Providing evidence-based family planning: Contraception Resources from the CDC

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Division of Reproductive Health
Disclaimer

- The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention
Objectives

- Understand the importance of contraceptive access for reproductive life planning
- Describe the U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (U.S. MEC) and U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (U.S. SPR)
- Understand how to apply CDC contraception guidance in specific situations, based on clinical scenarios
Unintended pregnancy in the United States

PREGNANCIES BY INTENTION STATUS

Nearly half of U.S. pregnancies were unintended in 2011.

- Intended: 55%
- Mistimed: 27%
- Unwanted: 18%

www.guttmacher.org
Contraception is highly effective

Among U.S. women at risk of unintended pregnancy...

the **68%** who use contraception consistently and correctly account for only **5%** of unintended pregnancies

[Source: www.guttmacher.org]
Most unintended pregnancies result from incorrect or nonuse of contraception
Unintended pregnancy and contraceptive use in American Indian and Alaskan Native populations

• Limited data

• Rural populations – historically high prevalence of unintended pregnancy (scant data)

• Urban populations – 2002 National Survey of Family Growth
  • 60% of sampled AI/AN women ages 15-24 not using any contraception at current time (38% nationally)

• Rutman et al, Matern Child Health Journal, 2012

  https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states
Birth rates for females aged 15-19

EFFECTIVENESS OF FAMILY PLANNING METHODS*

*The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

**Most Effective**

- Implant: 0.05%
- Intrauterine Device (IUD): 0.2% LNG, 0.8% Copper T

**Permanent Sterilization**

- Female (Abdominal, Laparoscopic, and Hysteroscopic): 0.5%
- Male (Vasectomy): 0.15%

**Reversible**

- Injectable: 6%
- Pill: 9%
- Patch: 9%
- Ring: 9%
- Diaphragm: 12%

Set repeat injections on time. Take a pill each day. Keep in place, change on time. Use correctly every time you have sex.

- Male Condom: 18%
- Female Condom: 21%
- Withdrawal: 22%
- Sponge: 12% Nulliparous Women, 24% Parous Women

**Fertility Awareness-Based Methods**

- Jan 1: 24%

**Least Effective**

- Condoms should always be used to reduce the risk of sexually transmitted infections.

- Spermicide: 28%

Other Methods of Contraception: (1) Lactational Amenorrhea Method (LAM): is a highly effective, temporary method of contraception; and

- Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Why is evidence-based guidance for contraceptive use needed?

- To base family planning practices on the best available evidence
- To address misconceptions regarding who can safely use contraception
- To remove unnecessary medical barriers
- To improve access and quality of care in family planning
Contraception resources from the CDC

**US MEC**

US MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE, 2016

**US SPR**

US SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE, 2016
U.S. Medical Eligibility Criteria for Contraceptive Use, 2016

- Safe use of contraceptive methods by women and men with certain characteristics or medical conditions

- Target audience: health care providers

- Purpose: to assist health care providers when they counsel patients about contraceptive use and to serve as a source of clinical guidance

- Content: more than 1800 recommendations for over 60 conditions
U.S. Selected Practice Recommendations for Contraceptive Use, 2016

- Recommendations for contraceptive management questions
- Target audience: health care providers
- Purpose: to assist health care providers when they counsel patients on contraceptive use and to serve as a source of clinical guidance
- Content: Guidance for common contraceptive management topics such as:
  - How to be reasonably certain that a woman is not pregnant
  - When to start contraception
  - Medically indicated exams and tests
  - Follow-up and management of problems
Methods for 2016 U.S. MEC and SPR

- Both documents adapted from WHO guidelines
- Ongoing monitoring of published evidence
- Expert meeting in August 2014 to discuss scope
- Expert meeting in August 2015 to review evidence and discuss specific recommendations
  - CDC staff and outside authors conducted independent systematic reviews to inform recommendations
  - These systematic reviews have been e-published
  - CDC determined final recommendations
Contraceptive Methods in MEC

- Intrauterine devices
- Progestin-only contraceptives
- Combined hormonal contraceptives
- Emergency contraceptive pills
- Barrier contraceptive methods
- Fertility Awareness-Based Methods
- Lactational Amenorrhea Method
- Coitus Interruptus
- Female and Male Sterilization
## U.S. MEC: Categories

