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Special Article

Society of Family Planning Committee Statement: Telemedicine in family planning care part 1 – Background and overarching principles☆,☆☆

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ABSTRACT

Telemedicine is an effective modality for remote family planning care delivery. Telemedicine increases reach, reduces barriers to care, and facilitates person-centered care. As the demand for telemedicine increases, evidence-based guidance is crucial for optimal practice. This clinical guidance series offers evidence-informed, person-centered, and equity-driven recommendations to enhance telemedicine delivery of contraceptive services and medication abortion in the US. Providing care via telemedicine may not be for everyone, and thus, clinicians should take a person-centered approach to ensure telemedicine meets the needs of the person receiving care. Ensuring that telemedicine remains accessible, regardless of whether a person also requires in-person clinical services, is essential to person-centered family planning care. Telemedicine family planning services should be integrated across practice settings and codesigned with persons from marginalized communities to ensure services are linguistically appropriate, equitable, and accessible. Clinicians should engage in implementation and advocacy efforts that combat health, digital, and structural inequities contributing to disparities in telemedicine family planning care access. Telemedicine family planning care should address the privacy and confidentiality of the person receiving care. Telemedicine family planning care clinicians should be familiar with their state, regional, and institutional laws or regulations regarding abortion care and, more broadly, telemedicine before providing care. Where uncertainty exists, clinicians should consult a lawyer experienced in telemedicine and abortion care. The companion documents, *Society of Family Planning Clinical Recommendation: Telemedicine for abortion and contraception part 2 – Contraception* and *Society of Family Planning Clinical Recommendation: Telemedicine for abortion and contraception part 3 – Abortion*, build upon this document and focus on actionable clinical recommendations.

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Disclaimer: This publication is designed as a resource to assist clinicians in providing family planning care. It should not be considered inclusive of all proper treatments or serve as the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations, considering individual circumstances, may be appropriate. This publication reflects the best-available evidence at the time of publication, recognizing that continued research or major changes in the practice environment may impact future recommendations and should be evaluated for incorporation into care. Clinical guidance, grounded in evidence-based research, is distinct from legal requirements and restrictions governing family planning care. Medical recommendations do not vary based on practice location. However, abortion is not legal in all states and circumstances, and this document is not intended to aid in or otherwise advocate for unlawful care. Any updates to this document can be found on https://societyfp.org/clinical/clinical-guidance-library/. SFP and its contributors provide the information contained in this publication "as is" and without any representations or warranties, express or implied, of any kind, whether of accuracy, reliability, or otherwise.

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1. Background

1.1. Purpose

Telemedicine is an effective modality for remote family planning care delivery. While telemedicine may not be suitable for all family planning needs, when appropriate, telemedicine increases reach, reduces barriers to care, and facilitates person-centered care. It enables health care facilities to respond to the growing demand for services while maintaining access to in-person care [1–3]. Clinicians who provide abortion care via telemedicine appreciate its scheduling flexibility, increased patient access, reduced scheduling delays and cancellations, and seeing persons earlier in pregnancy [4]. Telemedicine also reaches people who live farther away from abortion facilities, thereby increasing service access in more rural areas of the US [3,5–11].

Telemedicine medication abortion has demonstrated significant benefits by reducing the burdens of cost, travel, time, and the stigma associated with abortion, particularly for those living in rural areas or in states requiring two appointments for abortion care [9,11,12]. Remote follow-up for medication abortion decreases the average estimated cost per person by 39%, mostly due to forgoing ultrasonography [13]. Telemedicine can address barriers related to initiating or refilling contraception prescriptions, especially for individuals who have difficulty accessing or affording clinic appointments or are unable to take time off from work or school [14]. For postpartum persons, telemedicine improves attendance rates for postpartum visits, which increases the likelihood of obtaining postpartum contraception [15]. Moreover, persons receiving contraceptive counseling via telemedicine are equally likely to choose a contraceptive method as those seeking in-person care [16,17].

