implant. You review the patient's medical history, and there are not contraindications.

1. Explain what G4P2022 means.
    a. Alex has been pregnant 4 times (gravidity). They have carried 2 of these pregnancies to a viable gestational age (parity). Parity can be broken down into four numbers, or TPAL (term, preterm, induced abortion/miscarriage, and live births). None of these pregnancies were delivered pre-term. Two pregnancies ended in abortion or miscarriage. Two pregnancies ended in full term live births.
2. What additional information do you need before starting the implant today?
    a. Reference the U.S. Selected Practice Recommendations companion piece to the CDC's Medical Eligibility Criteria guide.
    b. You need to assess whether the patient is pregnant before starting contraception. A detailed history can provide enough information to accurately make this assessment. The criteria contained in the CDC guide (see box 1 in the guide) are highly accurate (i.e., a negative predictive value of 99%–100%) in ruling out pregnancy among patients who are not pregnant. More detailed information can be found in the guide.
    c. Has the patient been sexually active since their last menstrual period (LMP)? If so, was it with a partner who produces sperm? When did sexual activity occur? Was the patient using contraception, including condoms?
3. Can you use a urine pregnancy test to assess whether the patient is pregnant?
    a. Urine pregnancy tests are not helpful to rule out a new pregnancy so soon after an abortion. One study of serum beta-hCG levels after first-trimester abortion found detectable hCG levels 16 to 60 days after a procedural abortion, with a median of 30 days.
        i. Steier JA, Bergsjø P, Myking OL. Human chorionic gonadotropin in maternal plasma after induced abortion, spontaneous abortion, and removed ectopic pregnancy. *Obstet Gynecol*. 1984 Sep;64(3):391-4.
    b. According to the CDC criteria, if the patient had presented within 7 days after the procedure, you could be reasonably certain that the patient is not pregnant. Studies examining ovulation after early medication or procedural abortion have found that ovulation takes approximately 2-3 weeks to occur, but some people experienced ovulation as early as 8-10 days after.
        i. Stoddard A, Eisenberg DL*. Controversies in Family Planning: Timing of ovulation after abortion and the conundrum of post-abortion IUD insertion. *Contraception*. 2011 Aug; 84(2): 119–121.
4. What do you ask Alex before offering their preferred contraceptive method today?
    a. You would want to know if the patient has had unprotected sex with a partner who produces sperm since the procedure. Pregnancy is unlikely to occur within a week after an early abortion, but you may want to counsel the patient on the possibility of a new pregnancy.

b. Since the patient is interested in a contraceptive method that is not an IUD, the benefits of starting the contraceptive implant today likely exceeds any risk. Studies have not found any adverse effects of contraceptive methods on a new pregnancy, other than IUDs. The CDC recommends that you can consider starting the method today with a follow up pregnancy test in 2-4 weeks. If you are concerned about a new pregnancy, you could consider checking serial beta-HCGs in this case as the urine pregnancy test could stay positive in 2-4 weeks due to the prior pregnancy.

*Bonus: Practice role playing this case with varying medical histories. Use this Quick Start algorithm from RHEDI to help you ask the right questions and determine eligibility.

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Contraception Case #4- Student Worksheet

Alex is a 32-year-old G4P2022 who is seeing you for 2 weeks after an aspiration abortion at 8 weeks gestational age. Alex uses they/them pronouns. At the time of the abortion visit, they were unsure about starting contraception, but since then, they have decided on the contraceptive implant. You review the patient's medical history, and there are not contraindications.

1. Explain what G4P2022 means.

2. What additional information do you need before starting the implant today?

3. Can you use a urine pregnancy test to assess whether the patient is pregnant?

4. What do you ask Alex before offering their preferred contraceptive method today?

*Bonus: Practice role playing this case with varying medical histories. Use this Quick Start algorithm from RHEDI to help you ask the right questions and determine eligibility.

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Contraception Case #5- Facilitator's Guide

Jade is a 25-year-old G0P0 who is seeing you for an IUD. The patient uses she/her pronouns. Her last menstrual period (LMP) was two weeks ago. You review the patient's medical history and there are no contraindications to IUD use. Is she eligible for quick start today?

