

# Teen Pregnancy Prevention: Application of CDC's Evidence-Based Contraception Guidance

Division of Reproductive Health  
Centers for Disease Control and Prevention

November 1, 2013

# Learning Objectives

Participants will be able to:

- ❑ Review the trends in teen pregnancy, sexual behavior and contraceptive use
- ❑ Describe current contraceptive methods available to teens
- ❑ Describe the current evidence-based recommendations about the safety and effectiveness of contraceptive methods for teens

## **SECTION I.**

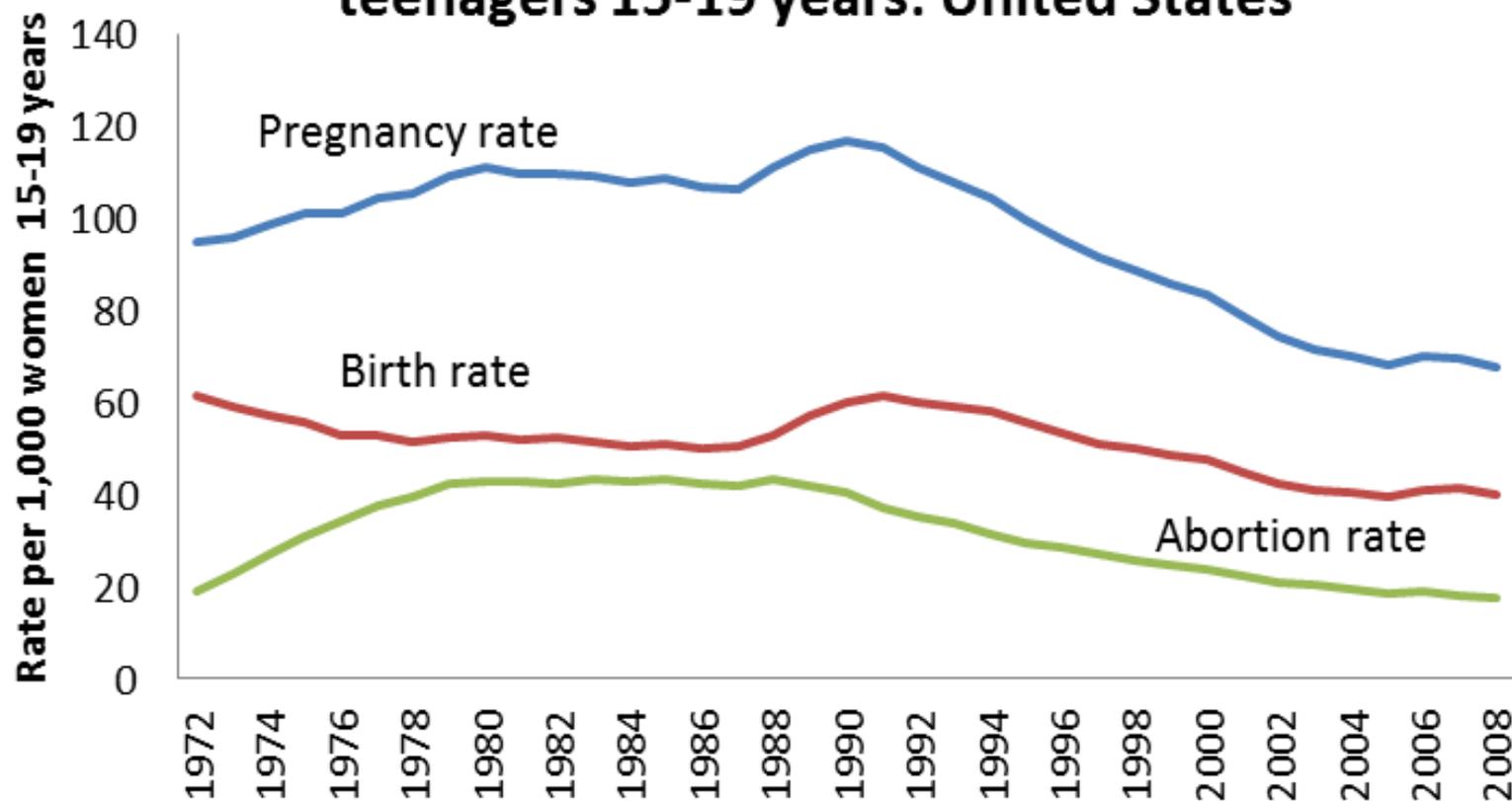
# **TRENDS IN TEEN PREGNANCY , SEXUAL BEHAVIOR AND CONTRACEPTIVE USE**

## Current Trends

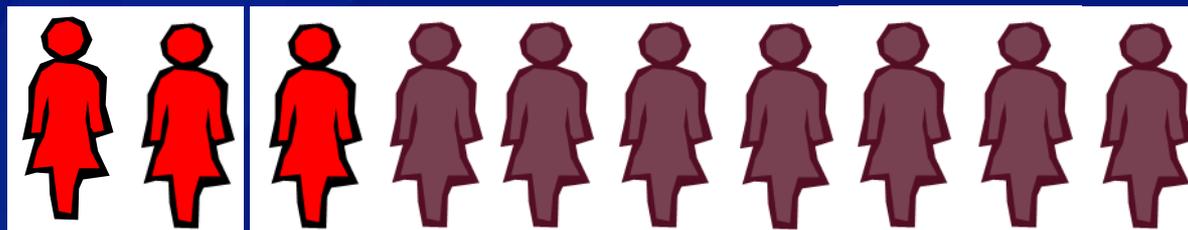
- 1. Pregnancy, birth and abortion rates are declining in the U.S. for teens aged 15-19 years old**
- 2. Teen birth rates vary by age, race/ethnicity and state**
- 3. The U.S. still has the highest teen birth rate of any industrialized country**
- 4. Teens use less effective methods and use these methods inconsistently**

