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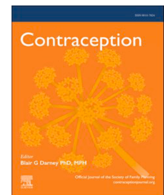

Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 2 – Contraception☆,☆☆

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ABSTRACT

This Clinical Recommendation provides evidence-informed, person-centered, and equity-driven guidance to optimize contraceptive care via telemedicine in the United States. Recommendations include offering the following contraceptive services via telemedicine: contraceptive counseling, initiation, renewals for methods not requiring procedural placement, and follow-up care for symptoms or complication management not requiring physical exam (GRADE 1B). The person receiving care should have the option to choose their preferred telemedicine service delivery mode, including audio-video, audio-only, or asynchronous care. When prescribing combined hormonal contraceptives (CHCs), we suggest clinicians provide clear guidance on how to remotely collect and report blood pressure measurements, why these data are important, and the availability of alternative contraception options if an unacceptable health risk is identified (GRADE 2C). We recommend prescribing a 1-year supply of CHCs without requiring follow-up within that year unless requested by the person receiving care (GRADE 1A). We recommend progestin-only methods as safe and effective options for telemedicine and self-administered contraception provision (GRADE 1A). We recommend a hybrid approach combining telemedicine and in-person care for long-acting reversible contraception (LARC) methods (GRADE 2B). However, it is important to maintain the option for same-day, in-person LARC provision without requiring prior telemedicine counseling. This document builds upon the *Society of Family Planning Committee Statement: Telemedicine in family planning care part 1 – Background and overarching principles* and parallels recommendations outlined in the *Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 3 – Abortion.* Readers are encouraged to review parts 1 and 3 for this additional context.

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1. Background

This Clinical Recommendation provides evidence-informed, person-centered, and equity-driven guidance to optimize the management of and access to contraceptive care via telemedicine within the United States. It builds upon the background, legal, and health equity considerations outlined in the *Society of Family Planning Committee Statement: Telemedicine in family planning care part 1 – Background and overarching principles* and parallels recommendations outlined in the *Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 3 – Abortion* [1,2]. Readers are encouraged to review parts 1 and 2 for this additional context.

2. Telemedicine contraceptive care

2.1. What contraceptive services are suitable for telemedicine care?

We recommend that clinicians offer the following contraceptive services via telemedicine: contraceptive counseling, initiation, renewals for methods not requiring procedural placement, and follow-up care for symptoms or complication management not requiring a physical exam (GRADE 1B) (Table 1). **The person receiving care should have the option to choose their preferred telemedicine service delivery mode, including audio-video, audio-only, or asynchronous care.** Table 2 summarizes contraceptive services that can be provided via telemedicine as opposed to services more suitable for in-person care [3–6]. Consistent with the US Selected Practice Recommendation for Contraceptive Use, contraceptive counseling should be tailored to the needs and preferences of the person receiving care, utilizing shared decision-making to determine the care plan [3,7–10].

2.2. How can clinicians assess contraindications to telemedicine for contraception?

Studies suggest that using health questionnaires in direct-to-patient or asynchronous contraceptive services is feasible [11–13]. These questionnaires should include queries that support screening for contraindications to contraceptive use and for symptoms that warrant in-person evaluation. Apart from methods that require procedural placement, physical exams and tests, breast exams, screening for sexually transmitted infections, cervical cancer screening, and other labs, are not medically necessary before initiating contraception, making telemedicine an appropriate mode of care in which to initiate most contraceptive methods [8]. An in-person evaluation should be conducted in the setting of heavy or unscheduled bleeding or method-specific complications, such as missing IUD strings or a nonpalpable contraceptive implant [3,8,14]. Routine pregnancy testing is unnecessary to initiate contraceptive methods that can be prescribed via telemedicine, including emergency contraception (EC) pills, as hormonal contraceptive methods have not been shown to harm a pregnancy or cause birth defects [8,15]. In the case of IUD placement for routine use or EC, a timely in-person appointment should be provided [15]. The US Selected Practice Recommendation suggests clinicians should screen for potential pregnancy before IUD placement using the *How to be reasonably certain that a patient is not pregnant* checklist [8]. If a clinician is not reasonably certain that a person is not pregnant, a quick start method of contraception initiation allows for same-day prescription and initiation with shared decision-making and a confirmatory home pregnancy test in 2 weeks [16] (Fig. 1). Quick start algorithms for long-acting reversible hormonal contraception (LARC) methods placed in person are beyond the scope of this document.