1. What additional information do you need?
    a. Has the patient been sexually active since her LMP? If so, when was this last sexual activity?
    b. If the patient was sexually active, was it with a partner who produces sperm?
    c. Was the patient using contraception?
2. Scenario One: The patient reports unprotected sex three days ago with a cis male partner. Is the patient eligible?
    a. Use the RHEDI quick start algorithm.
    b. Check a urine pregnancy test (UPT).
    c. Discuss the risks associated with IUD insertion during early pregnancy (increased risk of spontaneous abortion, pelvic infections, and preterm labor). IUD risks in situ can be found here.
    d. Since patient had unprotected sex five or fewer days ago, recommend emergency contraception. This can be levonorgestrel pills, ulipristal acetate, or a copper IUD.
    e. If the patient wants a hormonal IUD, offer the emergency contraception pill today.
    f. Either way, the patient can receive a hormonal or copper IUD today.
3. Scenario Two: The patient reports unprotected sex seven days ago with a cis male partner. Is the patient eligible for quick start?
    a. IUD insertion is not recommended today.
    b. Discuss the risks associated with IUD insertion during early pregnancy (increased risk of spontaneous abortion, pelvic infections, and preterm delivery). IUD risks in situ can be found here.
    c. You can offer a bridge method (pill/patch/ring) and recommend that the patient follow up in 2 weeks to repeat the UPT and insert the IUD if the test is negative.
    d. You could also offer the contraceptive implant today.

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Contraception Case #5- Student Worksheet

Jade is a 25-year-old G0P0 who is seeing you for an IUD. The patient uses she/her pronouns. Her last menstrual period (LMP) was two weeks ago. You review the patient's medical history and there are no contraindications to IUD use. Is she eligible for quick start today?

1. What additional information do you need?

1. Scenario One: The patient reports unprotected sex three days ago with a cis male partner. Is the patient eligible?

2. Scenario Two: The patient reports unprotected sex seven days ago with a cis male partner. Is the patient eligible for quick start?

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Contraception Case #6- Facilitator's Guide

Mary is a 27-year-old G2P1011. Mary uses they/them pronouns. They have brought their daughter in for her first week well baby visit, and the patient asks if they can get the contraceptive implant today.

1. What additional information do you need before starting the implant today?
    a. Look up medical eligibility using the CDC's U.S. Medical Eligibility Criteria for Contraceptive Use (MEC).
    b. Reference the U.S. Selected Practice Recommendations companion piece to the CDC's criteria.
2. You review the patient's medical history, and there are no contraindications. Can Mary quick start their preferred contraceptive method today? What if Mary is breastfeeding?
    a. You can be reasonably certain that the patient is not pregnant if they have no symptoms or signs of pregnancy and is within the 4 weeks postpartum period.
    b. The contraceptive implant is category 2 for breastfeeding patients who are less than one month postpartum and is category 1 for breastfeeding patients more than one month postpartum. Clinical studies have not demonstrated that progesterone only methods affect breastfeeding performance or the health of the infant.
3. Mary reports that they had breast cancer eight years ago, but has been seeing their breast surgeon since then and has been in remission. Would you still recommend the contraceptive implant?
    a. Having had breast cancer with no evidence of disease for at least five years is a category 3 condition. This means that the theoretical or proven risks usually outweigh the advantages of using the method.
    b. From the CDC's MEC: "Breast cancer is a hormonally sensitive tumor, and the prognosis for women with current or recent breast cancer might worsen with POC use."
    c. You may suggest the copper IUD instead, as it is a non-hormonal long-acting reversible contraceptive option.

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Contraception Case #6- Facilitator's Guide

Mary is a 27-year-old G2P1011. Mary uses they/them pronouns. They have brought their daughter in for her first week well baby visit, and the patient asks if they can get the contraceptive implant today.

1. What additional information do you need before starting the implant today?

2. You review the patient's medical history, and there are no contraindications. Can Mary quick start their preferred contraceptive method today? What if Mary is breastfeeding?

3. Mary reports that they had breast cancer eight years ago, but has been seeing their breast surgeon since then and has been in remission. Would you still recommend the contraceptive implant?

