A CLINICAL MASTER CLASS

Whole Person Contraceptive Counseling

Helping patients meet their own reproductive goals — shared decisions, the whole method menu, and the whole person.

Skin, Bones, Hearts & Private Parts 2026 · Jessica Bell, PA-C, MSCP, ISSWSH Fellow · GynJess

Disclosures

Financial disclosures

Jessica Bell, PA-C, MSCP, ISSWSH Fellow has no relevant financial relationships with ineligible companies to disclose.

Off-label use

This presentation discusses off-label use of long-acting reversible contraceptives beyond their FDA-approved duration (“extended use”).

Off-label uses are identified as such where they appear.

What we'll cover

1. **Contraceptive options** The full method menu — not just what you stock.
2. **Benefits vs. risks** Weigh both, honestly, per method.
3. **Mechanism explained** How each method actually works — and what that means for counseling.
4. **Counseling** Shared decision-making with the PATH framework.
5. **Individualized approach** Contraindications and the patient's own goals.
6. **Social media's impact** Meeting mis/disinformation without dismissing the patient.

Counseling: meet THEIR goals

Principles

- **Help individuals meet THEIR goals — not yours.**
- Give all the information needed for an informed decision.
- Shared decision-making; offer a menu of options.
- Discuss effectiveness; consider reproductive goals.

PATH questions

- **Pregnancy Attitudes, Timing, How important is prevention.**
- Do you want (more) children at some point?
- When do you think that might be?
- How important is preventing pregnancy until then?

Consider the individual

Any contraindications?

- **Screen the big ones:**

Smoking status

VTE history / risk

Migraine with aura

- These shape whether estrogen-containing methods are safe.

Use the eligibility criteria

- **WHO Medical Eligibility Criteria for Contraceptive Use.**
- **US Medical Eligibility Criteria (US MEC).**
- Both are freely available — use them at the point of care to match method to comorbidity.

Have the conversation

- **What is important to you?**
- Any idea how long you want the method to work?
- Do you know what your preference is?
- Do you have any concerns about the method?
- **Do you need to control symptoms — as well as prevent pregnancy?**

Have the conversation: what to cover

Effectiveness first

- **How effective is the method? Discuss it clearly.**
- Visual aids help — use the tiered chart.
- Consider abortion acceptability and access.
- **Will it impact bleeding?**

The whole person

- Other side effects to consider
- **Non-contraceptive benefits**
- **Impact on sexual health**
- Effect on future fertility

How well does birth control work?

MORE EFFECTIVE

LESS EFFECTIVE

Most effective **< 1 in 100**	Implant · IUD (hormonal & copper) · Sterilization
Very effective **4–7 in 100**	Injection (4) · Pill · Patch · Ring (7)
Effective **13–21 in 100**	Male condom (13) · Diaphragm (17) · Withdrawal (~20) · Internal condom (21)
Least effective **~21–28 in 100**	Spermicide · Fertility-awareness methods · Sponge

Typical-use failure per 100 people, first year — CDC / Guttmacher

Mis- and disinformation in media

- **Social media is entertainment and, for some, education — and mis/disinformation shapes patient opinion.**
- **Don't dismiss what they've learned.**
- Instead: offer the most up-to-date information so they can decide for themselves — and acknowledge it may not match what they've seen or heard.
- Invite them to share what they've learned, then discuss how it informs their decision.
- **Take time for this dynamic conversation — it's not a detour, it's the work.**

Clinician bias

- **Be cautious of your own bias.**
- **Clinicians often under-counsel on methods they have less experience with — or don't provide in their own clinic.**
- The patient deserves the full menu, not just your comfort zone. Refer out rather than steer.

