Society of Family Planning interim clinical recommendations: Contraceptive provision when healthcare access is restricted due to pandemic response

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Summary of key updates: New references regarding COVID-19 in pregnant people (Introduction); information about barrier methods and patient confidentiality (Section 2); resources for self-administered DMPA (Section 3); additional references regarding associations between COVID-19 and thrombotic risk (Section 7)

Introduction

It is imperative we acknowledge the significant impact that a global pandemic such as COVID-19 has on reproductive health access worldwide. Barriers to contraception increase as the healthcare system experiences shortages of medications and other supplies, and as healthcare providers are diverted to respond to the pandemic or become ill themselves. Patients face logistic and economic barriers to accessing reproductive healthcare including fears that accessing care may expose them to the SARS-CoV-2 virus [1].

Access to contraception is essential and should not be denied, even in the time of a global crisis. Effective contraception significantly reduces maternal mortality by preventing unintended pregnancy and the inherent risks associated with pregnancy [2]. The need for contraception may increase as individuals, and their partners, fear the effect of COVID-19 on their health, the health of potential offspring, and their economic futures. Much remains unknown regarding the effects of COVID-19 on pregnant people, fetuses, and infants [3–9]. Pregnant individuals with symptomatic COVID-19 likely experience more adverse clinical outcomes and face disproportionate adverse socioeconomic consequences compared with non-pregnant individuals with COVID-19 [10–12]. In addition, pregnancy and associated outcomes require increased interaction between individuals and the healthcare system. For these reasons and more, it is paramount to maintain timely access to contraception without unnecessary barriers.

1. Screening to determine whether an in-person clinic visit is required

We recommend that clinics implement a process to identify patients who require an in-person visit for contraceptive services versus those who are suitable for telemedicine services. This

approach minimizes unnecessary contact and reduces personal protective equipment (PPE) use. Recognizing that contraceptive counseling is often included as part of preventative health visits, whenever these visits are postponed patients should be screened for the need for contraceptive-specific services or counseling, including but not limited to extended refills for short-acting methods.

General approach to telephone screening for contraceptive visits:

- Assess current form of contraception, risk of pregnancy, intended contraceptive method, and desired timeframe for initiation.
- Assess for any concerning symptoms. Symptoms that may necessitate an in-person visit include heavy bleeding, severe pelvic pain, or symptoms of complications with specific contraceptive methods (such as non-palpable implant or missing IUD strings).
- Assess medical history, focusing on conditions that would affect contraceptive options. Patients with a contraindication to their requested method (such as a patient with hypertension requesting combined oral contraceptives) require additional counseling and screening to assist with identifying an appropriate method.

2. Using telemedicine for contraceptive initiation and maintenance

Telemedicine refers to the use of systems to provide healthcare to patients who are geographically separated from providers. Many contraceptive methods can be safely initiated or maintained using telemedicine. While video visits are preferred, if not available, a telephone call is sufficient. In response to the declaration of a national health emergency due to COVID-19, the Center for Medicare and Medicaid Services (CMS) broadened the definition of telemedicine, eliminating requirements for patients to reside in a rural area and travel to a healthcare facility, and expanding the types of providers that can bill for services [13]. In some states, pharmacist provision of hormonal contraception may be another option [14]. We recommend that providers follow guidance from the Centers for Disease Control and Prevention (CDC) US Selected Practice Recommendations for Contraceptive Use (US SPR) which advises that a physical examination is not required before initiation of any reversible method except for the IUD [15]. The following visit types can be conducted over telemedicine: contraceptive counseling: initiation or maintenance of oral contraception, transdermal patch or vaginal ring; provision of oral emergency contraception (EC); and consultation for permanent contraception. In-person visits are required for signing the Medicaid sterilization consent, however, counseling can be provided via telemedicine beforehand to limit the time required for the in-person visit.

Considerations for contraceptive provision over telemedicine:

Assessing pregnancy risk. We advise a standardized approach using US SPR guidelines on how to reasonably exclude pregnancy [15]. We recommend home urine pregnancy testing for all patients who may be pregnant. For patients reasonably certain they are not pregnant, immediate contraceptive initiation is preferred. Patients who cannot be reasonably certain they are not pregnant should be counseled about the risk of pregnancy. Immediate contraceptive initiation with follow up pregnancy testing may be appropriate, per guidance from the US SPR.

Provision of emergency contraception (EC). Provide a prescription for ulipristal acetate. Counsel patients about use of the copper IUD for EC, and availability of levonorgestrel EC over-the-counter. Consider advance provision of oral EC for all patients using short-acting or barrier methods of contraception.