# Pregnancy, birth and abortion rates for teens, 15-19 years old

**Figure 1. Pregnancy, birth and abortion rates for teenagers 15-19 years: United States**



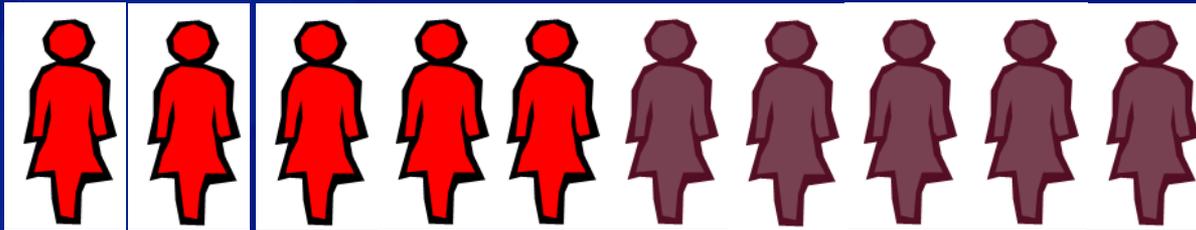
## Adolescent pregnancy in U.S.



**3 in 10** adolescent girls  
will become pregnant by age 20

The National Campaign to Prevent Teen and Unplanned Pregnancy, February 2011.  
[http://www.thenationalcampaign.org/resources/pdf/FastFacts\\_3in10.pdf](http://www.thenationalcampaign.org/resources/pdf/FastFacts_3in10.pdf)