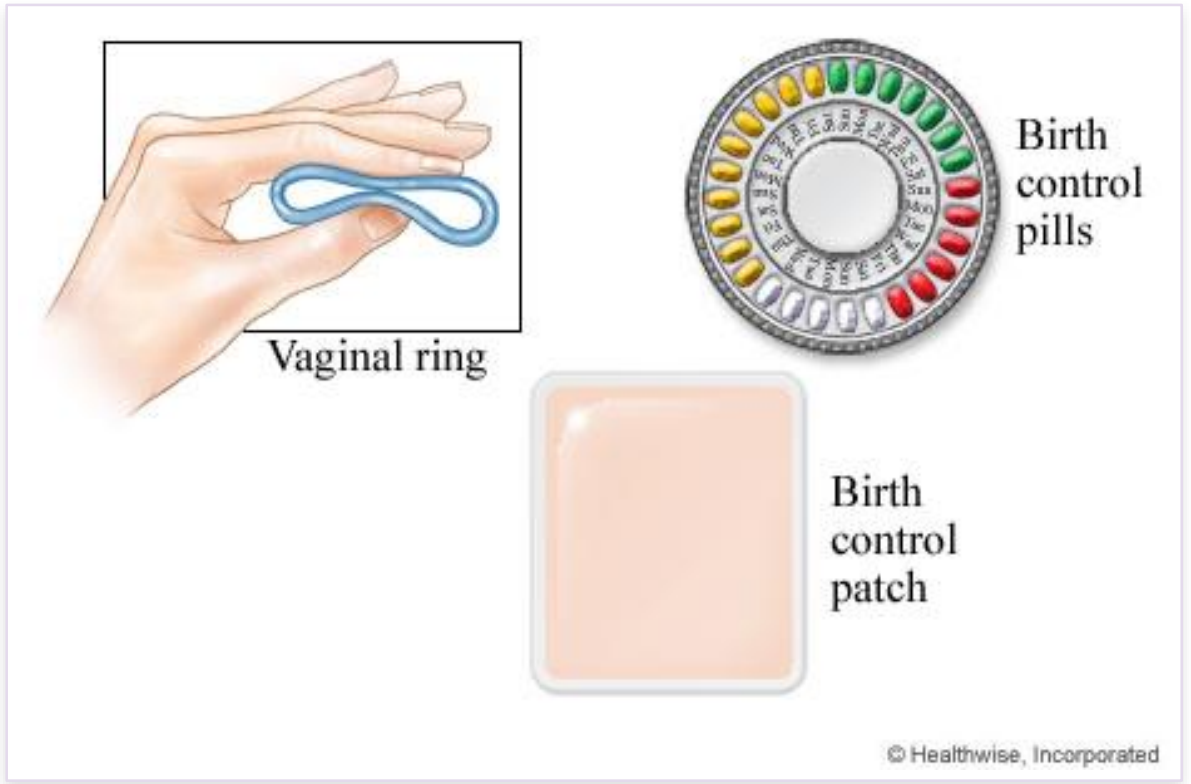
Oral contraceptives

The most familiar method — and the one where estrogen/progestin nuance matters most.

Table 1 Summary of Selected Currently Available Oral Contraceptives in the United States