Prescription of oral contraceptive pills, transdermal patch, vaginal ring. Review each patient's medical history and assess for contraindications and concurrent medication use, following guidance from the CDC US Medical Eligibility Criteria for Contraceptive Use (US MEC) [16]. Prescribe a one-year supply with the maximum number of cycles allowable at one time and consider mail-order when available. For estrogen-containing methods (combined oral contraception, transdermal patch, and vaginal ring), the US SPR recommends that individuals have blood pressure checked prior to initiation, and annually with continued use [15]. During the COVID-19 pandemic response, we do not advise limiting prescriptions for estrogen-containing methods to individuals who are medically eligible for these methods but do not have a documented normal blood pressure. For those individuals who do not have a documented blood pressure within the past year, we recommend the following approach:

- If a patient has access to a blood pressure cuff at home or at a pharmacy, she can check her blood pressure and inform the provider of the value.
- If a patient does not have access to a blood pressure cuff, confirm no known history of blood pressure elevation and inform her of the risks of estrogen-containing methods for women with hypertension, including stroke and myocardial infarction, and recommend that she schedule a non-urgent visit with a healthcare provider for blood pressure check once usual healthcare access resumes.

Counseling and prescription of barrier methods. Continue to recommend male and internal condoms for prevention of sexually transmitted infections, regardless of method of contraception chosen. Keep in mind that some patients may require prescriptions for contraceptive methods that are available over the counter (eg, condoms, spermicides, and levonorgestrel EC) in order for their insurance or flexible spending account to reimburse for the cost of those products.

The Caya® diaphragm may be prescribed without a physical exam, as long as none of the few contraindications are present, including being within 6 weeks postpartum, known significant pelvic organ prolapse, or having previously been fitted with conventional diaphragms of ≤60 mm or ≥85 mm [17]. It is not necessary to perform a fitting for a Caya® prescription. Patients must be able to ensure that the anterior edge of the diaphragm can be maintained behind the pubic bone, the posterior edge maintained in the posterior vaginal fornix, and the cervix can be felt, completely covered, through the diaphragm. Providers and patients should familiarize themselves with additional recommendations for diaphragm use, including that any diaphragm should be used with spermicide to be maximally effective. A video visit with pelvic models could facilitate counseling on first use, and a follow up telemedicine visit after prescription could ensure the patient's comfort with the method.

Contraceptive counseling prior to IUD or implant placement and removal. An initial telemedicine visit can be useful for assessing potential contraindications, reviewing alternative methods, and counseling the patient as part of informed consent. This step confirms that an in-person visit is required, and minimizes the time required for face-to-face counseling during an in-person visit.

Evaluation of contraceptive side effects. Individuals with side effects, such as cramping with an IUD or breakthrough bleeding with hormonal contraception, can be managed via telemedicine visit if there is no concern for pregnancy. Patients reporting a change in bleeding pattern or other pregnancy symptoms should be advised to check a home pregnancy test. For patients who are not pregnant, consider providing prescription for medication to manage bothersome bleeding as recommended by the US SPR [15].

Confidentiality considerations. Care must be taken to maintain confidentiality in the provision of reproductive healthcare by telemedicine, especially for vulnerable groups like adolescents and

patients experiencing domestic violence. The same legal standards, which differ from state to state, must be followed in protecting the health information of adolescents when providing telemedicine as in-person care.

3. Recommendations for in-person contraceptive visits

Some contraceptive visits require an in-person appointment. Healthcare providers must follow all institutional recommendations for COVID-19 symptom screening and PPE use. The following clinical situations may require an in-person appointment:

Initiation of the contraceptive implant or IUD. It is appropriate to schedule the procedure without delay if another effective method is not available or acceptable. Appointments for copper IUD placement for EC must be expedited. For non-EC IUD placement, evaluate the patient's willingness and appropriateness to use a short-acting contraceptive method until usual healthcare access resumes. When desired, IUD or implant placement should occur immediately after first or second trimester abortion, management of early pregnancy loss, or after vaginal or cesarean delivery to reduce the need for additional in-person visits.

Suspected IUD expulsion or non-palpable contraceptive implant. Consider providing EC and counsel patients to use a different form of contraception, such as condoms or a short-acting hormonal method, until able to be seen in-person. Severe symptoms require an immediate visit. Mild symptoms that are not bothersome (such as missing IUD strings or non-palpable implant) can be delayed only if (1) there is no concern for pregnancy, and (2) a patient is willing to use an alternate method of contraception.