## Adolescent pregnancy in U.S.

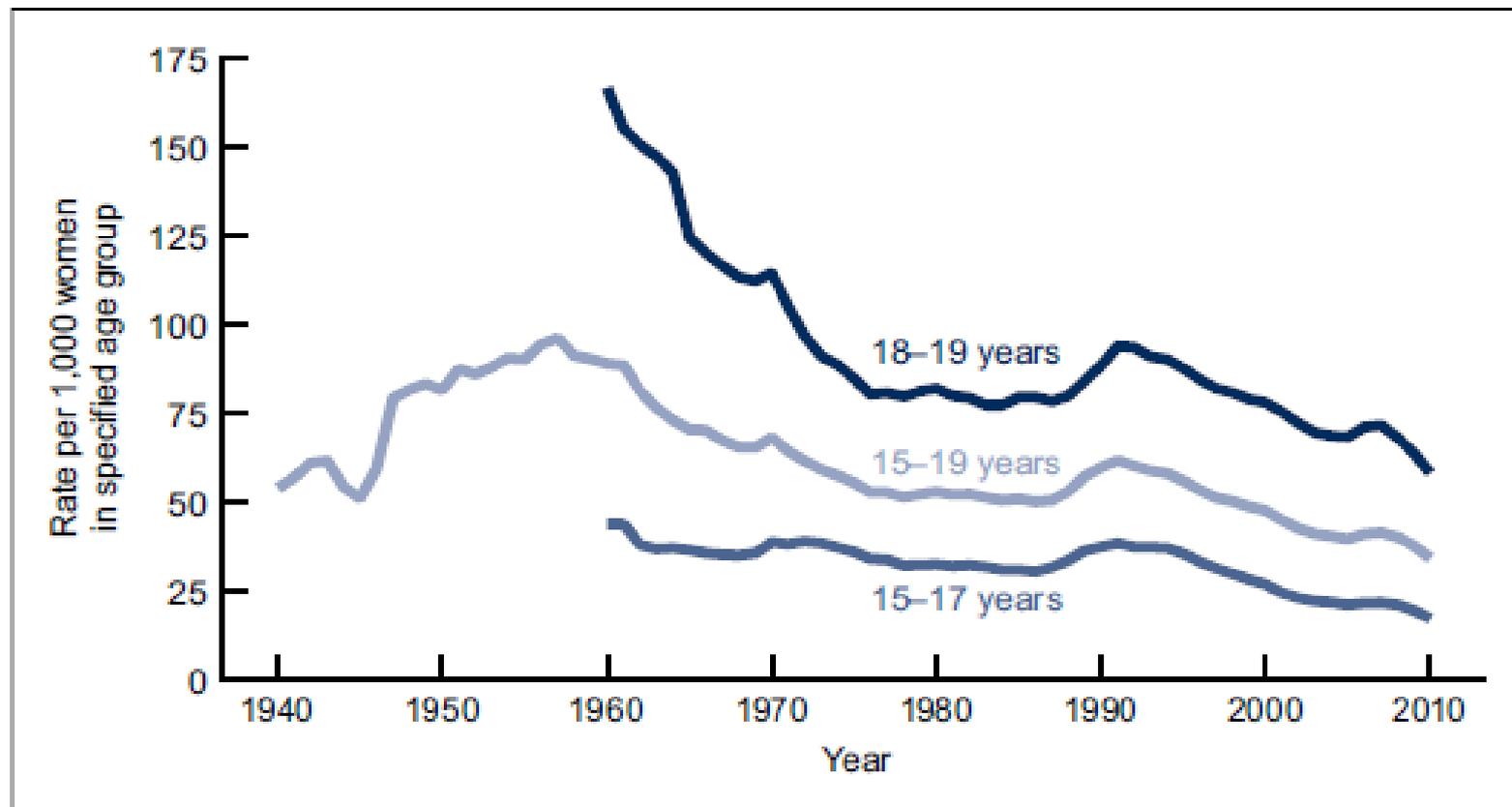


**5 in 10** black and Hispanic girls  
will become pregnant by age 20

The National Campaign to Prevent Teen and Unplanned Pregnancy, February 2011.  
[http://www.thenationalcampaign.org/resources/pdf/FastFacts\\_3in10.pdf](http://www.thenationalcampaign.org/resources/pdf/FastFacts_3in10.pdf)

# Teen Birth Rate by Age

Figure 1. Birth rates for women aged 15–19: United States, 1940–2010, and by age, 1960–2010

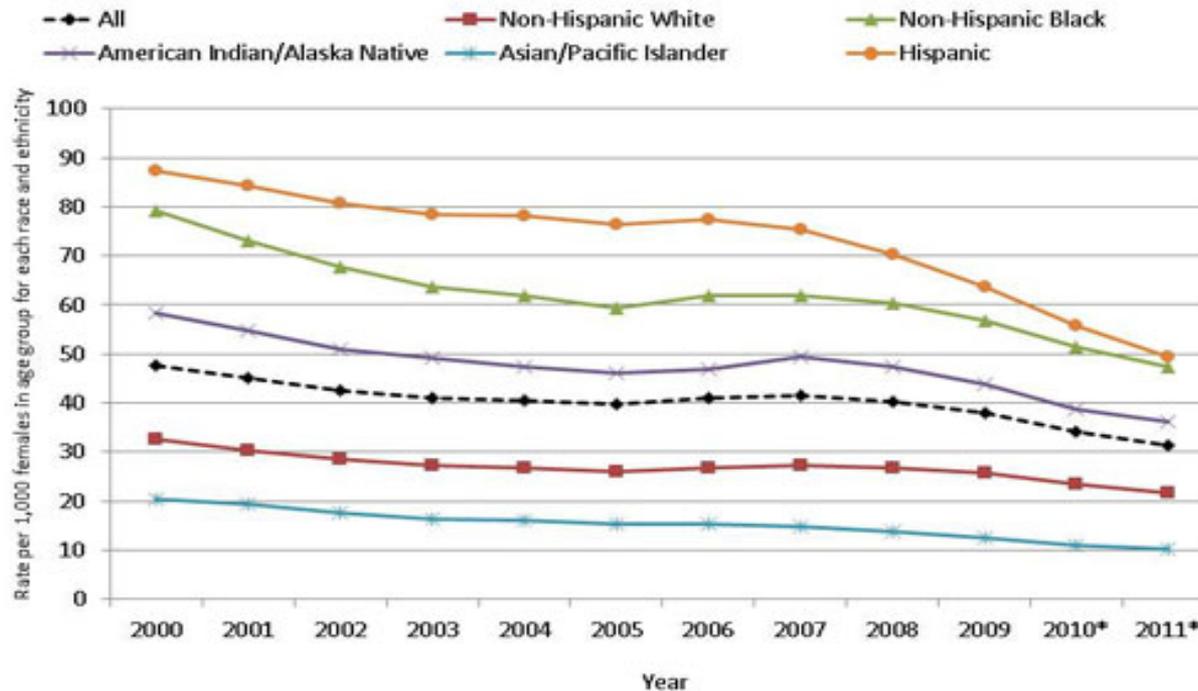


NOTE: Data for 2010 are preliminary.

SOURCE: CDC/NCHS, National Vital Statistics System.