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction for the use of the contraceptive method for a woman with that condition</td>
</tr>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that condition</td>
</tr>
</tbody>
</table>
## Example: Smoking and Contraceptive Use

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implants</th>
<th>DMPA</th>
<th>POPs</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Age &lt;35</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b. Age≥35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. &lt;15 cigarettes/day</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>II. ≥15 cigarettes/day</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Cu IUD: Copper IUD;  
LNG-IUD: Levonorgestrel IUD;  
DMPA: Depo-Medroxyprogesterone Acetate;  
POPs: Progestin-only pills;  
CHCs: Combined hormonal contraceptives including pills, patch, and ring
Conditions Associated with Increased Risk for Adverse Heath Events as a Result of Unintended Pregnancy

Consider long-acting, highly effective contraception for these patients

Breast cancer
Complicated valvular heart disease
Cystic fibrosis
Diabetes: insulin dependent; with nephropathy/ retinopathy/neuropathy or other vascular disease; or of >20 years’ duration
Endometrial or ovarian cancer
Epilepsy
Hypertension (systolic > 160 mm Hg or diastolic > 100 mm Hg)
History of bariatric surgery within past 2 years
HIV: not clinically well or not receiving anti-retroviral therapy
Ischemic heart disease
Hepatocellular adenoma and malignant liver tumors (hepatoma)
Peripartum cardiomyopathy
Gestational trophoblastic disease
Severe (decompensated) cirrhosis
Sickle cell disease
past 2 years
Systemic lupus erythematosus
Thrombogenic mutations
Tuberculosis
2016 Updates to U.S. MEC: New Recommendations

- **4 new conditions**
  - Cystic fibrosis
  - Multiple sclerosis
  - Women using selective serotonin reuptake inhibitors (SSRIs)
  - Women using St. John’s wort

- **1 new emergency contraception method**
  - Ulipristal acetate (UPA)

- **Revised emergency contraception section**
2016 Updates to U.S. MEC: Changes to Existing Recommendations

- **Hormonal methods (Implants, DMPA, POP, CHCs)**
  - Migraine headaches
  - Superficial venous disease
  - Women using antiretroviral therapy
  - Women with known dyslipidemia

- **Intrauterine devices (Cu-IUD, LNG-IUD)**
  - Gestational trophoblastic disease
  - Postpartum and breastfeeding women
  - Human immunodeficiency virus
  - Factors related to sexually transmitted diseases
CLINICAL SCENARIOS
Scenario 1

28 year old G1P0 female is pregnant and being counseled for postpartum family planning. She is not planning on breastfeeding. What options are available to her postpartum?

A. IUD (copper or levonorgestrel)
B. Progestin-only methods (pill, injectable, implant)
C. Combined hormonal methods (pill, patch, ring)
Why is postpartum contraception important?

- Avoid unintended pregnancy and short birth interval

- May be ideal time to provide contraception
  - Motivation
  - Access to health care services, especially during delivery hospitalization

- Prevent repeat adolescent pregnancies
  - 20% of adolescent births are repeat births

Hormonal methods for non-breastfeeding postpartum women

<table>
<thead>
<tr>
<th>Postpartum (non-breastfeeding)</th>
<th>CHCs</th>
<th>Progestin-only methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>21-42 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With other risk factors for VTE</td>
<td>3*</td>
<td>1</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>&gt;42 days</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Clarification: Other risk factors might increase classification to “4”
## Postpartum IUD insertion

<table>
<thead>
<tr>
<th>Postpartum (breastfeeding or non-breastfeeding, including post cesarean section)</th>
<th>LNG-IUD</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10 min after delivery of placenta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Non-breastfeeding</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10 min to &lt;4 weeks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>≥4 weeks</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Postpartum sepsis</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Scenario 1

28 year old G1P0 female is pregnant and being counseled for postpartum family planning. She is not planning on breastfeeding. What options are available to her immediately postpartum?

A. IUD (copper or levonorgestrel)
B. Progestin-only methods (pill, injectable, implant)
C. Combined hormonal methods (pill, patch, ring)
   (Wait until 21-42 days postpartum, depending on VTE risk factors)
Scenario 2

- 38 year old G2P2 female with diabetes has been using condoms for contraception and is looking for a more effective method. What methods are safe for her to use?