Symptoms concerning for ectopic pregnancy. A patient who has a positive pregnancy test and vaginal bleeding or pelvic pain, or any patient who is pregnant with an IUD in place, should have an immediate in-person visit with pelvic exam and serum labs with pelvic ultrasound if indicated.

Patient desiring DMPA. Consider prescription for subcutaneous DMPA (DMPA-SC) which can be self-administered, if available [18,19]. Self-injection of DMPA-SC is safe and effective and further decreases the need for in-person provider visits [20]. For intramuscular DMPA (DMPA-IM), consider telemedicine consult prior to visit, with in-person care for injection only in order to limit exposure. According to the US SPR, DMPA can be given at intervals of up to 15 weeks, enabling injections to be delayed if needed [15].

4. Recommendations for IUD and implant removal and/or replacement.

Access to IUD and implant removal should continue during the COVID-19 pandemic response in order to maintain individual reproductive autonomy [21]. However, an initial visit via telemedicine may assist with exploring reasons for removal and enable provision of an alternate contraceptive method for the patient to use after the removal procedure. This initial visit may decrease the amount of time spent face-to-face with a provider in the clinic, or may eliminate the need for a clinic visit in certain situations. We advise the following approach:

- For individuals requesting removal due to side effects, discuss the severity of symptoms and consider whether removal can be safely delayed until usual healthcare access resumes using a patient-centered approach. Individuals requesting immediate removal, for any reason, should be scheduled for in-person visit. IUD self-removal can be discussed with individuals as an option to avoid an in-person visit [22–24].

- For individuals requesting removal and replacement, consider extended use guidelines (12 years for copper IUD, 7 years for LNG-52 IUD, and 5 years for etonogestrel contraceptive implant) [25,26]. Proceed with removal and replacement immediately if the patient prefers.
- If patients are considering IUD or implant removal for the purpose of achieving pregnancy, they should be counseled that the effects of COVID-19 on pregnancy are not fully understood. This is not a reason to withhold access to contraceptive removal. Patients should be counseled to start folic acid supplementation.

5. Permanent contraception and other procedures requiring operating room (OR) setting

Non-postpartum setting

For patients seeking permanent contraception outside of the postpartum setting, we recommend considering regional, institutional, and individual patient factors in the decision to maintain access or postpone these procedures. Regional and institutional considerations may include:

- COVID-19 prevalence
- Availability of PPE
- Institutional strategies for prioritizing surgical procedures
- Regional access to permanent contraception, reversible contraception, and abortion, which may include legal barriers and insurance coverage

Individual factors may include the availability and acceptability of alternate forms of effective contraception, and insurance coverage of permanent contraception for patients whose procedures may be delayed.

We recognize that postponing permanent contraception surgery during this time may be considered due to the need for PPE preservation, infectious risk from intubation and extubation, and the theoretical infectious risk from aerosolization of surgical smoke during laparoscopy [27]. It is important to confirm alternative effective contraception with patients seeking permanent contraception at this time.

Postpartum setting

For patients seeking postpartum permanent contraception, we recommend maintaining access to postpartum tubal ligation, while considering institutional and regional factors that may affect this service. These patients are already admitted to the hospital and, regardless of mode of delivery, rarely require intubation. Even without COVID-related barriers to care, patients who experience unfulfilled desire for immediate postpartum tubal ligation have very high rates of loss to follow up and subsequent unplanned pregnancy [28,29]. Preservation of access to postpartum permanent contraception may also decrease the need for additional in-person follow-up for contraception.

All patients receiving prenatal care and requesting a postpartum tubal ligation should be made aware of the possibility that they may not obtain their desired option, and access may be challenging for COVID-related reasons for an unknown time period. Medicaid beneficiaries in states receiving federal financial support from the Families First Coronavirus Response Act cannot have their benefits terminated until the end of the month of the emergency period. This has been interpreted by the American College of Obstetricians and Gynecologists (ACOG) to include beneficiaries who qualify for Medicaid due to pregnancy. Some states separately

extended Medicaid coverage for interval tubal ligation or salpingectomy procedures for patients whose pregnancy-related Medicaid is expiring [30]. Alternative options of short-acting and long-acting methods (in the immediate or interval setting) should be discussed prior to delivery whenever possible.