2.3. How can clinicians provide telemedicine contraceptive care?

There is currently limited published research around the safety and efficacy of telemedicine for contraceptive care. However, there is guidance on and experience with the provision of telemedicine for contraception during the COVID-19 pandemic [3–5,17,18]. Additionally, two studies incorporating telemedicine support after an initial in-person visit demonstrate similar rates of contraception use and pregnancy compared with in-person-only care [19,20].

When contraception provision is delivered via telemedicine, certain method-specific considerations exist.

2.3.1. Combined hormonal contraceptives

These methods include oral contraceptives, transdermal patches, and vaginal rings with a combination estrogen and a progestin.

When prescribing combined hormonal contraceptives (CHCs), we suggest clinicians provide clear guidance on how to remotely collect and report blood pressure measurements, why these data are important, and the availability of alternative contraception options if an unacceptable health risk is identified (GRADE 2C). We recommend prescribing a 1-year supply of combined hormonal contraceptives (CHCs) without requiring follow-up within that year unless requested by the person receiving care (GRADE 1A). While CHCs are largely safe, important contraindications outlined in the CDC US Medical Eligibility Criteria must be identified to determine eligibility for CHC prescribing. Self-reported medical history is equally reliable in both in-person and telemedicine care, and asynchronous online telemedicine can effectively screen for unacceptable health risks, ensuring safe CHC prescribing [13]. BP should be evaluated before initiating CHCs [8]. Access to a BP cuff or measurements outside of a health care facility may be a barrier to the initiation of CHC via telemedicine [21,22]. For persons without a history of hypertension who do not have access to a BP evaluation, clinicians should not withhold CHCs [3]. CHCs can be initiated, and clinicians should (1) inform the person receiving care of the risks these methods pose for those who have hypertension, and (2) encourage them to schedule a visit with a clinician or go to a pharmacy for a BP check and report back to their provider [3,8]. After BP measurement is obtained and confirmed to be within normal limits,

Table 1
Key for GRADE recommendations[a]

Symbol	Meaning
1	Strong recommendation
2	Weaker recommendation
A	High-quality evidence
B	Moderate-quality evidence
C	Low-quality evidence, clinical experience, or expert consensus
Best practice	A recommendation in which either (1) there is an enormous amount of indirect evidence that clearly justifies a strong recommendation; direct evidence would be challenging and an inefficient use of time and resources to bring together and carefully summarize, or (2) a recommendation to the contrary would be unethical

[a] Society of Family Planning Clinical Recommendations use a modified GRADE system. The GRADE system is described in several publications, with a comprehensive set of articles in the Journal of Clinical Epidemiology (J Clin Epidemiology, (2011) 64:383–394, 64:395–400, 64:401–406, 64:407–415, 64:1277–1282, 64:1283–1293, 64:1294–1302, 64:1303–1312, 64:1311–1316, (2013) 66:140–150, 66: 151–157, 66:158–172, 66:173–183, 66:719–725, 66:726–735).

Table 2
Summary of contraceptive services suitable for telemedicine vs services that typically require in-person visits

Contraceptive services that are suitable for telemedicine provision	Contraceptive services that typically require in-person visits
Counseling about IUD self-removal; video or telephone coaching for IUD self-removal	IUD removal (if patient is unable to or unwilling to attempt self-removal)
Prescription (initiation or continuation) of oral contraceptive pills, transdermal patch, or vaginal ring	Contraceptive implant removal
Provision of oral emergency contraception	Contraceptive implant or IUD insertion
Prescription (initiation or continuation) of self-administered DMPA-SC, possible video coaching for DMPA-SC self-administration	Administration of DMPA-IM
Prescription of barrier and other pericoital methods (including diaphragm, spermicides, contraceptive sponge, condoms, vaginal pH regulator gel)	Symptoms concerning for ectopic pregnancy, including pregnancy with IUD in situ
Counseling before IUD and contraceptive implant insertion, removal, or replacement, including counseling about extended use of IUDs and contraceptive implants	Suspected IUD expulsion or nonpalpable contraceptive (if symptomatic and/or if there is concern for pregnancy)
Evaluation and potential management of some contraceptive issues or side effects (e.g., heavy or unscheduled bleeding)	Some contraceptive issues or side effects (if severe symptoms)
Consultation for permanent contraception	Initiation of permanent contraception
Contraceptive counseling, including counseling about fertility awareness–based methods	