Telemedicine can enhance person-centered care. Satisfaction rates among persons receiving care for telemedicine abortion are high, ranging from 80–100%, with dissatisfaction rates under 2.5% [4,13,18–27]. For abortion care, satisfaction stems from the removal of barriers, enhancement of the relationship between the clinician and the person receiving care, autonomy, and a sense of control over the process [1,11,13,18,19,22,24,26,28–35]. For contraceptive care, persons from diverse backgrounds and with unique needs are highly satisfied with the availability of telemedicine contraceptive care [36–45]. Persons feel that they have more time with the clinician to consider contraceptive options, address side effects, switch methods, and feel less pressure to make an immediate decision [46,47].

Telemedicine in family planning care has increased significantly in recent years due in part to the COVID-19 pandemic, which led to rapid innovation in health care delivery models to reduce in-person visits [48,49]. During COVID-19, 71% of independent abortion facilities chose telemedicine for abortion follow-up and 41% for pre-abortion consultation [50]. Many facilities adopted no-test medication abortion protocols, omitting in-person exams, ultrasonography, and pre-abortion testing, such as Rh testing. Others introduced curbside and mail-order delivery of abortion medications [50,51]. Similarly, the percentage of US-based reproductive health care clinicians offering telemedicine contraceptive care rose from 11% pre-pandemic to nearly 80% during the pandemic [52]. Telemedicine in family planning care continues to rise post-pandemic, making evidence-based guidance essential for optimal practice [53].

This clinical guidance series provides evidence-informed, person-centered, and equity-driven recommendations to enhance the management of and access to contraceptive services and medication abortion via telemedicine within the US. It's companion documents, *Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 2 – Contraception* and *Society of Family Planning Clinical Recommendation: Telemedicine in family planning care part 3 – Abortion*, build upon this document and focus on actionable clinical recommendations [54,55].

1.2. Definitions

The exact definitions of telemedicine and telehealth vary. *Telemedicine* falls under *telehealth,* which includes a broad range of virtual nonclinical services such as contraceptive reminder programs or mobile health (mHealth) [56]. This guidance defines *telemedicine* as providing clinical care virtually via synchronous and asynchronous approaches within the formal health care system. In synchronous care, persons receiving care and clinicians engage in a virtual visit simultaneously, either "direct-to-clinic" (also known as "site-to-site"), where a person goes to a clinical facility and communicates with a clinician who is off-site via teleconference, or "direct-to-patient", in which persons receive care in their home or another place of their choosing [57]. Both audio-video and audio-only visits are acceptable for virtual synchronous care. Clinicians may use them to provide care according to the preference of the person receiving care. An audio-only option should be available if technical difficulties with video conferencing arise [58,59]. In asynchronous care, persons first provide the relevant medical information via a questionnaire. A clinician then reviews this information and provides treatment virtually if the person receiving care is eligible. Asynchronous telemedicine services can enhance access, offering greater convenience and timeliness by eliminating the need for synchronous phone or video calls [60–62]. *Telemedicine care* can be entirely virtual or a hybrid of virtual and in-person. Clinicians providing this care include licensed physicians, nurses, and advanced practice clinicians.

Telemedicine medication abortion differs from self-managed abortion, in which a person ends a pregnancy outside of the formal health care system and may involve a range of interactions with community support, clinicians, or both [63,64]. Please see the *Society of Family Planning Interim Clinical Recommendations: Self-managed abortion* for further information on this topic [63].

2. Committee statements

2.1. Clinicians should take a person-centered approach to ensure telemedicine meets the needs of the person receiving care.

Although telemedicine family planning satisfaction rates are high, clinicians should understand individual preferences, acceptability, and needs to deliver person-centered care. Successful telemedicine contraceptive care should align with best-practices, accommodating a person's complex and nuanced views and framing each method according to their overall health and well-being [65]. Overall people greatly value their choice in service modality and consider it an important aspect of meeting their healthcare needs [66].