# Teen Birth Rate by Race and Ethnicity

**Birth Rates (Live Births) per 1,000 Females Aged 15–19 Years, by Race and Hispanic Ethnicity, 2000–2011**

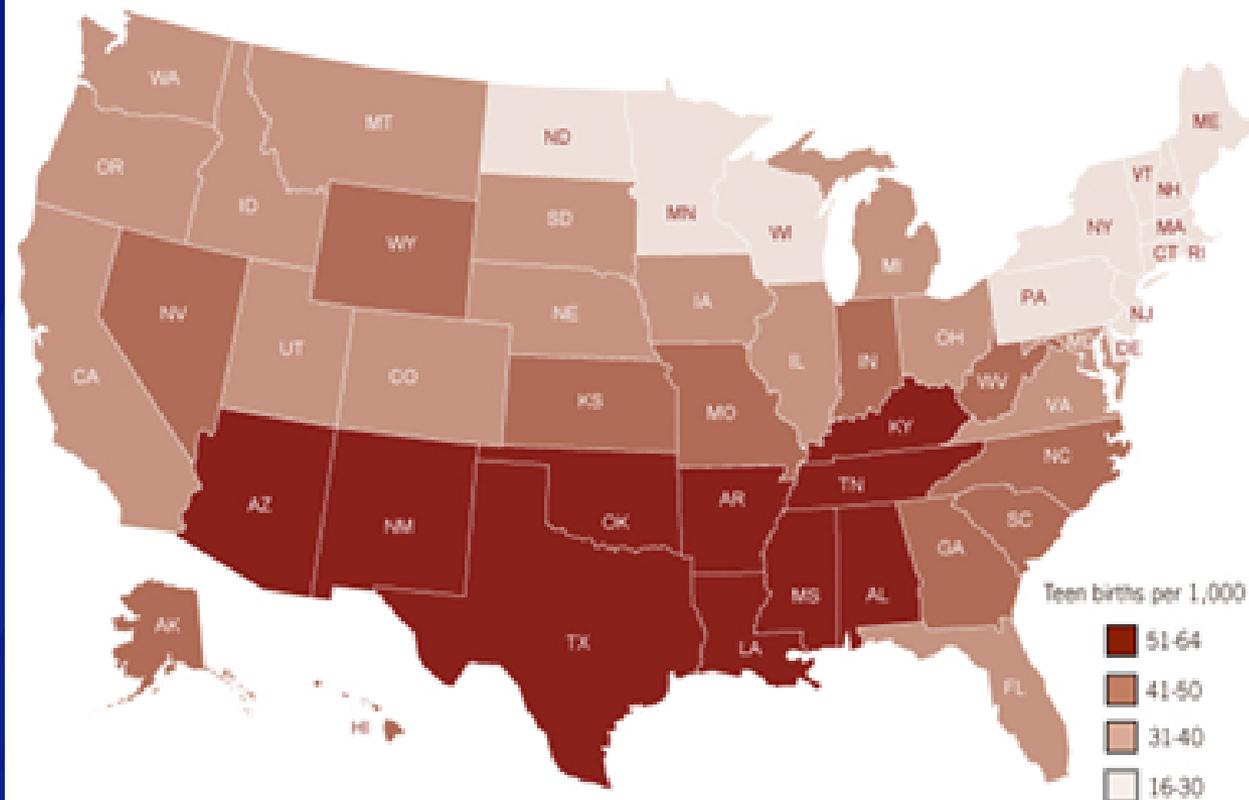


**Source:** Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2010. *National Vital Statistics Reports*. 2011;60(2):Table S-2.

\*Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2011. *National Vital Statistics Reports*. 2012;61(5). Table 2.

## Teen birth rates by state per 1,000 girls aged 15-19 years, 2009

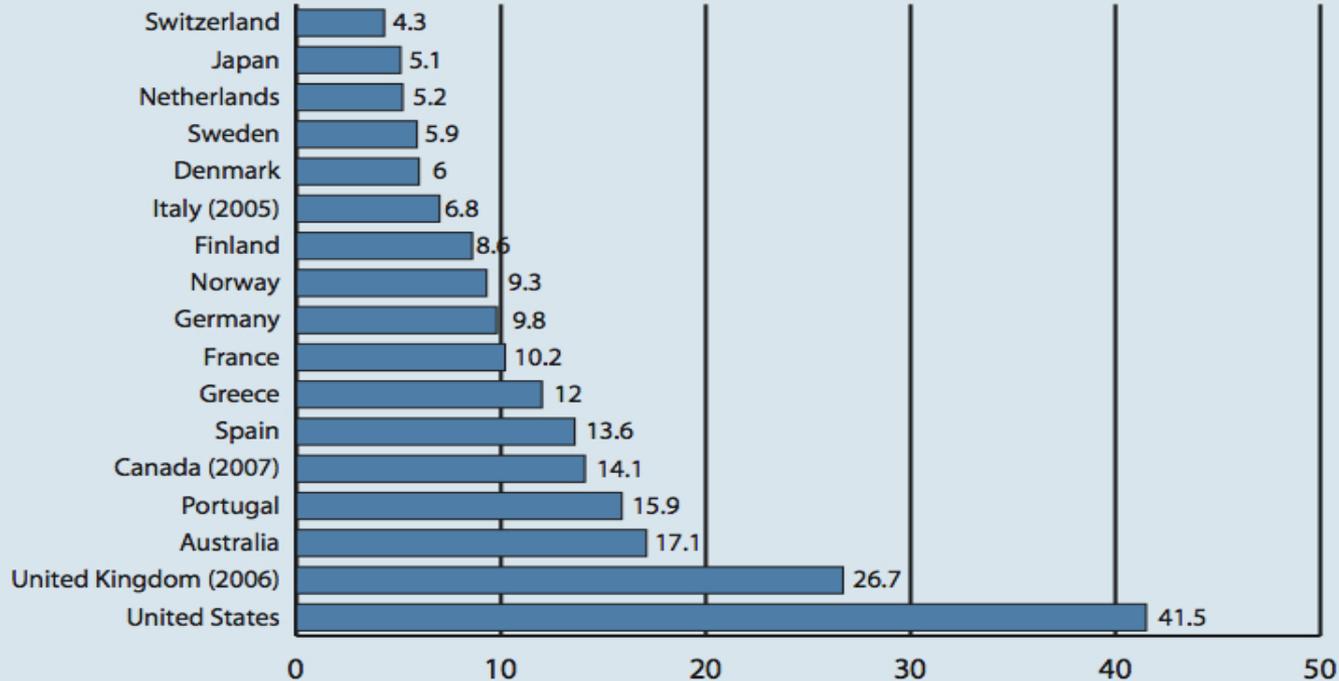
Teen birth rates were lowest in the Northeast and upper Midwest and highest across the southern states.



