**(insert AGENCY name)**

Reproductive Health Program

Clinical Practice Standard

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| **Subject:** Diaphragm and Cervical Cap | | **No.** |
| **Approved by:** |  | **Effective Date:** |
| **Revised Date:** January 2019,January 2021, **October 2022** | | |
| **References:** U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016; U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016; Contraceptive Technology, 20th Ed | | |

**POLICY:** This Clinical Practice Standard follows the recommendations of the U.S. MEC, 2016; U.S. SPR, 2016; and Contraceptive Technology, 20th Ed.

**PURPOSE:** This Clinical Practice Standard provides direction for reproductive health clinics to assist clients in their use of the diaphragm or cervical cap.

Diaphragms/cervical caps provide contraception by blocking sperms’ entry into the cervix by both a barrier effect and by spermicidal activity from the spermicides used with the diaphragm/cervical cap. These contraceptive devices are used with a spermicidal agent in front of the cervix in order to kill the sperm. In typical use, 12 out of 100 people who use a diaphragm/cervical cap will experience an unintended pregnancy within the first year.

The diaphragm is a reusable dome-shaped rubber cup which covers the cervix and is inserted into the vagina before intercourse. The diaphragm may provide effective contraceptive protection up to 6 hours. If a longer interval has elapsed, insertion of additional doses of spermicides into the vagina with an applicator (without removing the diaphragm) is recommended. After intercourse, the diaphragm should be left in place for at least 6 hours. Wearing it longer than 24 hours is not recommended because of rare risk of toxic shock syndrome.

The cervical cap is a reusable bowl-shaped silicone rubber cap with a brim that flares outward. The concave side covers the cervix completely. Spermicides can be placed on the inside and outside of the cap. The cervical cap can be worn for up to 48 hours.

Diaphragms and cervical caps do not protect against sexually transmitted infections (STIs).

**STANDARD:**

1. (**insert AGENCY name**) MDs, NPs, PAs, DOs, and NDs may prescribe a diaphragm or cervical cap to any client who requests this method and has no U.S. MEC category 4 risk conditions.
2. (**insert AGENCY name**) RNs may dispense a diaphragm or cervical cap that does not require fitting to any client who requests this method and has no U.S. MEC category 3 or 4 risk conditions. RNs may dispense a diaphragm or cervical cap to clients with U.S. MEC category 3 conditions only under a current written or verbal order from a prescribing provider.

**PROCEDURE:**

1. Follow [*Core Reproductive Health Services Clinical Practice Standard*](https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/Clinical-Practice-Standards/CPS-Core_RH.docx).
2. Follow the [U.S. MEC](https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixe.html) guidelines to determine client eligibility for use of the diaphragm/cervical cap:
3. RNs may initiate the client’s contraceptive method of choice as long as the client has no U.S. MEC category 3 or 4 risk conditions for its use.
4. If client has any MEC category 3 conditions, an NP, PA, DO, ND or MD *may* prescribe the method according to their clinical judgement, if requested by the client. Documentation must show that the client understands the risks of the method and finds other, lower-risk methods unacceptable. RNs may not dispense the method unless under explicit verbal order after discussing the client's case with the prescribing provider.
5. Clients requesting a method for which they have a category 4 risk condition will be offered lower risk methods and referred to an OB/GYN or specialist provider.
6. Each client will receive client instructions regarding warning signs, common side effects, risks, method of use, alternative methods, use of secondary method, and clinic follow-up schedule. Document client education and understanding of the method of choice.

**PLAN:**

1. Diaphragms/Cervical caps may be initiated at any time.
2. Allow the client to practice insertion and removal.
3. Provide the client with spermicides.
4. Review the client’s history and access of recommended health screenings. Send a Release of Records for past health screenings, if performed elsewhere.
5. Schedule the client for a Reproductive Health Well Visit if the client has not been screened appropriately within the past 12 months or if an earlier assessment is clinically indicated.

**ROUTINE FOLLOW-UP:**

1. These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy clients. Although routine follow-up is not necessary for the use of the diaphragm/cervical cap, recommendations might vary for different users and different situations. Specific populations such as adolescents, those with certain medical conditions or characteristics, and those with multiple conditions may benefit from more frequent follow-up visits.
2. Advise the client to return at any time to discuss side effects or other problems if they want to change the method being used.
3. At other routine visits, healthcare providers should do the following:

* Assess the client’s satisfaction with the contraceptive method and whether the client has any concerns about method use.
* Assess any changes in health status that would change the appropriateness of the vaginal barrier for safe and effective continued use on the basis of U.S. MEC.
* Assess any significant weight changes (gain or loss of 10 or more pounds) or recent pregnancy which may affect the fitting of the diaphragm.
* Diaphragms/cervical caps should be replaced every 2 years or sooner if there is visible deterioration or damage.

Managing Problems:

1. Recurrent vaginal or vulvar irritation, without sign of infection, may indicate an allergy or sensitivity to the product; may suggest client try another contraceptive method.
2. If symptoms persist after discontinuing the method, reevaluate for other etiology (e.g. STI exposure, yeast vaginitis, or bacterial vaginitis).
3. Counsel the client that recurrent urinary tract infections (UTI) may occur—the client should contact the prescribing provider for a possible refitting with smaller diaphragm size or an alternative rim style if needed.
4. Instruct the client using the cervical cap to seek emergency medical care if they develop any signs and symptoms of Toxic Shock Syndrome (TSS).