For telemedicine medication abortion, remote consultations that omit pretreatment ultrasonography and exam are considered acceptable and trustworthy due to time and cost savings, privacy, avoiding uncomfortable procedures, and not having to view ultrasound images [19,67–69]. Remote follow-up is also highly acceptable [70–73]. However, some express anxiety about not having ultrasonography confirmation of the pregnancy [19].

Some persons value being in the same room as the clinician for abortion visits, while others experience stigma or uncomfortable power dynamics with the clinician in an in-person clinical setting [19,38]. Those undergoing a telemedicine medication abortion are likely to choose it again for a future abortion and recommend it to a friend [21,22,68]. Studies comparing in-person and telemedicine medication abortion experiences show no overall difference in preparedness of the person receiving care, including their expectations for pain and bleeding. In some studies, the telemedicine experience exceeds expectations [25,68,74].

For telemedicine contraceptive care, persons prefer having multiple options for obtaining contraception, including in-person, telemedicine, direct-to-patient telemedicine, and pharmacies, when

clinically appropriate (Table 1) [75]. Despite the preference of persons receiving care for and the appropriateness of telephone-only telemedicine for prescribing contraception, some health care systems require video visits due to system regulations, clinical preferences, and higher insurance reimbursement rates [39,46]. Where permissible, clinician preferences for video visits should be balanced against the broader accessibility of telephone-based care [36,37,46]. Preferences can vary by community setting. For example, some school-based health center studies show a preference for telemedicine, while others prefer in-person care [76,77]. The content of the counseling visit may also impact preferences. One study from New York reports a preference for telemedicine for "basic" contraception options counseling but in-person care for more "complex" topics like pregnancy and preconception [38].

It is important to consider the unique needs of different populations, such as persons seeking contraception postabortion, pregnant and postpartum persons, adolescent and young adults (AYA), persons with disabilities, and those living in rural areas, when providing contraceptive counseling. Contraception counseling is often offered during in-person abortion visits (i.e. "integrated counseling"), which can be challenging due to operational and time constraints. The person receiving care may not want to discuss contraception at the time of their abortion [78]. Virtual individual or group contraceptive counseling sessions scheduled ahead of an in-person abortion visit are feasible and acceptable [79,80]. One study found persons opting for telemedicine contraceptive counseling separate from the abortion encounter were more likely to be non-White, have had difficulty obtaining contraception in the past, and not be using contraception at the time of conception [80]. Telemedicine counseling before in-person abortion care is more strongly associated with choosing and receiving a desired long-acting reversible contraceptive (LARC) method at the time of in-person abortion care compared to integrated counseling. However, one study indicates that persons who chose LARC during telemedicine medication abortion may be less likely to obtain a LARC method after completing the abortion, while another study shows no difference [17,81]. These differences in outcomes of contraceptive choice and provision between in-person and telemedicine medication abortion care underscores the importance of providing both telemedicine and in-person options for those seeking contraception at the time of abortion.

Most AYA perceive synchronous video-based telemedicine care for contraceptive services as acceptable and accessible, and their high levels of digital competency may make them particularly well-suited to telemedicine [42,82]. Screening protocols can help identify AYA at risk of sexual abuse or exploitation in remote contraception services [83]. However, access to a private space to discuss sexual and reproductive health needs is crucial and may lead to a preference for asynchronous or in-person care [42,43,84]. Insurance status can also limit AYA access to telemedicine contraceptive care [85].

The diversity of preferences across populations, clinical contexts, and care modalities highlights the importance of adaptable service models. In this context, ensuring that telemedicine remains accessible, regardless of whether a person also requires in-person clinical services, is essential to person-centered family planning care.

2.2. Telemedicine abortion and contraceptive services should be integrated across practice settings and codesigned with persons from marginalized communities to ensure services are linguistically appropriate, equitable, and accessible.