SOURCE: National Center for Health Statistics; 2009.

# Teen Birth Rate (per 1,000 females, 15-19 years old) by Country

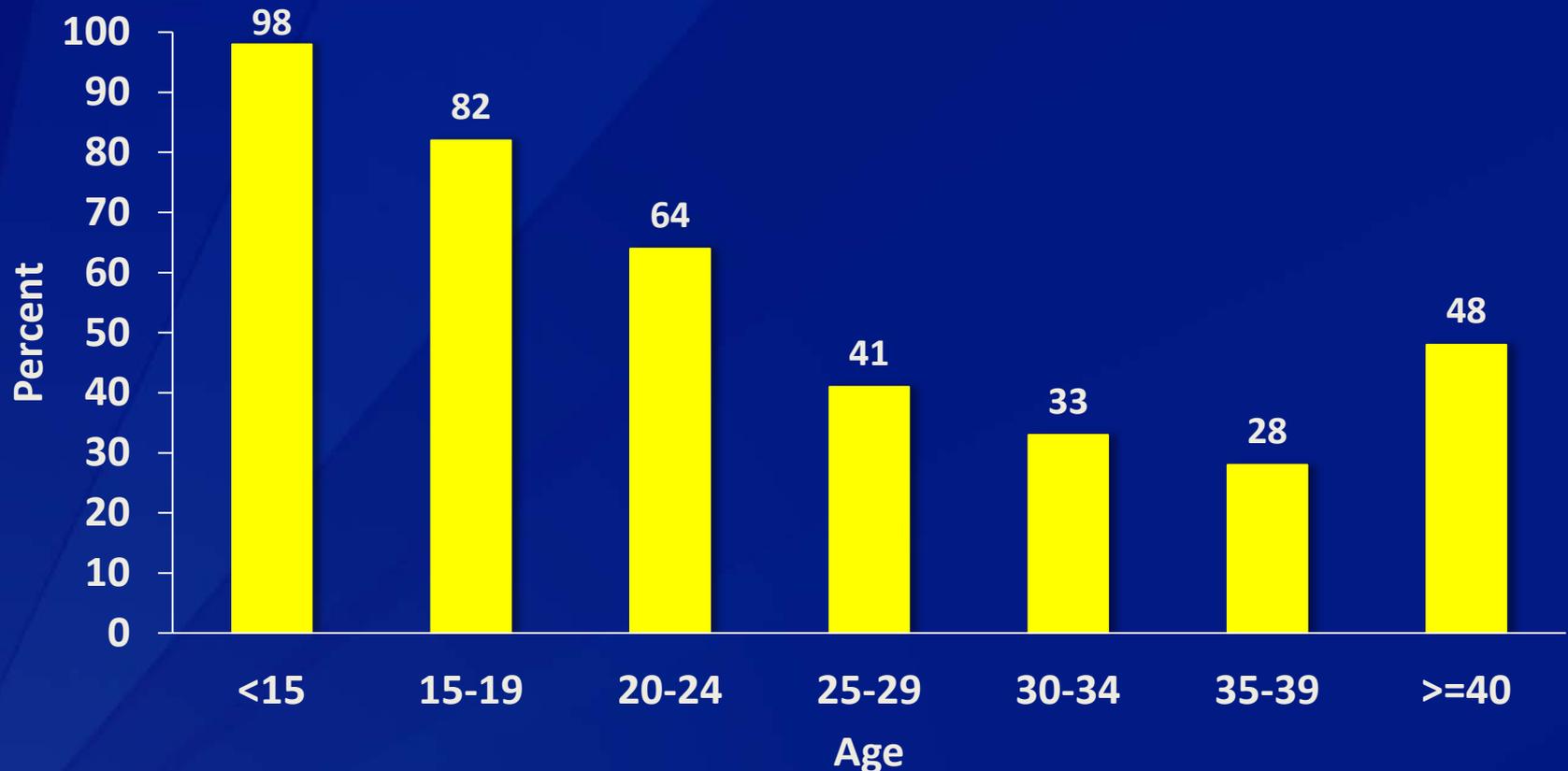
FIGURE 1. Teen Birth Rate (per 1,000 Girls Age 15-19) by Country\*



\*All birth rates are for 2008 unless otherwise noted.

Source: United States: Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Matthews, T.J., & Osterman, M.J.K. (2010). Births: Final data for 2008. *National Vital Statistics Reports*, 59 (1). Other countries: United Nations Statistical Division. *Demographic Yearbook 2008*. New York: United Nations.

# Percent of pregnancies that are unintended U.S., 2006



Finer, Contraception, 2011;84:478.