A. IUD (copper or levonorgestrel)
B. Progestin-only methods (pill, injectable, implant)
C. Combined hormonal methods (pill, patch, ring)
# Diabetes

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of gestational disease</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nonvascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noninsulin-dependent</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Insulin-dependent§</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nephropathy/retinopathy/neuropathy§</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3/4†</td>
</tr>
<tr>
<td>Other vascular disease or diabetes of &gt;20 yrs' duration§</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3/4†</td>
</tr>
</tbody>
</table>

§ This condition is associated with increased risk for adverse health events as a result of pregnancy
† This category should be assessed according to the severity of the condition
Scenario 2

- 38 year old G2P2 female with diabetes has been using condoms for contraception and is looking for a more effective method. You now know that she is non-insulin dependent and has no vascular disease. What methods are safe for her to use?

A. IUD (copper or levonorgestrel)
B. Progestin-only methods (pill, injectable, implant)
C. Combined hormonal methods (pill, patch, ring)
ALL OF THE ABOVE
**Scenario 3**

- A 30 year old female has a history of migraine headaches with light sensitivity. She does not experience any visual warning signs for a coming headache. She is interested in starting contraception. What methods are safe for her to consider?

A. Combined hormonal methods (pill, patch, ring)
B. Progestin implant
C. Intrauterine device
## Headaches

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cu-IUD</th>
<th>LNG IUD</th>
<th>Implants</th>
<th>DMPA</th>
<th>POP</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-migraine</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Migraine Without aura</strong> (including menstrual migraine)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Migraine With aura</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note: The asterisk (*) indicates additional information or context related to the condition.*
Scenario 3

- A 30 year old female has a history of migraine headaches with light sensitivity. She does not experience any visual warning signs for a coming headache. She is interested in starting contraception. What methods are safe for her to consider?

Answer:
A. Combined hormonal methods (pill, patch, ring)
B. Progestin implant
C. Intrauterine device

All of the above, so long as she does not have other risk factors for stroke. (If so, progestin-only methods and IUDs are safe or generally safe to use.)
Scenario 4:

- A 19 y.o. woman comes to the office desiring an IUD. She has a history of chlamydia 6 months ago that was treated, and reports one new partner since then.

- Q: Given her STD risk factors, can you place an IUD today?
<table>
<thead>
<tr>
<th>Condition</th>
<th>IUDs Init.</th>
<th>IUDs Cont.</th>
<th>Implants</th>
<th>DMPA</th>
<th>POP</th>
<th>CHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current purulent cervicitis or chlamydial infection or gonococcal infection</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vaginitis (including trichomonas and bacterial vaginosis)</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other factors related to STDs</td>
<td>2*</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Clarification: If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC STD treatment guidelines, screening may be performed at the time of IUD insertion and insertion should not be delayed.
Scenario 4:

- A 19 y.o. woman comes to the office desiring an IUD. She has a history of chlamydia 6 months ago that was treated, and reports one new partner since then.

  - Q: Can you place an IUD today?

  - A: Yes, so long as she does not have purulent cervicitis. Perform screening for gonorrhea/chlamydia at the time of IUD insertion. Refer to the SPR for guidelines on assessment of pregnancy and follow-up.
US SPR

US SELECTED PRACTICE
RECOMMENDATIONS
FOR CONTRACEPTIVE USE, 2016
2016 U.S. SPR

- Recommendations for common contraceptive management questions

- Arranged by method and presented in order of effectiveness
  - Each method section is sub-divided into recommendation sections

- Recommendations are presented first and followed by comments and evidence summary

- Several tables and flow charts are included for use by clinicians
Major Updates to 2016 U.S. SPR

- **New recommendation**
  - Using medications to ease IUD insertion

- **Update of existing recommendation**
  - When to start regular contraception after ulipristal acetate

- Updates consistent with changes in U.S. MEC 2016
CLINICAL SCENARIOS
Clinical scenario 1: When to start a contraceptive method

- 24 y.o. woman comes to office desiring contraception and wants to start pills

- Q: When can she start?
When to start a contraceptive method

- **Barriers to starting**
  - Filling a prescription
  - Starting during menses
  - Coming back for a second (or more) visit

- **Starting when woman requests contraception (“Quick start”)**
  - May reduce time woman is at risk for pregnancy
  - May reduce barriers to starting
Evidence for Risk of Pregnancy

Two types of risk:

- **Risk of already being pregnant**
  - Risk that woman already pregnant with “Quick start” of CHCs low

- **Risk of becoming pregnant**
  - Risk of pregnancy with “Quick start” of CHCs low

Brahmi, Contraception, 2013.
Other findings

- Starting CHCs on different days of the cycle does not affect bleeding or other side effects.

