Resources for Providers: 10 Contraception, Cervical, STI, Infectious Disease Screening, and HIV Prophylaxis

Strength of Recommendations
Bold = Good
Italics = Fair
Plain Text = consensus or inconclusive evidence

Selected Guidelines and Resources are found at greighealthrecord.ca

Contraception Recommendations

Note – recommendations for contraception do not address STI prevention

Recommend contraceptives in order of effectiveness.

1. Long-acting, reversible (LARC) - IUD or IUS or implantable etonogestrel device
2. Hormonal plus time of intercourse method
3. Hormonal – OCPs, transdermal patch, vaginal ring, injectable
4. Used at time of intercourse – male and female condoms, diaphragms, cervical caps, sponges and spermicide.

History and Physical
Take a complete medical history,
Ask about migraines with aura – an absolute contraindication to estrogen use, progesterone only methods may be used
Examination – weight and BP
Provide contraception without a pelvic examination unless required eg for IUC insertion

Prescribing
Quick-start approach – do not wait for next menses if reasonable certainty that they are not pregnant, use a back up method for 7 days after starting an OCP or implantable etonogestrel device outside of days 1 to 5 of the menstrual cycle.
Provide one-year prescriptions to increase adherence (ie for non LARC)
Choose OCP with 30 or 35 mcg of ethinyl estradiol – lower levels may have negative effects on bone mineral density for adolescents
For OCPs extended cycles and continuous use of active pills are effective

Precautions and contraindications
For individuals over 90kg – certain contraceptives may have reduced effectiveness
Combined OCP Contraindications: containing estrogen
Migraine with aura, history of venous thromboembolism or pulmonary embolus, SLE with anti-phospholipid antibodies, Factor V Leiden deficiency, estrogen sensitive tumours etc (see guidelines)
Use SOGC guidelines to inform contraceptive choice

Discuss emergency contraception and condom use as appropriate

CPS, SOGC Di Meglio G, Paediatrics & Child Health, 2018, 271-277

Emergency Contraception

Options:
1. Emergency over-the-counter hormonal pills (easiest to obtain, but reduced efficacy for patients weighing ≥75 kg)
   - Oral levonorgestrel (LNG)
   - Ulipristal acetate (UPA)
   - Combined OCP (lower efficacy than above)
2. Copper IUD (most effective)
3. Levonorgestrel IUS

When prescribing
- Ask about timing of unprotected intercourse (determine if within window of effectiveness)
- Assess re risk for pre-existing pregnancy
- Ask if unprotected intercourse was coerced
- Assess for STI risk, need for post exposure prophylaxis, offer testing for STIs
- Consider a pregnancy test 3 weeks post use

Reference: https://www.jogc.com/article/S1701-2163(16)39372-0/fulltext

Adapted from JOGC, October 2015;37(10):S20-8. Bancsi & Grindrod Can Fam Phys 2020;66(1):42-4.

Post Exposure Prophylaxis (PEP)

Post Exposure Prophylaxis indications
- Needs to be started within 72 hrs (the sooner the better)
- Recommended for HIV negative individuals after moderate to high risk exposure for HIV transmission with a person who has a substantial risk of having transmissible HIV
- Can be considered for HIV negative individuals after an exposure that is moderate or high risk for HIV transmission with a person who has a low but non-negligible risk of having transmissible HIV
- https://www.cmaj.ca/content/189/47/E1448 for transmission risk and exposure risk information

Consider doxycycline for prophylaxis of gonorrhea, chlamydia and syphilis

See full guideline for details.

https://www.cmaj.ca/content/189/47/E1448
https://www.cfp.ca/content/70/2/107
https://www.catie.ca/doxycycline

Cervical cancer, STI and Infectious Disease Screening

Cervical Cancer Screening - Not recommended in the pediatric population

Chlamydia and Gonorrhea	*Screen all asymptomatic sexually active individuals under age 25 years*
	Self-collected vaginal or provider collected vaginal or cervical swabs, or urine (use first 10 to 20 ml of urine, Preferable to avoid voiding 2hrs prior but does not preclude testing)*
	** Vaginal self-administered swabs are preferred for patients with vagina / cervix..* Instructions for sample collection should be given.
	Pharyngeal or rectal -can use self collected, for those at risk due to oral or anal sex.
	NAAT (nucleic acid amplification test) is preferred. If antibiotic resistance is a concern, add a culture swab as well.
	Use vaginal* or cervical swabs (not urine) for those with female anatomy who are symptomatic or case contacts or *pregnant.*
HIV	**Offer screening age 15 and above. Screen younger individuals if sexually active or other risk factors** **Consider PrEP for individuals at higher risk**
Syphilis	**Screen anyone with a new partner or multiple partners or anyone who asks.** For those with multiple partners, screen every 3 to 6 months. Screening guidelines in pregnancy are updated.
Hepatitis A	Risk with anal-oral contact, **advise immunization in those at risk**
Hepatitis B	**Ensure immunization is up to date** *Screen high risk for HepBSAg* Risk factors: • High risk sexual practices • Sharing of drug paraphernalia for injection or inhalation • Using contaminated/shared equipment that breaks the skin eg tattoos, piercing, glucometers • Exposure to blood/ body fluids – eg occupational • HIV positive, immune compromised or on immunosuppressive medication • Household or sexual contacts of or born to a HBsAg-positive person, family history of Hep B or hepatoma • Region of higher endemicity: born, lived in or travelled to • Exposure through blood in endemic region without routine precautions/screening • Incarcerated or institutionalized
Hepatitis C	High risk Risk factors: • Born to HCV pos mother • Unprotected sex with risk of blood exposure • Sexual assault • Non-sterile or inadequately sterilized equipment for injections, tattoos, piercings and procedures • Shared drug equipment – injection, nasal or inhalation • Shared personal care items • Having visited or lived in a region with high HCV prevalence • Medical procedures with potentially non-sterile equipment
Herpes simplex	Not recommended for primary screening

Pre-exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis indications
- **MSM and transgender women those reporting condomless anal sex and other risk factors (see guideline – link below).**
- **Heterosexual partner reporting condomless vaginal or anal sex with a partner with a substantial** *or non-negligible* **risk of transmissible HIV**
- *People who inject drugs and share injection paraphernalia with a person with a non-neglibible risk of HIV infection*

Medication: tonfovir dioproxil fumarate/ emtricitabine 300/200 mg in a single tablet (TDF/FTC)

Recommended Regimen: one tablet of TDF/FTC daily
Alternative on demand: two tablets TDF/FTC 2 to 24 hours prior to first sexual exposure, followed by one pill daily until 48 hours after last sexual activity. (See guideline for patient selection)

Note – Post Exposure prophylaxis requires additional medications and dosing
See guidelines (links below) for full prescribing details

https://www.cmaj.ca/content/189/47/E1448 PHAC https://www.canada.ca/en/public-health/services/diseases/hiv-aids/health-professionals.html