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Canadian Contraception Consensus (Part 2 of 4)

This clinical practice guideline has been prepared by the Contraception Consensus Working Group, reviewed by the Family Physicians Advisory, Aboriginal Health Initiative, Clinical Practice – Gynaecology, and Canadian Paediatric and Adolescent Gynaecology and Obstetrics (CANPAGO) Committees, and approved by the Executive and Board of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To provide guidelines for health care providers on the use of contraceptive methods to prevent pregnancy and on the promotion of healthy sexuality.

Outcomes: Guidance for Canadian practitioners on overall effectiveness, mechanism of action, indications, contraindications, non-contraceptive benefits, side effects and risks, and initiation of cited contraceptive methods; family planning in the context of sexual health and general well-being; contraceptive counselling methods; and access to, and availability of, cited contraceptive methods in Canada.

Evidence: Published literature was retrieved through searches of Medline and The Cochrane Database from January 1994 to January 2015 using appropriate controlled vocabulary (e.g., contraception, sexuality, sexual health**)** and key words (e.g., contraception, family planning, hormonal contraception, emergency contraception). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies published in English from January 1994 to January 2015. Searches were updated on a regular basis and incorporated in the guideline to June 2015. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

Values: The quality of the evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table).

Key Words: contraception, family planning, hormonal contraception, emergency contraception, barrier contraceptive methods, contraceptive sponge, spermicide, natural family planning methods, tubal ligation, vasectomy, permanent contraception, intrauterine contraception, counselling, statistics, health policy, Canada, sexuality, sexual health, sexually transmitted infection (STI)

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Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207–8.

Chapter 4. Natural Family Planning

Summary Statements

21. Natural family planning methods may be appropriate methods of contraception for couples who are willing to accept a higher rate of contraceptive failure than with other more effective contraceptive methods. (III)
22. The exact effectiveness of natural family planning (NFP) methods is difficult to estimate. When NFP methods are not adhered to and intercourse takes place during the fertile window, the risk of conception from a single failure is high. (III)
23. Many women and couples have used natural family planning methods, particularly withdrawal, at some point in their reproductive lives. (III)
24. Coitus interruptus (“withdrawal”) as a risk-reduction strategy is preferable to no contraception at all, but typical-use failure rates are relatively high and it does not reliably protect against sexually transmitted infections. (II-2)
25. Lactational amenorrhea is an effective method of birth control when used by women who are less than 6 months postpartum, fully or nearly fully breastfeeding, and have not resumed menses postpartum. (II-2)
26. Abstinence is a contraceptive choice that requires supportive counselling and information-sharing from health care providers. (III)

Recommendations

23. Health care providers should respect the choice of a natural family planning (NFP) method, be aware of options for NFP, and be able to provide appropriate resources/counselling on the correct use of a woman or couple’s chosen method. (II-2B)
24. Natural family planning methods should not be proposed to women solely based on contraindications to another contraceptive method without a thorough review of other potentially safe and more effective methods. (II-2B)
25. Couples using natural family planning methods, including withdrawal and abstinence, should be provided with information about effective methods of emergency contraception and screening for sexually transmitted diseases. (III-B)
26. All pregnant or postpartum women should receive clear instructions on the lactational amenorrhea method of birth control and the criteria that must be met to achieve reliable contraception. (III-B)

Chapter 5. Barrier Methods

Summary Statements

27. Latex condoms, used consistently and correctly, will provide protection against pregnancy (II-2) and sexually transmitted infections (STIs), including human immunodeficiency virus infection (II-1). However, no barrier contraceptive method can provide 100% protection from all STIs. (III)
28. Polyurethane and other non-latex male condoms have an increased incidence of breakage and slippage compared to latex condoms; hence, the protection they provide against sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) infection is inferior to that of latex condoms (I). Polyurethane and polyisoprene condoms remain important options for contraception and reduction of STIs in the presence of latex allergies. Lambskin condoms do not protect against HIV infection. (III)
29. The effectiveness of barrier methods can be complemented by the use of emergency contraception. (III)
30. The contraceptive sponge and spermicides used alone are not highly effective contraceptive methods; their effectiveness may be enhanced when used in combination with another contraceptive method. (II-2)

31. Contraceptive products containing nonoxynol-9 may cause vaginal epithelial damage and increase the risk of human immunodeficiency virus infection. (I)