- “Quick start” may increase continuation of combined oral contraceptives (COCs) and patch in the short term; this difference disappears over time.

- No increased risk for adverse outcomes (congenital anomalies, neonatal death, infant death) among infants exposed in utero to COCs.

Brahmi, Contraception, 2013.
### When to Start Using Specific Contraceptive Methods

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>When to start (if the provider is reasonably certain that the woman is not pregnant)</th>
<th>Additional contraception (i.e., back up) needed</th>
<th>Examinations or tests needed before initiation¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper-containing IUD</td>
<td>Anytime</td>
<td>Not needed</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Levonorgestrel-releasing IUD</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Implant</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Injectable</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Combined hormonal contraceptive</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Blood pressure measurement</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 2 days.</td>
<td>None</td>
</tr>
</tbody>
</table>
Clinical scenario 1: When to start a contraceptive method?

- 24 y.o. female comes to office desiring contraception and wants to start pills

  - Q: When can she start?
  - A:
    - Anytime, if reasonably certain she is not pregnant.
    - If it has been more than 5 days since menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 7 days.
Clinical scenario 2:
How to be reasonably certain that a woman is not pregnant

- 24 y.o. female comes to office desiring contraception and wants to start pills

  Q: How can you be reasonably certain she is not pregnant?
Evidence: Pregnancy test limitations

- Pregnancy detection rates can vary based on sensitivity of test and timing with respect to missed menses
- Pregnancy test not able to detect pregnancy resulting from recent intercourse
- Pregnancy test may remain positive several weeks after pregnancy ends

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is \( \leq 7 \) days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is \( \leq 7 \) days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [\( \geq 85\% \)] of feeds are breastfeeds), amenorrheic, and <6 months postpartum
Clinical scenario 2: How to be reasonably certain that a woman is not pregnant

- 24 y.o. female comes to office desiring contraception and wants to start pills
  - Q: How can you be reasonably certain she is not pregnant?
  - A: If she has no signs or symptoms of pregnancy and fulfills one of the SPR criteria, a provider can be reasonably certain that the woman is not pregnant.
Clinical scenario 3:
Exams and tests

- 24 y.o. female comes to office desiring contraception and wants to start pills

- **Q:** Do you need to do any exams or tests before she starts?
U.S. SPR
Exams and tests prior to initiation

- **Unnecessary tests may create barriers to starting contraception**
  - Women (adolescents) may not be comfortable with pelvic exam
  - Coming back for a second (or more) visit to receive test results

- **Recommendations address exams and tests needed prior to initiation**
  - Class A = essential and mandatory
  - Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context
  - Class C = does not contribute substantially to safe and effective use of the contraceptive method
### US SPR Exams and tests prior to initiation

**Contraceptive method and class**

<table>
<thead>
<tr>
<th>Examination</th>
<th>LNG and Cu-IUD</th>
<th>Implant</th>
<th>Injectable</th>
<th>CHC</th>
<th>POP</th>
<th>Condom</th>
<th>Diaphragm or cervical cap</th>
<th>Spermicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A*</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>—†</td>
<td>—†</td>
<td>—†</td>
<td>—†</td>
<td>—†</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C</td>
</tr>
</tbody>
</table>

**Laboratory test**

<table>
<thead>
<tr>
<th>Test</th>
<th>LNG and Cu-IUD</th>
<th>Implant</th>
<th>Injectable</th>
<th>CHC</th>
<th>POP</th>
<th>Condom</th>
<th>Diaphragm or cervical cap</th>
<th>Spermicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Lipids</td>
<td>C</td>
<td>C</td>
<td>C</td>
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Evidence: BP measurement

- **6 case-control studies**
  - Women who did not have blood pressure check prior to COC initiation had higher odds of acute myocardial infarction and ischemic stroke than women who had blood pressure check
  - No increased risk for hemorrhagic stroke based on whether or not blood pressure measured

No evidence identified on other hormonal methods

Tepper, Contraception, 2012.
Pelvic Exam before Initiating CHCs

- **Is not necessary before starting CHCs**
- **No concerning conditions will be detected by pelvic**

**Evidence:**
- Two case-control studies
- Delayed versus immediate pelvic exam before contraception
Clinical scenario 3: Exams and tests

- **24 y.o. female comes to office desiring contraception and wants to start pills**
  - **Q:** Do you need to do any exams or tests before she starts?
  - **A:** Blood pressure measurement essential
Clinical scenario 4:
Emergency Contraception

- 38 y.o. obese female had unprotected intercourse 4 days ago and is worried about pregnancy.