DMPA-IM, depot medroxyprogesterone acetate – intramuscular; DMPA-SC, depot medroxyprogesterone acetate – subcutaneous; IUD, intrauterine device.
Reprinted from Society of Family Planning Clinical Recommendations: Contraceptive care in the context of pandemic response [3].

a 1-year supply, ongoing refills, and method switching with annual BP measurement can be safely prescribed without requiring additional follow-up unless requested by the person receiving care [23]. Progestin-only pills (POPs) may be appropriate for persons with unacceptable health risks to estrogen-containing methods or when there are barriers to obtaining a BP measurement.

2.3.2. Progestin-only contraception

These methods include progestin-only pills (POPs) and self-administered depot medroxyprogesterone acetate-subcutaneous (DMPA-SC).

We recommend progestin-only methods as safe and effective options for telemedicine and self-administered contraception provision (GRADE 1A). These methods also demonstrate the potential to improve equity in access to contraception.

2.3.2.1. Progestin-only pills. POPs available for use in the US include norethindrone, norgestrel, and drospirenone. Norgestrel was approved in 2023 by the Food and Drug Administration for over-the-counter use, while the other POP formulations require a prescription. POPs are highly effective and are safe even for users with cardiovascular risk factors. For this reason, there is no requirement for BP measurement before initiation, making them a good option for telemedicine and over-the-counter access [24–27].

2.3.2.2. Depot medroxyprogesterone acetate-subcutaneous. DMPA-SC has been shown to be a feasible and acceptable method for self-administration at home or in the clinic, per the preference of the person receiving the DMPA-SC [28]. Research suggests that those using self-administered DMPA-SC feel empowered and appreciate not needing an in-person visit [28,29]. A systematic review and meta-analysis of six studies with a total of 3851 participants conducted in 2019 demonstrates that DMPA-SC has a similar efficacy and side effect profile as in-person administration, with up to 20% higher continuation rates [30]. Some persons who switch from clinic-administered DMPA-IM to a self-administered subcutaneous route experience challenges, including confusion about needle size, dose, and administration location [29]. Providing educational handouts, video recordings, or video telemedicine visits after medication and injection supply pick-up may preempt some of these concerns [28,31]. Routinely offering the option of self-administered DMPA-SC has the potential to increase access for persons who may already experience barriers to in-person care and expand contraceptive equity in the telemedicine setting [32]. For more information on DMPA-SC, we recommend reading the *Society of Family Planning committee consensus on self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC)* [28].

DMPA is US MEC Category 3 for persons with multiple cardiovascular risk factors. Thus, when counseling persons with known medical problems or conditions that may increase their cardiovascular risk profile, a baseline BP measurement can inform shared decision-making to help the person receiving care determine the appropriateness of DMPA after balancing factors, such as disease severity, alternate options, and their preference [8,27].

2.3.3. Long-acting reversible hormonal contraception

These methods include the copper and levonorgestrel intrauterine devices (IUDs) and the etonogestrel subdermal contraceptive implant.

We recommend a hybrid approach combining telemedicine and in-person care for long-acting reversible hormonal contraception (LARC) methods (GRADE 2B). However, it is important to maintain the option for same-day, in-person LARC provision without requiring prior telemedicine counseling. Telemedicine may be used for LARC counseling before initiation and as needed for follow-up, with LARC insertion itself occurring in person. Research suggests that utilizing a hybrid model for LARC care is acceptable among clinical staff [22]. Advantages of the hybrid model include having adequate time for counseling, shorter appointment times needed for LARC placement, and greater capacity to see patients [33,34]. A hybrid model also allows clinicians to have a discussion with the person desiring the LARC beforehand about their pain goals and concerns and prescribe analgesic or anxiolytic medications ahead of the placement [8]. However, the hybrid model may not be well-suited to all persons. In contrast to LARC counseling with in-person medication abortion care, research suggests LARC counseling with telemedicine medication abortion demonstrates a decreased uptake of LARC despite a desire for initiation [35]. Thus, offering same-day, in-person LARC placement visits without a requisite telemedicine counseling visit for those who have already decided on a desired LARC method remains an important option for access.