Facilities that already use telemedicine technology for different appointment types can readily apply this technology for telemedicine medication abortion [86]. Facilities not already using telemedicine may require additional training with the technology and guidelines for online consultations [30]. Facilities should use platforms that support obtaining patient signatures to meet the Risk Evaluation and Mitigation Strategy (REMS) requirements for mifepristone administration [86]. For contraceptive visits, self-selection of the encounter type is an important factor in care quality assessments [36,47]. Telemedicine appointments are more successful when persons receive instructions on how to join their visit before the telemedicine visit [87].

Key factors for successful implementation include a supportive institution [88], a facility champion, formal or informal mentoring by organizations within and outside the facility who can help overcome challenges such as meeting regulatory compliance and current standards of care [89,90], and creating standing operating procedures with clear guidelines [30,91]. Challenges include effectively marketing the telemedicine services and raising awareness about their availability [1].

Language is a critical consideration for telemedicine care globally, as linguistic diversity poses challenges across many countries. In the US, almost 10% of the population has limited English proficiency [92]. Most platforms require a degree of English proficiency to navigate scheduling and accessing the visit [1,93]. Cultural values and beliefs around health care also influence how persons and communities prefer to access reproductive health care and may limit telemedicine's benefit [94]. To ensure equitable access, health care facilities should codesign telemedicine care during the implementation process with persons receiving care [95].

Table 1
Summary of contraceptive services suitable for telemedicine versus 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 subcutaneous 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 implant (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 [58].

2.3. Clinicians should engage in implementation and advocacy efforts that combat health, digital, and structural inequities contributing to disparities in telemedicine family planning care access.

State-level abortion bans are not evidence-based and do not improve the safety or efficacy of clinical care [96,97]; However, they have severely limited in-person abortion care, forcing farther travel to obtain an abortion. Telemedicine family planning care has the potential to increase access for those who must travel the longest distances and who face the most barriers, including people of color; those without insurance, with low income, facing food insecurity, or living in rural locations; AYA; incarcerated individuals; people with disabilities; immigrants; and gender diverse individuals [8,98].

Research suggests persons who are younger, have at least one medical condition, whose first language is not English, who identify as Black, and others from under-resourced and rural communities have limited access to and are less likely to use telemedicine services for abortion care and contraceptive counseling [5,99-103]. Over 50% of abortions in the US are provided to Black and Latine/X individuals, more than 70% are to people under 30%, and 75% are to people with low incomes [104,105]. This demonstrates the disproportionate impact that challenges to telemedicine medication abortion access may have on these groups [106]. Internet access and digital literacy challenges also reduce telemedicine access and usability [107-111]. Connectivity issues remain barriers for some [37,47,112]. Up to 30% of Americans still experience internet connectivity problems, and those with lower incomes or less formal education are less likely to have reliable internet access [113]. AYAs, who account for 6% of all abortions in the US, encounter additional obstacles when trying to use telemedicine services [105]. These barriers include lack of awareness, stigma, financial and insurance constraints, and confidentiality concerns related to parental notification and consent requirements [85,114,115].

Despite the rapid adoption and innovation of telemedicine by many health care clinicians, facilities in under-resourced areas still face significant implementation barriers, exacerbating the inequity in telemedicine care provision [116]. Smaller outpatient facilities and those serving many persons with publicly-funded health insurance often do not offer telemedicine due to lower reimbursement rates compared to in-person visits, as well as the higher costs and effort required to establish the necessary infrastructure [93,117-120].

2.4. Telemedicine family planning care should address the privacy and confidentiality of the person receiving care.

Privacy. Clinicians should conduct telemedicine visits in a private space and address confidentiality and privacy concerns, especially for vulnerable populations such as AYAs or those experiencing intimate partner violence. Access to a safe and private space for persons receiving care to discuss sexual and reproductive health needs is crucial and may lead to a preference for asynchronous or in-person care [42–44,61].

Confidentiality. Persons receiving care and clinicians express concern about confidentiality in telemedicine [9,38,121]. Concerns about the security of personal health data when utilizing telemedicine services are especially significant for individuals residing in states with restrictive abortion laws who seek abortion care in other states [122]. Clinicians should document only clinically relevant information to minimize risk to the person receiving care and make notes confidential. Digital encryption is a crucial security measure to safeguard protected health information (PHI). Telemedicine providers should use Health Insurance Portability and Accountability Act (HIPAA)-compliant platforms that limit or prohibit automatic medical record sharing with other health systems.