Q: What are her emergency contraception options?
Four options for EC available in the US

- **Intrauterine device**
  - Copper intrauterine device (Cu-IUD)

- **Emergency contraceptive pills (ECPs)**
  - Ulipristal acetate (UPA) available in a single dose (30 mg)
  - Levonorgestrel (LNG) in a single or split dose
  - Estrogen/progestin in 2 doses
SPR Recommendation on Effectiveness

- Large systematic review of 42 studies showed that the pregnancy rate among emergency IUD users is 0.09%.

- UPA and LNG ECPs have similar effectiveness when taken within 3 days after unprotected intercourse.
  - UPA has been shown to be more effective than the LNG formulation between 3 and 5 days after unprotected intercourse.

- UPA may be more effective than LNG for women who are obese.

- The combined estrogen/progestin regimen is less effective than UPA or LNG and is associated with more frequent side effects.
Clinical scenario 4:
Emergency Contraception

- 38 y.o. obese female had unprotected intercourse 4 days ago and is worried about pregnancy.

  - Q: What are her emergency contraception options?
  - A:
    - Copper IUD
    - Ulipristal acetate
    - Levonorgestrel ECPs
    - Combination estrogen/progestin pills
Take Home Messages, U.S. SPR

- U.S. SPR can help providers decrease medical barriers to initiating and using contraception
- Most women can start most methods anytime
- Few, if any, exams or tests are needed
- Routine follow-up generally not required
- Regular contraception should be started after emergency contraception
- Recommendations for anticipatory counseling for potential bleeding problems and proper management are provided
Accessing the MEC and SPR in everyday practice
2016 U.S. MEC and SPR App

Select Method (MEC)
- Intrauterine Contraception
- Progestin-only Contraceptives
- Combined Hormonal Contraceptives
- Barrier Methods
- Fertility Awareness-based Methods
- Lactational Amennorhea Method
- Coitus Interruptus

SPR
- How To Be Reasonably Certain That A Woman Is Not Pregnant
- Cu-IUD
- LNG-IUD
- Implants
- Injectables
- Combined Hormonal Contraceptives
- Progestin Only Pills
Using the U.S. MEC App

Headaches
- b. Migraine
  i. Without aura (this category of migraine includes menstrual migraine)
  ii. With aura

Classification depends on accurate diagnosis of those severe headaches that are migraines and those headaches that are not, as well as diagnosis of ever experiencing aura. Aura is a specific focal neurologic symptom. For more information about headache classification, see The International Classification of Headache Disorders, 2nd edition (http://ihc-classification.org/en). Any new headaches or marked changes in headaches should be evaluated.

Classification is for women without any other risk factors for stroke (e.g., age, hypertension, and smoking).
Summary tables and charts

- **MEC summary table in English, Spanish**
- **SPR quick reference charts**
  - When to start contraceptive methods and routine follow up
  - What to do for late or missed combined hormonal contraception
  - Management of IUD when PID is found
  - Management of women with bleeding irregularities while using contraception
Online access

CDC Contraceptive Guidance for Health Care Providers

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (US MEC)

The 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC) comprises recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions. The recommendations in this report are intended to assist health care providers when they counsel women, men, and couples about contraceptive method choice.

U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR)

The 2016 U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR) addresses a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods. The recommendations in this report are intended to serve as a source of clinical guidance for health care providers and provide evidence-based guidance to reduce medical barriers to contraception access and use.

Quality Family Planning

Providing Quality Family Planning Services (QFP) recommends how to provide family planning services so that individuals can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.

http://wwwdev.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
Other Tools and Aids

- MEC Wheel
- Continuing Education Activities
- Speaker-ready slides
- Contraceptive Effectiveness Charts
- Online alerts to receive updates
- eBook for SPR
- Residency training and certification
Resources


- Sign up to receive alerts!