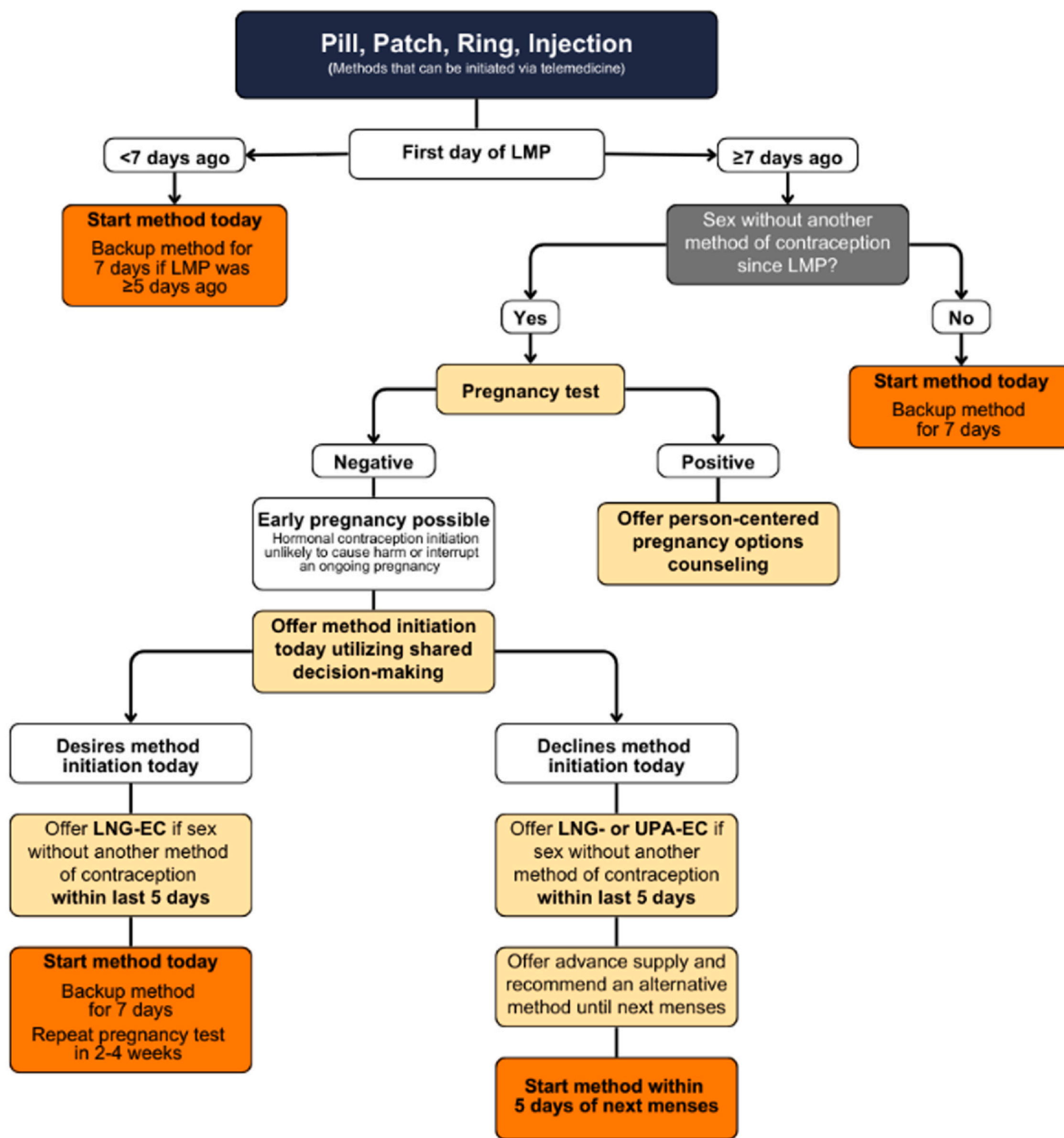

Fig. 1. Contraception quick start algorithm. EC, emergency contraception; LMP, last menstrual period; LNG-EC, levonorgestrel emergency contraception; UPA-EC, ulipristal acetate emergency contraception; UPT, urine pregnancy test.
Adapted from Reproductive Health Access Project, Quick start Algorithm, February 2021.