Other procedures in the OR setting

Patients who are already having an OR procedure should continue to have access to IUD or implant placement if desired (eg, postabortion contraception). For patients who require an OR setting for IUD or implant placement in the absence of any other procedure, these procedures should be deferred to conserve hospital resources. Offer alternative effective contraception until these patients can have their IUD or implant placed.

6. Contraceptive services for individuals with confirmed or suspected COVID-19 infection

All patients should be screened for symptoms consistent with COVID-19 infection prior to any in-person visit. Patients should be informed of clinic policies when they schedule the appointment and should be screened again upon arrival for an in-person appointment. Per the most recent CDC guidelines, asymptomatic patients should wear a cloth or simple mask during encounters [31].

If a patient reports concerning symptoms (eg, fever, cough, or shortness of breath) prior to in-person visit, follow testing protocol and determine whether the visit can be delayed until result is available. Non-emergent visits including IUD and implant placement and removal and consultation for permanent contraception should be delayed. In these settings, consider bridging with a short-acting reversible method (i.e. pill, patch, ring, condoms) until the patient is well. Recommend that the patient self-isolate and seek additional medical care as needed. Reschedule the visit when they are asymptomatic and meet CDC criteria for discontinuation of self-isolation based on whether they were tested for COVID-19 [21].

Patients who report symptoms concerning for COVID-19 at the time of an in-person appointment should not be seen for non-emergent care. Any healthcare personnel who encounter a symptomatic patient should be instructed to self-monitor for symptoms per institutional and CDC guidelines [32].

Only emergent in-person visits are acceptable for patients who have confirmed or suspected COVID-19. This includes visits for severe pelvic pain, heavy vaginal bleeding, and high level of concern for ectopic pregnancy. Depending on the clinical site, this visit may occur in the emergency department, a specially designated triage clinic, or routine outpatient clinic with appropriate precautions. These precautions include use of appropriate PPE and recommended cleaning/decontamination of the clinic site.

7. Contraceptive method considerations for individuals with active COVID-19 infection

Severe COVID-19 infection appears to be associated with an increased risk of venous and arterial thromboembolism among critically ill hospitalized patients [33–41]. The overall rate of death associated with COVID-19 appears to be lower in women than in men [42].

The proportion of women of reproductive age with COVID-19 affected by venous and arterial

thromboembolism is unknown. Whether combined hormonal contraceptive (CHC) use affects the incidence of COVID-19-related thrombotic complications is similarly unknown. However, given the known increased risk of thromboembolism among CHC users, it important to consider that COVID-19 infection theoretically may further increase this risk. It is critical that providers and patients weigh this theoretical increase in risk against the known increased risks of thromboembolism associated with pregnancy and the postpartum period as well as other medical and social risks of unplanned pregnancy.

As with all patient-centered contraceptive care, we recommend that providers discuss the risks and benefits of CHC initiation and continuation using a shared decision making approach. Counseling should weigh theoretical and proven risks of contraceptive methods, consider the individual's values and preferences, and take into account whether alterative contraceptive options are available or acceptable to the individual.

Based on the limited data regarding the association between COVID-19 infection and venous and arterial thrombosis, we advise the following approach:

Patients hospitalized due to complications of COVID-19: We recommend discontinuation of CHC. The theoretical risks of thromboembolism in this acutely ill population likely outweigh the benefits of continuing CHC. CHC re-initiation can occur after recovery from COVID-19, however it is important to consider new comorbidities or immobilization that may affect eligibility for CHC [16]. Progestin-only and non-hormonal contraceptive methods do not pose additional thromboembolic risk and should be continued when possible and may be an alternative option for those on CHC with recent severe COVID-19 symptoms.

Patients who are asymptomatic or with mild symptoms with known COVID-19 infection: CHC continuation is reasonable in this population. Providers should discuss the theoretical increased risk of thromboembolism among CHC users with COVID-19. Increased caution should be used in those patients with prolonged immobilization from longer COVID-19 disease courses. If patients desire CHC discontinuation, offer progestin-only or non-hormonal method, if available and acceptable.

Intended use

In times of public health crisis, it is essential to respond to immediate needs by supplying the most up-to-date clinical guidance for family planning providers. The Society of Family Planning (the Society) intends this interim document to serve as guidance for clinicians providing family planning care during pandemic conditions. This document is not intended to dictate care or to serve as substitute for clinical judgement. Due to geographic variability in both the pandemic and the legislative environment, not all recommendations will apply to all providers. This document will be revised and revisited as conditions stabilize and additional evidence emerges. Recommendations in this document may also reduce barriers to care in a post-pandemic state.

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