Type Progestin/estrogen	Brand	Progestin (mg)	Estrogen (mcg)	Packaging Notes
Combination Extended Cycle				
Levonorgestrel/ethinyl estradiol (EE)	Jolessa	0.15	30	
	LoSeasonique	0.1 none	20 10	84 active 7 inactive
	Seasonale	0.15	30	
	Seasonique	0.15 none	30 10	84 active 7 inactive
Combination Monophasic				
Norethindrone/EE, ferrous fumarate	Generess Fe	0.8	25	
	Junel Fe 1/20[ab]	1	20	
	Junel Fe 24	1	20	24 active 4 inactive
	Lo Loestrin Fe	1 none	10 10	24 active 2 active
Norethindrone/EE	Junel 21 1/20[ab]	1	20	
	Necon 0.5/35[c]	0.5	35	
Levonorgestrel/EE	Lessina Portia	0.1 0.15	20 30	
Norgestrel/EE	Low-Ogestrel Ogestrel 0.5/50	0.3 0.5	30 50	
Desogestrel/EE Drospirenone/EE	Apri[d] Yasmin[e] Yaz	0.15 3 3	30 20 20	
Norgestimate/EE	Sprintec[f]	0.25	35	
Combination Monophasic With Folate				
Drospirenone/EE, Levomefolate calcium 451 mcg (active and inactive)	Beyaz	3	20	24 active 4 inactive
Combination Biphasic				
Norethindrone/EE	Necon 10/11	0.5 1	35 35	10 active 11 active
Desogestrel/EE	Kariva	0.15 none	20 10	21 active 5 active
Combination Triphasic				
Desogestrel/EE	Cyclessa	0.1 0.125 0.15	25 25 25	7 active 7 active 7 active
Norethindrone/EE	Necon 7/7/7[g]	0.5 0.75 1	35 35 35	7 active 7 active 7 active
Norgestimate/EE	Ortho Tri-Cyclen[h]	0.18 0.215 0.25	35 35 35	7 active 7 active 7 active
	Ortho Tri-Cyclen Lo	0.18 0.215 0.25	25 25 25	7 active 7 active 7 active
Levonorgestrel/EE	Enpresse	0.05 0.075 0.125	30 40 30	6 active 5 active 10 active
Progestin Only				
Norethindrone	Camilla[i]	0.35	none	

Note: This is a summary of available products; for an exhaustive list, see Reference 32. [a] Also available as 1.5/30. [b] Also marketed as Microgestin. [c] Also available as 1/35. [d] Also marketed as Desogen and Reclipsen. [e] Also marketed as Ocella. [f] Also marketed as Ortho-Cyclen and Mononessa. [g] Also marketed as Nortrel 7/7/7 and Ortho-Novum 7/7/7. [h] Also marketed as Tri-Sprintec and Trinessa. [i] Also marketed as Errin, Jolivette, Nor-QD, Nora-be, Ortho Micronor. Fe: iron. Source: Reference 32.



Mechanism: androgenic activity of progestins

High androgenic activity	Norgestrel, Levonorgestrel
Moderate androgenic activity	Norethindrone
Little androgenic activity	Desogestrel, Norgestimate
Anti-androgenic & anti-mineralocorticoid	Drospirenone

Adverse effects: estrogen

Most often estrogen-related: menstrual irregularities, headaches, nausea/vomiting, breast tenderness, weight gain, VTE risk, mood changes.

Too much estrogen

- Nausea
- Headache
- Bloating
- Blood-pressure changes
- Breast tenderness

Too little estrogen

- **Spotting / breakthrough bleeding**

Early cycle (days 1–14).

Adverse effects: progestin

Most often progestin-related: menstrual irregularities, water retention/weight gain, acne, hirsutism, mood changes, fatigue, headache.

Too much progestin

- Breast tenderness
- Fatigue
- Headache
- Mood changes

Too little progestin

- **Late-cycle breakthrough bleeding**

Days 15–28.

Oral contraceptives: quick reference

Table 4

Managing Adverse Effects

Adverse Effect	Management Strategy
Bloating/fluid retention	• Reduce estrogen dose • Change to progestin with mild diuretic effect (drospirenone)
Breakthrough bleeding	• If EE dose 20 mcg, increase to maximum of 35 mcg • Change progestin if already taking EE dose of 30-35 mcg
Breast tenderness	• Reduce estrogen or progestin dose • Change progestin (less androgenic with less water retention) • Consider OC with drospirenone
Dysmenorrhea	• Extended-cycle regimen to decrease frequency of bleeding
Headache	• Reduce estrogen dose and/or change progestin • If during hormone-free week, can consider extended-cycle OC
Nausea	• Reduce estrogen dose • Take with food or at bedtime • Consider progestin-only contraceptive

EE: ethinyl estradiol; OC: oral contraceptive.
Source: Reference 18.