Telemedicine can be used for follow-up visits after LARC placement to address concerns about symptoms or side effects (e.g., menstrual irregularities, acne) [36]. For LARC removal, the etonogestrel contraceptive implant requires in-person removal. However, IUD self-removal is possible. Though published success rates are low (19%–30%), most participants in the studies would still recommend self-removal to a friend or try self-removing again in the future [37,38]. Telemedicine may allow clinicians to help guide persons through the steps of IUD self-removal, such as squatting when attempting removal [39]. For persons not interested in self-removal, in-person removal would be required.

2.4. How can telemedicine be used for EC, pericoital contraception, permanent contraception, fertility awareness–based methods, and lactational amenorrhea?

Telemedicine care (synchronous and asynchronous, fully virtual, and hybrid) can be used for EC and pericoital methods, and counseling for permanent contraceptive methods, fertility awareness methods, and lactational amenorrhea [11–13].

2.4.1. Emergency contraception

Many studies support the use of telemedicine, including telephone and asynchronous online prescription, for both advanced and as-needed provision of EC [40,41]. To reduce barriers and facilitate use within the recommended timeframe, clinicians should offer advanced provision of EC for any person who requests it and qualifies for it. The *Society of Family Planning Clinical Recommendation: Emergency Contraception* reviews indications, efficacy, safety, and considerations for EC provision [15]. Telemedicine access to EC empowers people to obtain EC when needed, can better reach AYA, and can expand access to people of color and individuals across different socioeconomic status communities [40–42]. Some people prefer asynchronous and online telemedicine services with expedited shipping through a mail-order pharmacy because it helps them avoid the challenges of getting timely in-person

appointments. It also reduces barriers such as social stigma, racism, and mobility issues when obtaining EC in person from a pharmacy [40].

2.4.2. Pericoital contraception

Available prescription pericoital methods include contraceptive gel, the cervical cap, and the one-size-fits-most diaphragm. Contraceptive gel is a nonhormonal gel in pre-filled applicators that is applied to the vagina at least one hour before sexual activity. Contraceptive gel can be safely used in combination with barrier methods like condoms. While the cervical cap is available in three sizes, the correct size is determined based on obstetric history and can, therefore, be assessed via telemedicine. Of the diaphragms currently available in the United States, the one-size-fits-most diaphragm does not require a pelvic exam for fitting and thus is suitable for telemedicine prescribing. Other pericoital methods, including those that are available over the counter, such as condoms, spermicide, contraceptive sponges, as well as the withdrawal method, may be included in contraceptive counseling via telemedicine [3]. Clinicians can illustrate how to use a diaphragm or cervical cap using pelvic models via video [3].

2.4.3. Permanent contraception counseling

Telemedicine also has a role in providing permanent contraceptive counseling. During the COVID-19 pandemic, when postpartum sterilization procedures after vaginal delivery were often postponed, studies showed mixed results regarding sterilization rates when telemedicine was used for postpartum visits [43,44]. Several studies suggest that virtual vasectomy consultations are both feasible and effective [45–47] and may even be preferable [48]. Telemedicine may also allow the signing of federally required sterilization consent forms for individuals using federally funded health insurance (e.g., Medicaid) via online platforms to reduce delays in care. These forms must be completed at least 30 days prior to the procedure, initially thought to protect people from forced or nonconsensual sterilization. However, the requirement has not prevented coercive sterilization but has introduced barriers to accessing care [49]. While completing these forms via telemedicine certainly increases convenience and reduces access burdens, there is uncertainty about the validity of sterilization consent forms signed virtually. During the COVID-19 pandemic, the Centers for Medicare and Medicaid Services revised their telemedicine reimbursement and encouraged increasing its use. However, it did not provide guidance regarding the sterilization consent form, leaving individual states to create policies. Clinicians should consult with their specific institutions about whether telemedicine consent forms for sterilization are acceptable [50].