# Consequences

## ☐ Infant

- Prematurity
- Infant mortality
- Abuse
- Future teen pregnancy

## ☐ Teen Mom

- Low educational attainment
- Unemployment
- Poverty
- Risk for repeat pregnancy

## ☐ Society

- \$9.1 billion in 2004

Santelli and Melnikas, 2010

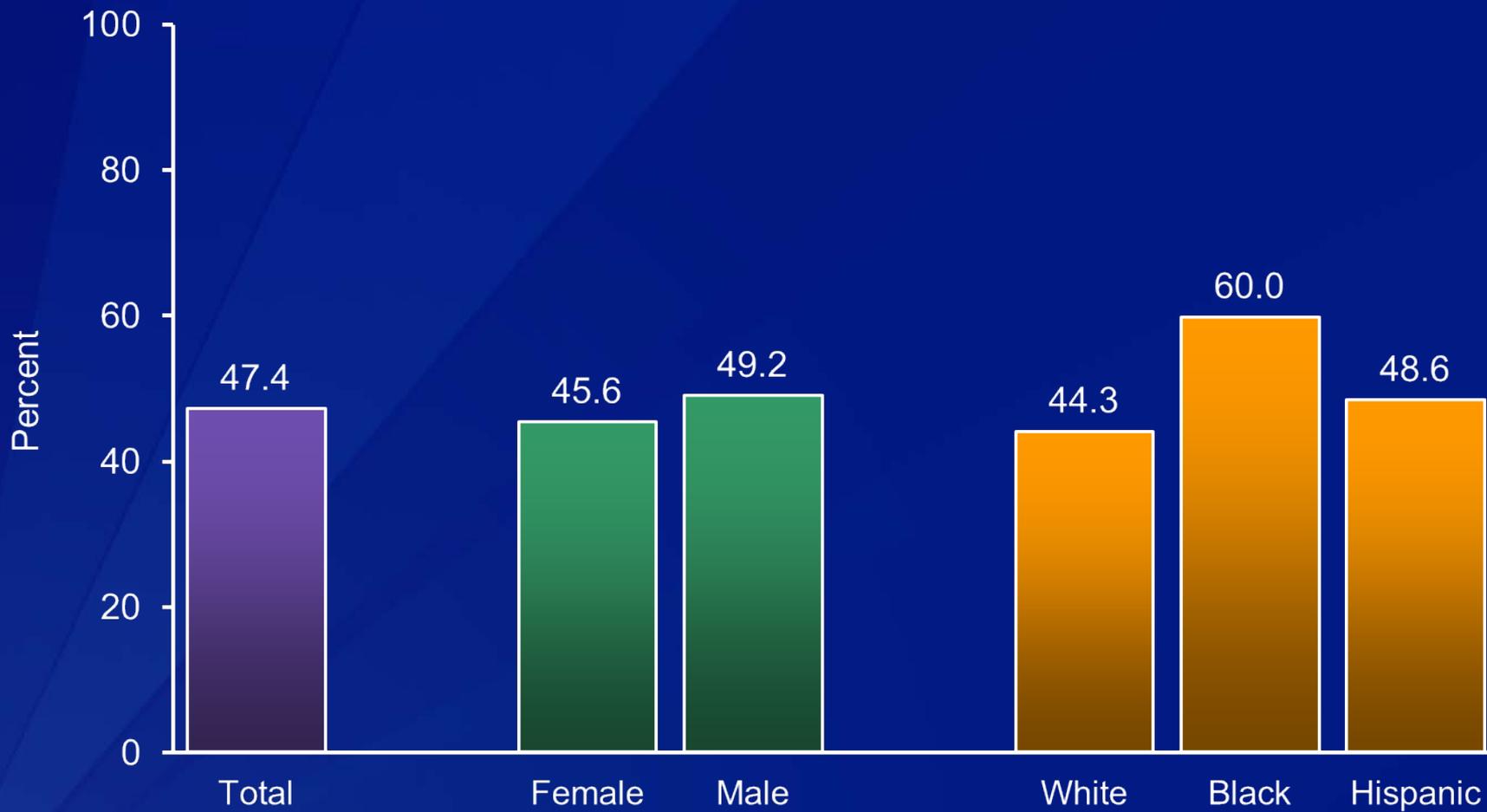
<http://www.guttmacher.org/pubs/FB-ATSRH.html>

Klein, JD and the Committee on Adolescence, 2006

# Goals of Teen Pregnancy Prevention

- ❑ Decrease pregnancies among female teens
- ❑ Delay initiation of teen sexual activity
- ❑ Increase use of effective contraceptive methods