Long-acting reversible contraceptives (LARC)

- **Highly reliable, easy to use, cost-effective, non-surgical — and as effective at preventing pregnancy as surgical sterilization.**
- Nothing to remember, nothing to do daily — which is why typical use ≈ perfect use.
- **Options: hormonal IUD, non-hormonal (copper) IUD, and the arm implant.**

IUD mechanism of action

How IUDs work

- Foreign-body effect: a sterile inflammatory reaction toxic to sperm and ova.

By type

- Copper: enhances the cytotoxic inflammatory response; impairs sperm migration and viability → prevents fertilization.
- Levonorgestrel (LNG): thickens cervical mucus, decidualizes the endometrium, causes glandular atrophy.

IUD mechanism: ovulation & the abortifacient myth

Ovulation

- **Copper IUDs do not affect ovulation.**
- **LNG IUD users are mostly ovulatory.**
- First year of the LNG-52 IUD: ovulation in ~45% of cycles; lower-dose LNG IUDs ovulate in ~88–97%.
- Ovulation may dip after insertion, then normalize.

Not an abortifacient

- **No studies show IUDs disrupt an implanted pregnancy.**
- **The mechanism is pre-fertilization — this is worth stating plainly to patients.**

IUD benefits & risks

Benefits

- **> 99% effective at preventing pregnancy.**
- Nothing to remember; long-acting.
- **Duration: copper up to 10 yr; LNG-52 up to 8 yr.**
- Reversible — removal is easier than placement.
- Fine for nulliparous patients and teens.
- Lower risk of endometrial cancer (and associations with lower cervical & ovarian cancer).

Risks

- **Overall complication and pregnancy risk is low.**
- Insertion pain and (uncommon) complications can occur.

IUD counseling: what to expect

Copper IUD

- **Can cause heavier, more painful periods.**
- Fully non-hormonal.
- Best for patients who want to avoid hormones.

LNG IUD

- **Can lighten periods — or stop them entirely.**
- **Locally acting (almost non-hormonal systemically).**
- Often chosen for heavy bleeding / cycle control.

IUD placement: managing the fear of pain

Offer pain options

- **Pre-medication.**
- **Lidocaine gel.**
- **Cervical block.**
- **Nitrous oxide assist.**

Gentler technique

- **A tenaculum is sometimes needed — but not always.**
- **A long Alice clamp can work and is less traumatic.**
- Talk through each step; give the patient control.

The arm implant

- **Etonogestrel single-rod progestin implant, placed subdermally in the inner side of the non-dominant UPPER ARM.**
- **68 mg etonogestrel; FDA-approved for up to 5 years (extended from 3).**

Mechanism

- Thickens cervical mucus; alters tubal motility.
- Higher doses inhibit gonadotropins → no follicular maturation or ovulation.

