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Canadian Contraception Consensus (Part 1 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 Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline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 1).

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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Table 1. 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 1: Contraception in Canada

Summary Statements

1. Canadian women spend a significant portion of their lives at risk of an unintended pregnancy. (II-2)
2. Effective contraceptive methods are underutilized in Canada, particularly among vulnerable populations. (II-2)
3. Long-acting reversible contraceptive methods, including contraceptive implants and intrauterine contraception (copper-releasing and levonorgestrel-releasing devices/systems), are the most effective reversible contraceptive methods and have the highest continuation rates. (II-1)
4. Canada currently does not collect reliable data to determine the use of contraceptive methods, abortion rates, and the prevalence of unintended pregnancy among reproductive-age women. (II-2)
5. A universal subsidy for contraceptive methods as provided by many of Canada's peer nations and a few Canadian provinces may produce health system cost-savings. (II-2)
6. Health Canada approval processes for contraceptives have been less efficient than those of other drug approval agencies and Health Canada processes for other classes of pharmaceuticals. (II-2)
7. It is feasible and safe for contraceptives and family planning services to be provided by appropriately trained allied health professionals such as midwives, registered nurses, nurse practitioners, and pharmacists. (II-2)

Recommendations

1. Contraceptive counselling should include a discussion of typical use failure rates and the importance of using the contraceptive method consistently and correctly in order to avoid pregnancy. (II-2A)
2. Women seeking contraception should be counselled on the wide range of effective methods of contraception available, including long-acting reversible contraceptive methods (LARCs). LARCs are the most effective methods of reversible contraception, have high continuation rates, and should be considered when presenting contraceptive options to any woman of reproductive age. (II-2A)
3. Family planning counselling should include counselling on the decline of fertility associated with increasing female age. (III-A)
4. Health policy supporting a universal contraception subsidy and strategies to promote the uptake of highly effective methods as cost-saving measures that improve health and health equity should be considered by Canadian health decision makers. (III-B)
5. Canadian health jurisdictions should consider expanding the scope of practice of other trained professionals such as nurses, nurse practitioners, midwives, and pharmacists and promoting task-sharing in family planning. (II-2B)
6. The Canadian Community Health Survey should include adequate reproductive health indicators in order for health care providers and policy makers to make appropriate decisions regarding reproductive health policies and services in Canada. (III-B)
7. Health Canada processes and policies should be reviewed to ensure a wide range of modern contraceptive methods are available to Canadian women. (III-B)

Chapter 2: Contraceptive Care and Access

Summary Statements

8. Although there are many contraceptive options in Canada, only a narrow range of contraceptive methods are commonly used by those of reproductive age. (II-3)