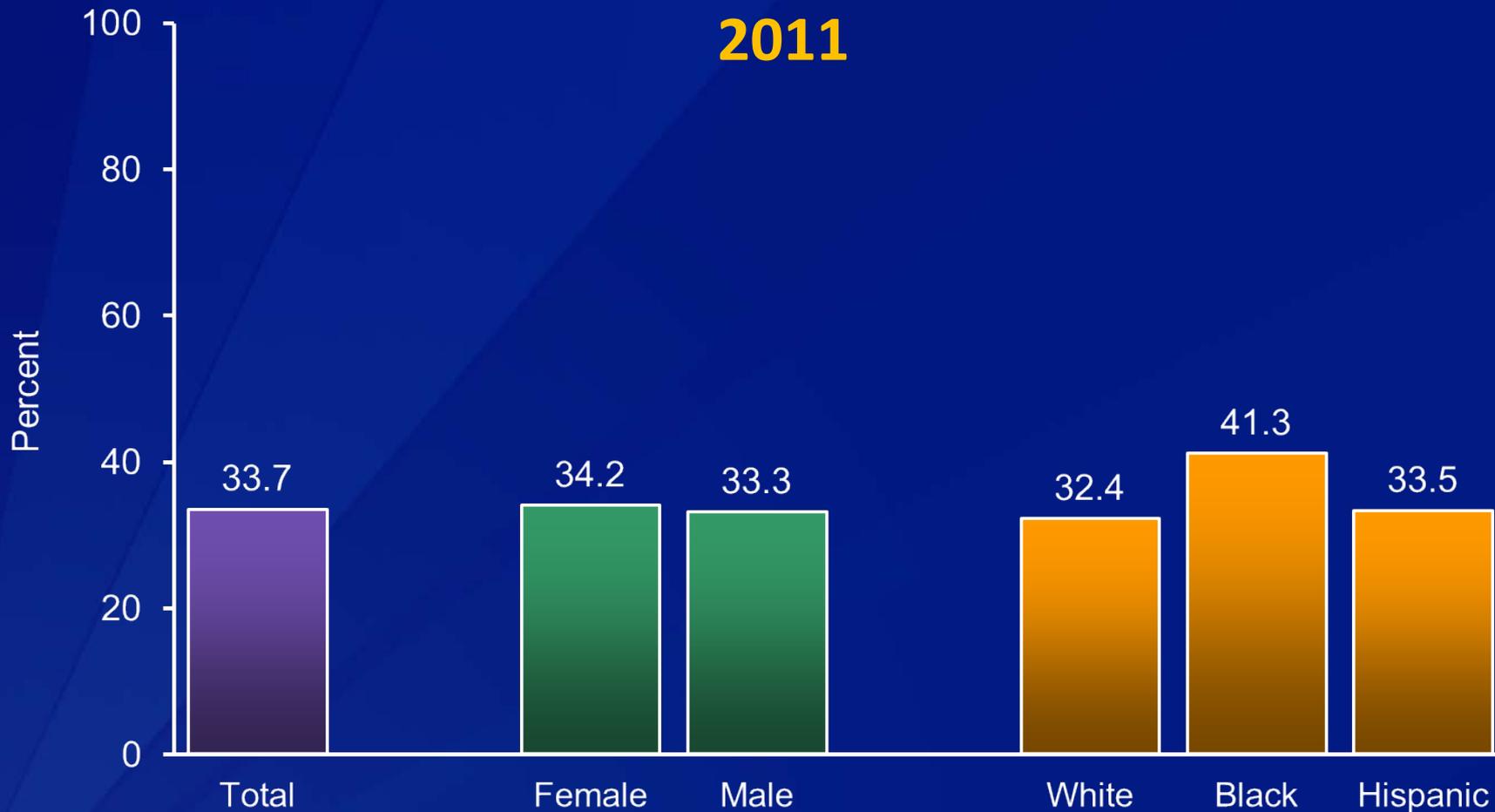
# Percentage of High School Students Who Ever Had Sexual Intercourse, by Sex\* and Race/Ethnicity,† 2011