**CLIENT EDUCATION:**

1. Advise the client to use the diaphragm/cervical cap every time vaginal intercourse occurs; ensure the diaphragm/cervical cap is in proper place before the penis enters the vagina.
2. Advise the client if unsure about the proper fit or placement of the diaphragm/cervical cap, use an alternative method until evaluated by a medical provider.
3. Instruct the client on the use of the diaphragm/cervical cap (see **Attachment 1**):
4. Ideally it is inserted into the vagina less than two hours before sexual intercourse.

* Place one tablespoon of spermicide into the dome and along rim.
* Place an additional applicator of spermicide in the vagina.
* If the diaphragm is placed 3 to 6 hours before intercourse, another applicator full of spermicides needs to be inserted into the vagina prior to sexual intercourse.
* Each new episode of intercourse while the diaphragm is in place should be preceded by the insertion of fresh spermicide, and the diaphragm should remain in place for at least six hours after the last episode of intercourse to maximize effectiveness.
* For the cervical cap, once it is in place, it is not necessary to use more spermicide with each vaginal intercourse.

1. Instruct the client to minimize the risk of vaginal irritation, cystitis and, rarely, toxic shock.
2. The diaphragm should be removed by 24 hours after initial insertion.
3. The cervical cap must be removed within 48 hours.
4. Counsel the client on their individual risk of STI acquisition or transmission; when using N-9 spermicides more than 3 applications per day, the risk of HIV is increased compared to a placebo.
5. Instruct the client when using the diaphragm to avoid lubricants such as mineral oil, baby oil, suntan oil, vegetable oil, and butter; and vaginal cream such as Femstat cream, Monistat cream, estrogen cream, and vagisil.
6. Inform the client to use contraceptive jelly or water-soluble lubricant intended for use with condoms for lubrication, if needed.
7. Advise the client that douching after intercourse is not recommended. If the client chooses to douche, wait at least 6 hours after intercourse.
8. Advise the client to store the diaphragm/cervical cap in a location that is clean, cool, and out of the sunlight.
9. Instruct the client to wash diaphragm/cervical cap and spermicides inserter after each use with plain soap and water.
10. Instruct the client to check diaphragm/cervical cap before each use to make sure there are no holes or tears and that the device is not damaged.
11. Inform the client of signs and symptoms of Toxic Shock Syndrome (clients should be informed to seek immediate care if any warning signs are noted):
12. Sudden high fever;
13. Chills;
14. Vomiting;
15. Diarrhea;
16. Muscle aches; or
17. Sunburn-like rash.

**REFERENCES:**

Centers for Disease Control and Prevention. 2016. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf>

Centers for Disease Control and Prevention. 2016. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>

Cates, W. & Harwood, B. 2011. Vaginal Barriers and Spermicides, In Deborah Kowal (Ed) *Contraceptive Technology*, 20th Ed. Pg 391-407. Ardent Media: Atlanta, GA

**ATTACHMENT 1: Explaining How to Use the Diaphragm**

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| **IMPORTANT:** Whenever possible, show the client the location of the pubic bone and cervix with a model or a picture. Explain that the diaphragm is inserted behind the pubic bone and covers the cervix. | |
| **Explain the 5 Basic Steps to Using a Diaphragm** | |
| **Basic Steps** | **Important Details** |
| **1. Squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim** | * Wash hands with mild soap and clean water, if possible. * Check the diaphragm for holes, cracks, or tears by holding it up to the light. * Check the expiration date of the spermicide and avoid using any beyond its expiration date. * Insert the diaphragm less than 6 hours before having sex. |
| **2. Press the rim together; push into the vagina as far as it goes** | * Choose a position that is comfortable for insertion—squatting, raising one leg, sitting, or lying down. |
| **3. Feel diaphragm to make sure it covers the cervix** | * Through the dome of the diaphragm, the cervix feels like the tip of the nose. * If the diaphragm feels uncomfortable, take it out and insert it again.   Steps 1 through 3 on how to use a diaphragm |
| **4. Keep in place for at least 6 hours after sex** | * Keep the diaphragm in place at least 6 hours after having sex but no longer than 24 hours. * *Leaving the diaphragm in place for more than one day may increase the risk of toxic shock syndrome.* It can also cause a bad odor and vaginal discharge. (Odor and discharge may go away after the diaphragm is removed.) * For multiple acts of sex, make sure that the diaphragm is in the correct position and also insert additional spermicide in front of the diaphragm before each act of sex. |
| **5. To remove, slide a finger under the rim of the diaphragm to pull it down and out** | * Wash hands with mild soap and clean water, if possible. * Insert a finger into the vagina until the rim of the diaphragm is felt. * Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail. * Wash the diaphragm with mild soap and clean water and dry it after each use.   **Retrieved from Family Planning, A Global Handbook for Providers @** [**https://www.fphandbook.org/explaining-how-use-diaphragm**](https://www.fphandbook.org/explaining-how-use-diaphragm) |