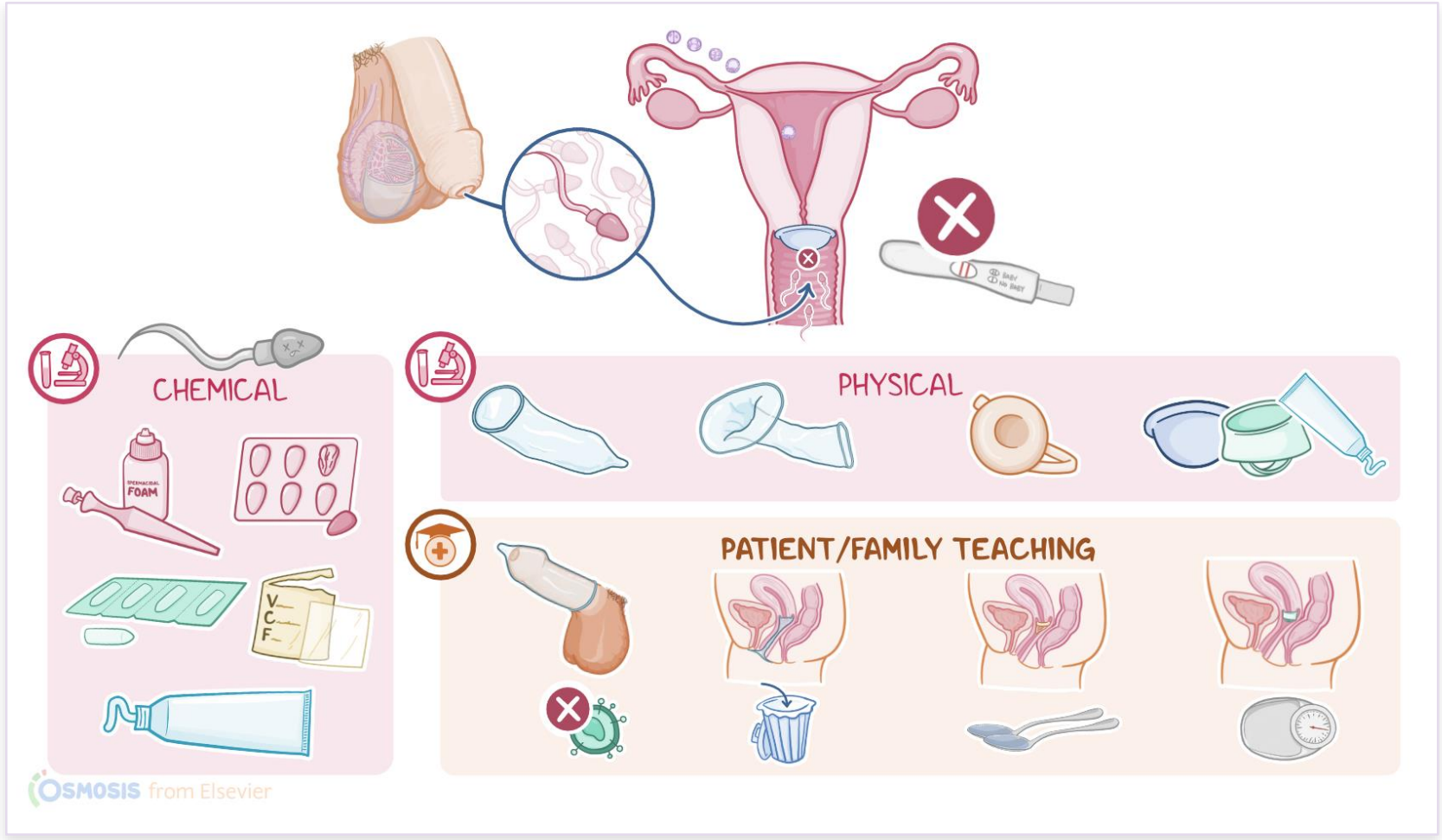
Bleeding pattern

- **Unpredictable — “who knows!” It's all over the place.**
- Counsel on this up front; it drives most removals.

Nexplanon label; FDA 5-year extension (Organon, 2026)

Barrier methods

Coitally-dependent, non-hormonal, and STI-relevant — the patient-controlled tier.



Non-hormonal vaginal gel

- **Lactic acid + citric acid + potassium bitartrate gel — an on-demand, non-hormonal method.**
- Works by keeping vaginal pH low (hostile to sperm) — not a spermicide in the traditional sense.
- **NOT effective if used after intercourse.**
- **Dose: one prefilled 5 g applicator vaginally, immediately before or up to 1 hour before each act of intercourse.**

Objectives revisited

- **Contraceptive options** The full menu — covered.
- **Benefits vs. risks** Weighed per method.
- **Mechanism explained** Copper, LNG, implant, gel.
- **Counseling** PATH and shared decisions.
- **Individualized approach** MEC and the patient's goals.
- **Social media's impact** Engaged, not dismissed.

Resources & references

- US Medical Eligibility Criteria (US MEC) & WHO MEC for Contraceptive Use — free online
- US Selected Practice Recommendations for Contraceptive Use, 2024. MMWR Recomm Rep 2024;73(3)
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