Additional confidentiality considerations for AYAs must account for local laws on parental notification and consent for family planning services. Clinicians may find these requirements more uncertain in a telemedicine context [84,123]. While many states allow for confidential contraceptive services without parental consent or notification, insurance factors may limit confidentiality [84,124]. Laws for abortion care are more complex, with many states requiring parental involvement, though most allow a judicial bypass for court-approved abortion decisions [125].

2.5. Clinicians should be familiar with their state, regional, and institutional laws and regulations regarding abortion care and, more broadly, telemedicine before providing care. Where uncertainty exists, clinicians should consult a lawyer experienced in telemedicine and abortion care.

Some states specifically prohibit the use of telemedicine for abortion care despite its demonstrated safety, efficacy, and acceptability [126]. Other states that protect abortion access have instituted “shield laws”, which provide certain protections for clinicians in that state to provide abortion care to persons living in other states, including states that ban or restrict abortion. Some shield laws provide protections for telemedicine care rendered across state lines to persons who are in states that ban abortions. Other shield laws strictly apply to clinicians providing care for persons who have traveled from banned states to receive an abortion in a state where it is legal [127].

When providing telemedicine across state lines, clinicians render care in the state where the person receiving care is physically located. Therefore, they must practice under the laws of and, generally, be licensed in the state where the person receiving care is located, unless there is a cross-state waiver or a shield law allowing them to prescribe medication abortion in states where they are not licensed. Waivers providing exceptions for licensing requirements for most states have ended, since they were primarily in place during the COVID-19 Public Health Emergency [128].

3. Continued discussion

During the development of this document, we identified multiple areas where further discussion, research and consensus are needed, and we invite further exploration:

- Insurance coverage of and policy barriers to telemedicine for contraception and abortion care.
- Evaluation of barriers and facilitators to telemedicine to address health care access inequity, particularly among adolescents and young adults (including parental consent and privacy concerns) and rural and underserved communities.
- Development and evaluation of culturally and linguistically appropriate telemedicine services.
- Exploration of emerging technologies (AI, mobile health apps) to enhance telemedicine contraceptive care.
- Patient preferences for and satisfaction with counseling and education methods for telemedicine medication abortion.

4. Summary of statements

- Clinicians should take a person-centered approach to ensure telemedicine meets the needs of the person receiving care.
- Telemedicine abortion and contraceptive services should be integrated across practice settings and codesigned with persons from marginalized communities to ensure services are linguistically appropriate, equitable, and accessible.
- Clinicians should engage in implementation and advocacy efforts that combat health, digital, and structural inequities contributing to disparities in telemedicine family planning care access.

- Telemedicine family planning care systems should address the privacy and confidentiality of the person receiving care.
- Clinicians should be familiar with their state, regional, and institutional laws and regulations regarding abortion care and, more broadly, telemedicine before providing care. Where uncertainty exists, clinicians should consult a lawyer experienced in telemedicine and abortion care.

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 Turning Research Into Practice (TRIP) database to identify relevant articles published between 2003 and July 2024. 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 (FDA) prescribing information were also considered when developing critical statements on topics involving medications. When relevant evidence was not available or too limited to inform practice, the expert opinion of clinicians with complex family planning expertise was used to develop the critical statements.

6. Intended audience

This Committee Statement 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, advocates, and policymakers.

Authorship

This Committee Statement 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 Clinical Affairs Committee members on behalf of the SFP Board of Directors.

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Contraception xxx (xxxx) xxx

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

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Telemedicine
Virtual

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.