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Contraception Case #7- Facilitator's Guide

Sophie is a 16-year old G0P0 who is seeing you for emergency contraception (EC). Sophie uses she/her pronouns. She reports that the condom broke when she had sex with her boyfriend two nights ago. You notice from the chart that this is her fourth time asking for emergency contraceptive pills (ECP) in the past three months. She reports that she used to use a combined oral contraceptive (COC), but her mother found the pack and threw it away.*

1. What tests do you need before providing a prescription for ECP?
    a. A clinical examination and pregnancy testing are not required before provision of ECP. Requiring testing or a clinic visit unnecessarily impedes access and utilization of ECP.
        i. American College of Obstetrics and Gynecology. Practice Bulletin No. 152: Emergency Contraception. *Obstet Gynecol*. 2015 Sep;126(3):e1-11.
2. You review Sophie's medical history and notice that her BMI is 30. Which EC methods would you recommend?
    a. Ulipristal acetate (brand name ella) or copper IUD. EC methods include levonorgestrel (LNG) EC (such as plan B), ulipristal acetate (UPA), and copper IUD. Clinical trials of LNG EC suggest that efficacy declines as BMI increases --pregnancy rates among participants with BMI of 26 or over were no different than would be expected if they hadn't used EC at all. The efficacy of UPA appeared to decline at a BMI of 35 and over. However, the studies were not powered adequately to evaluate a threshold weight or BMI at which ECP would be ineffective.
        i. Glasier A , Cameron ST, Blithe D, et al. Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception*. 2011;84:363–7.
        ii. Moreau C, Trussell J. Results from pooled Phase III studies of ulipristal acetate for emergency contraception. *Contraception*. 2012;86:673-680.
    b. Due to the limitations of the studies and the safety of ECP, the CDC has not yet recommended restricting levonorgestrel ECP from patients due to weight. From CDC MEC: "ECPs might be less effective among women with BMI ≥30 kg/m2 than among women with BMI <25 kg/m2. Despite this, no safety concerns exist." If the patient still wants to take LNG EC or if LNG EC is the only method easily available, then you can still provide the prescription.
3. Is there a problem with Sophie taking ECP so frequently?
    a. ECP works by delaying ovulation. Therefore, patients who have already taken EC once in their cycle can still become pregnant later in the same cycle. Repeat use in the same cycle has not been found to be harmful and can be considered if needed. There is limited data on the efficacy of repeat ECP use so you can use this opportunity to discuss whether Sophie would like a more regular and more effective method of contraception. Due to the safety of repeat use of ECP, you can provide a prescription with refills if Sophie wants to continue with this method.
        i. The International Consortium for Emergency Contraception has additional information on repeated use of emergency contraception here.
4. Do you need to know Sophie's last menstrual period (LMP) before providing EC?
    a. If Sophie decides on the copper IUD for EC, knowing her LMP would be helpful to determine if this method can be inserted today. While ECP are not effective once ovulation occurs, ECP provision should not be withheld as ovulation can vary,

particularly with irregular menses. In addition, ACOG recommends **against** withholding of ECP based on time of cycle. Studies have found that patients are more likely to underestimate their risk of pregnancy and underuse ECP.

5. What strategies can you use to improve access to ECP?
    a. You can educate your patients that one-pill LNG EC are available over-the-counter without age restrictions and regardless of gender. ID is not required to purchase one-pill LNG EC. However, pharmacies still place barriers on access.
        i. For more information on guidelines for pharmacies and retailers, check out this fact sheet.
    b. You can improve access to ECP by providing advanced prescriptions with refills and recommend that the patient fill the first prescription. In general, insurance plans will not cover ECP unless there is a prescription.
6. Sophie is interested in starting another contraceptive method, but is worried that her mother will find out. Which method(s) would you suggest?
    a. IUDs and contraceptive implants are good options for patients who are worried about privacy. The contraceptive ring is another option.
7. Sophie decides on the contraceptive ring. Can she start this method today?
    a. UPA is a selective progesterone receptor modulator that inhibits ovulation after binding to the progesterone receptor. There is theoretical concern that starting a contraceptive method with progesterone on the same day as administration of UPA may decrease the effectiveness of UPA and vice versa. One pharmacodynamic study found that desogestrel, a type of progestin, might decrease the effectiveness of UPA.
        i. Brache V, Cochon L, Duijkers IJ, *et al.* A prospective, randomized, pharmacodynamic study of quick-starting a desogestrel progestin-only pill following ulipristal acetate for emergency contraception. *Human Reproduction* 2015;30:2785–2793.

    While there have not been any studies examining pregnancy rates, the CDC now recommends delaying initiation of hormonal contraception for at least 5 days after use of UPA. If Sophie does not want to wait to start the contraceptive ring, you could offer LNG EC instead.

Bonus: Practice contraception counseling by role-playing the conversation with Sophie.

*Adapted from Physicians for Reproductive Health's Adolescent Reproductive and Sexual Health Education Program. Reference the module "Emergency Contraception and Adolescents" for more information.