Recommendations

27. Health care providers should promote the consistent and correct use of latex condoms to improve protection against pregnancy, human immunodeficiency virus infection, and other sexually transmitted infections. (II-2A)
28. Health care providers should educate women and men about the correct use of barrier methods. They should emphasize the need for dual protection against pregnancy and infections. (II-2B)
29. Women who use barrier methods of contraception should be counselled about emergency contraception. (III-B)
30. The use of spermicide-coated condoms should no longer be promoted. (I-A)
31. Diaphragms and cervical caps should continue to be available in Canada and appropriate training should be available for health care providers to become proficient in fitting diaphragms. (III-C)
32. Nonoxynol-9 products should not be used to reduce the risk of sexually transmitted infections and human immunodeficiency virus (HIV) infection and should not be used by women at high risk for HIV transmission. (I-A)

Chapter 6. Permanent Contraception

Summary Statements

32. Women who do not desire a future pregnancy and who do not wish to use a reversible method of contraception, particularly long-acting reversible methods, may be candidates for a permanent contraception procedure. (III)
33. Only individuals who have capacity to give informed consent can agree to have a permanent contraceptive procedure. A proxy decision-maker cannot consent to the non-therapeutic sterilization of a mentally incompetent person. (III)
34. The 10-year cumulative failure rate of female permanent contraceptive procedures is less than 2%. (II-2)
35. Although the risk of pregnancy after a permanent contraception procedure is low, there is a substantial risk of an ectopic pregnancy if a pregnancy occurs after tubal ligation. (II-2) The absolute risk of ectopic pregnancy is lower than the risk among women not using contraception. (III)
36. Tubal ligation is associated with a decreased risk of ovarian cancer. (II-2)
37. Regret is one of the most common complications following a permanent contraceptive procedure with young age being a major risk factor. (II-2)
38. Tubal occlusion may not be complete for several months after the hysteroscopic procedure. An additional method of contraception is required for at least 3 months and until imaging confirms bilateral tubal occlusion. (II-2)
39. Salpingenctomy may provide women, who are absolute in their decision, the additional benefit of risk reduction against ovarian cancer. (II-2)
40. Women and men who do not desire a future pregnancy and who do not wish to use a reversible method of contraception, particularly long-acting reversible methods, may be candidates for permanent contraception. (III)
41. Compared to tubal ligation, vasectomy is generally safer, more effective, less expensive, and is a less invasive surgical procedure that can be performed under local anaesthetic. (II-2)
42. Vasectomy is not effective immediately. Once one fresh post-vasectomy semen analysis shows azoospermia or ≤ 100 000 non-motile sperm, the risk of contraceptive failure is 1 in 2000 (0.05%). Repeat vasectomy is necessary in ≤ 1% of vasectomies. (II-2)
43. Vasectomy does not increase the risk of prostate/testicular cancer, coronary heart disease, stroke, hypertension, or dementia. (II-2)

Recommendations

33. Before providing permanent contraception, women should be counselled on the risks of the procedure, the risk of regret, and alternative contraceptive methods, including long-acting reversible contraceptives and male vasectomy. Informed consent must be obtained. (II-2A)
34. In a well-informed woman who understands her contraceptive options and the permanency of the procedure and who is capable of consent, age and parity should not be a barrier to permanent contraception. (III-B)
35. Women should be advised to use an effective method of contraception up until the day of their permanent contraception procedure. A pregnancy test should be performed on the day of the procedure. (III-A)
36. Women undergoing a laparoscopic procedure should continue to use an effective method of contraception for one week following the procedure. (III-B)
37. Women having a hysteroscopic tubal occlusion procedure should use an effective method of contraception up until the day of surgery and for at least 3 months afterward until imaging studies have confirmed bilateral tubal occlusion. (II-2A)
38. Isolation of the vas deferens should be performed using a minimally invasive vasectomy technique such as the no-scalpel vas occlusion technique. Vas occlusion should be performed by any 1 of 4 techniques that are associated with occlusive failure rates consistently below 1%. (III-B)
39. Patients who have had a vasectomy should be advised that they may stop using a second method of contraception when one uncentrifuged fresh semen specimen shows azoospermia or ≤ 100 000 non-motile sperm/mL. (III-B)

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