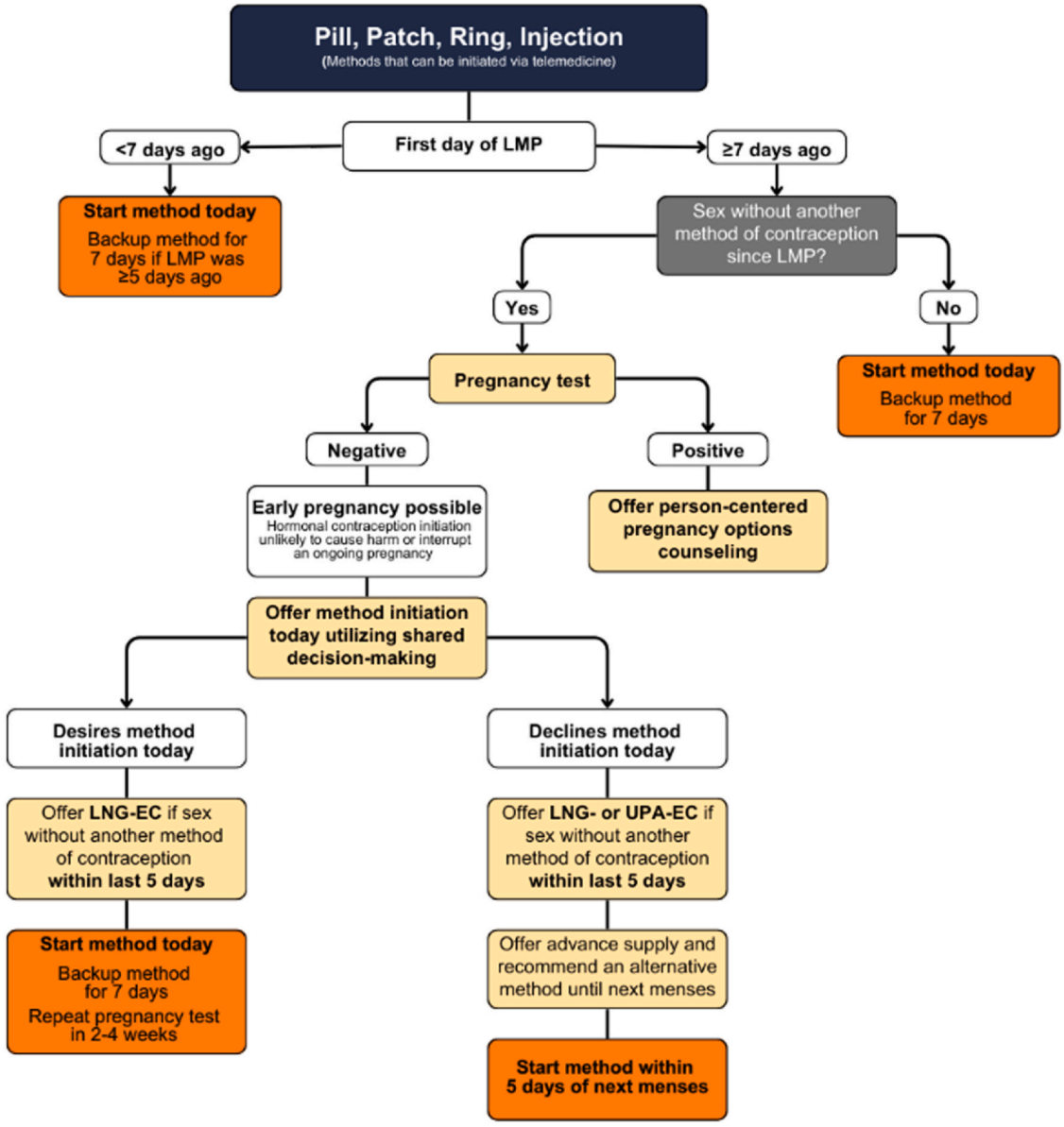

Fig. 1. Contraception quick start algorithm. EC, emergency contraception; LMP, last menstrual period; LNG-EC, levonorgestrel emergency contraception; UPA-EC, ulipristal acetate emergency contraception; UPT, urine pregnancy test.
Adapted from Reproductive Health Access Project, Quick start Algorithm,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

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