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Contraception Case #7- Student Worksheet

Sophie is a 16-year old G0P0 who is seeing you for emergency contraception. She reports that the condom broke when she had sex with her boyfriend two nights ago. In reviewing the patient's medical history, you find that she has a BMI of 30. You also see that this is her fourth time asking for emergency contraception in the past three months. She reports that she used to use combined oral contraceptives (COC's), but her mother found them and threw them away.

1. What tests do you need before providing a prescription for ECP?

2. You review Sophie's medical history and notice that her BMI is 30. Which EC methods would you recommend?

3. Is there a problem with Sophie taking ECP so frequently?

4. Do you need to know Sophie's last menstrual period (LMP) before providing EC?

5. What strategies can you use to improve access to ECP?

6. Sophie is interested in starting another contraceptive method, but is worried that her mother will find out. Which method(s) would you suggest?

7. Sophie decides on the contraceptive ring. Can she start this method today?

Bonus: Practice contraception counseling by role-playing the conversation with Sophie.

*Adapted from Physicians for Reproductive Health's Adolescent Reproductive and Sexual Health Education Program. Reference the module "Emergency Contraception and Adolescents" for more information.

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Contraception Case #8- Facilitator's Guide

Alice is a 25-year-old G0P0 patient who wants to start the contraceptive injection Depo Provera today, and has never used contraception before. Alice uses she/her pronouns. You review the patient's medical history, and there are no contraindications to progesterone-only contraceptive use.

1. What information do you need before starting a method today?
    a. When was the patient's first day of her last menstrual period (LMP)?
    b. Has the patient been sexually active since LMP?
        i. Was the patient active with partner who produces sperm, and if so, were condoms used?
2. The patient says that her LMP was 4 days ago. Can she start the injection today?
    a. You can use the Quick Start algorithm from RHEDI to determine eligibility. Since LMP was within the last 7 days, the method can be started immediately.
3. The patient says that her LMP was 21 days ago, and that she had unprotected sex 14 days ago. Can she start the injection today?
    a. Following the algorithm, since the LMP was more than 7 days ago and unprotected sex occurred more than 5 days ago, a urine pregnancy test (UPT) needs to be done. If the test is negative, the patient can start the method today. You should advise the patient to use a barrier method or abstain from sex in the first week. A repeat urine pregnancy test in 2 weeks is not necessary in this case because last unprotected sex was over 12 days ago.
4. The patient says that her LMP was 12 days ago, and she had unprotected sex 3 days ago. Can she start the injection today?
    a. Use the algorithm. If the UPT is negative, then you can offer emergency contraception (EC) and start the injection today. Regardless of whether the patient decides to take EC today, you should discuss that the negative UPT today is not conclusive for ruling out pregnancy and that her chosen method will not have adverse effects on a pregnancy. If the patient decides to start the injection today, you should recommend that the patient repeat the UPT in 2 weeks. Also advise that the patient use a backup method in the first week.
    b. Inform the patient that she should use a backup method or abstain from sex for the first week after the injection.
5. Can the patient start the injection today if she is also taking ulipristal acetate for EC?
    a. For methods that rely on a visit to the health care provider, such as the contraceptive injection and LARC methods, the CDC recommends weighing the benefits and risks of not starting a regular contraceptive method that day against the potential risk of decreased effectiveness of UPA. You could also discuss LNG EC as an alternative.

*Bonus: Practice role playing this case with varying medical histories. Use this Quick Start algorithm from RHEDI to help you ask the right questions and determine eligibility.

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Contraception Case #8- Student Worksheet

Alice is a 25-year-old G0P0 patient who wants to start the contraceptive injection Depo Provera today, and has never used contraception before. Alice uses she/her pronouns. You review the patient's medical history, and there are no contraindications to progesterone-only contraceptive use.

1. What information do you need before starting a method today?

2. The patient says that her LMP was 4 days ago. Can she start the injection today?

3. The patient says that her LMP was 21 days ago and she had unprotected sex 14 days ago. Can she start the injection today?

4. The patient says that her LMP was 12 days ago, and she had unprotected sex 3 days ago. Can she start the injection today?

5. Can the patient start the injection today if she is also taking ulipristal acetate for EC?

*Bonus: Practice role playing this case with varying medical histories. Use this Quick Start algorithm from RHEDI to help you ask the right questions and determine eligibility.