2.4.4. Fertility awareness–based methods and lactational amenorrhea

Telemedicine can be used to counsel persons about fertility awareness–based methods, such as symptom-based and calendar-based methods [51]. Counseling via telemedicine can also be used to counsel about lactational amenorrhea, which can be used in the first 6 months postpartum if the birthing/lactating parent is exclusively breast/chestfeeding (with no other liquid or solid given to the infant) and has not experienced their first postpartum menses [52].

3. Summary of recommendations

- We recommend that clinicians offer the following contraceptive services via telemedicine: contraceptive counseling, initiation, renewals for methods not requiring procedural placement, and follow-up care for symptoms or complication management not requiring a physical exam (GRADE 1B). The person receiving care should have the option to choose their preferred telemedicine service delivery mode, including audio-video, audio-only, or asynchronous care.
- When prescribing combined hormonal contraceptives (CHCs), we suggest clinicians provide clear guidance on how to collect and report blood pressure measurements remotely, why these data are important, and the availability of alternative contraception options if an unacceptable health risk is identified (GRADE 2C).
- We recommend prescribing a 1-year supply of combined hormonal contraceptives (CHCs) without requiring follow-up within that year unless requested by the person receiving care (GRADE 1A).
- We recommend progestin-only methods as safe and effective options for telemedicine and self-administered contraception provision (GRADE 1A). These methods also demonstrate the potential to improve equity in access to contraception.
- We recommend a hybrid approach combining telemedicine and in-person care for long-acting reversible hormonal contraception (LARC) methods (GRADE 2B). However, it is important to maintain the option for same-day, in-person LARC provision without requiring prior telemedicine counseling.

4. Recommendations for future research

- Effectiveness of contraception with telemedicine compared to in-person provision.
- Acceptability of POP over-the-counter vs telemedicine for contraception.
- Acceptability of pharmacist prescription of contraception vs telemedicine.
- Patient experience and acceptability of contraceptive counseling and education methods via telemedicine.
- Comparison of timeliness of EC dispensing and ingestion between in-person and different telemedicine modalities.

5. Sources

A series of clinical questions was developed by the authors and reviewed by representatives from the Society of Family Planning's (SFP) Clinical Affairs Committee. We searched PubMed, Ovid Medline, Cochrane Library of Clinical Trials, Embase, and the TRIP database to identify relevant articles published between 2003 and May 2023. Search terms included, but were not limited to, abortion, contraception, family planning, telehealth, telephone, telemedicine, video, and virtual. The search was restricted to articles published in the English language. We also identified studies by reviewing the references of relevant articles and clinical guidelines published by organizations or institutions with related recommendations, such as the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, and SFP. The content of and references cited in relevant product labels and Food and Drug Administration prescribing information were also considered when developing critical statements on topics involving medications. When relevant evidence was unavailable or too limited to inform practice, the expert opinion of clinicians with expertise in complex family planning was used to develop the critical statements.

6. Intended audience

This Clinical Recommendation is intended for SFP members, family planning and sexual and reproductive health service clinicians, family planning and reproductive health researchers, consumers of family planning care, and policymakers.

Authorship

This Clinical Recommendation was prepared by Rajita Patil, MD; Divya Dethier, MD; Montida Fleming, MD; Emily Godfrey, MD, MPH; and Julia E. Kohn, PhD, MPA, with the assistance of Jennifer Chin,

MD, MS; Bhavik Kumar, MD, MPH; Jennifer Lesko, MD, MPH; April Lockley, DO; Shawana S. Moore, PhD, DNP, APRN, WHNP-BC, FNAP, FAAN, FNPWH; and Laurie Ray, DNP, WHNP-BC on behalf of the Clinical Affairs Committee, and Robert Johnson. It was reviewed and approved by the Clinical Affairs Committee on behalf of the SFP Board of Directors.

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