\* M > F

† B > H > W

# Percentage of High School Students Who Were Currently Sexually Active,\* by Sex and Race/Ethnicity,† 2011

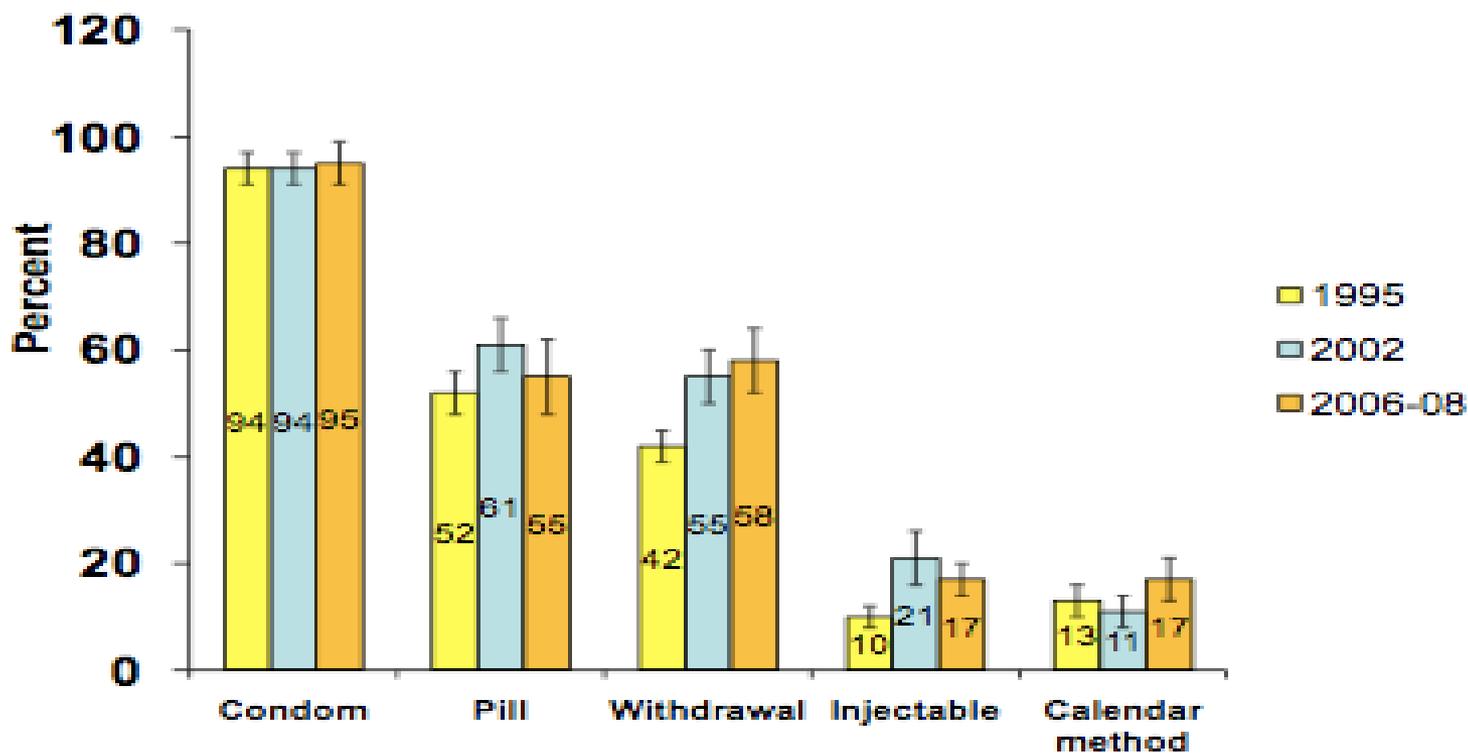


\* Had sexual intercourse with at least one person during the 3 months before the survey.

† B > W, H

# Use of contraception among sexually experienced females, 15-19 years old

Figure 8. Ever-use of contraception among sexually experienced females aged 15-19, by method of contraception: United States, 1995, 2002, and 2006-2008.



Source: CDC/NCHS, National Survey of Family Growth, 2006-2008. Table 13 in this report.

# Use of contraception at first sex among females, 15-19 years old

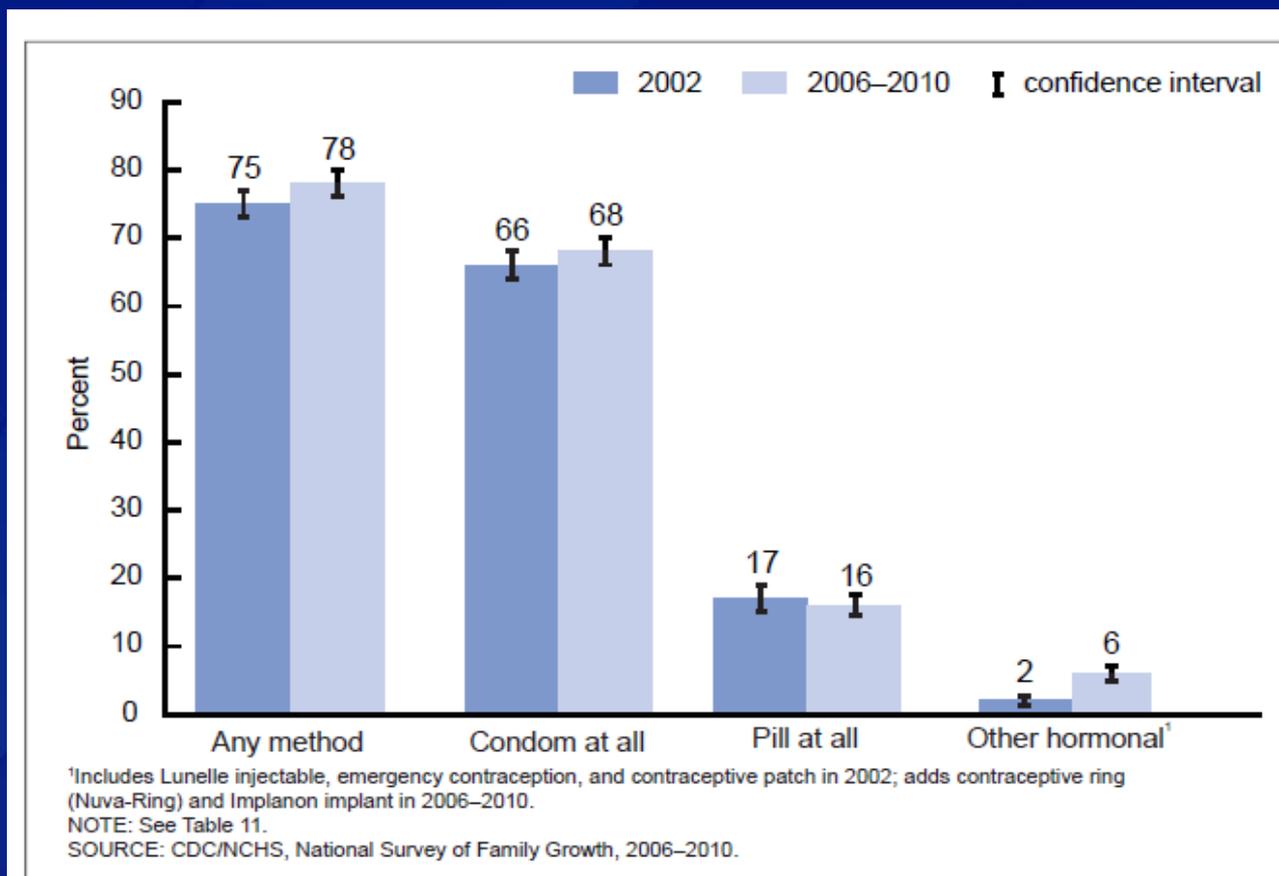
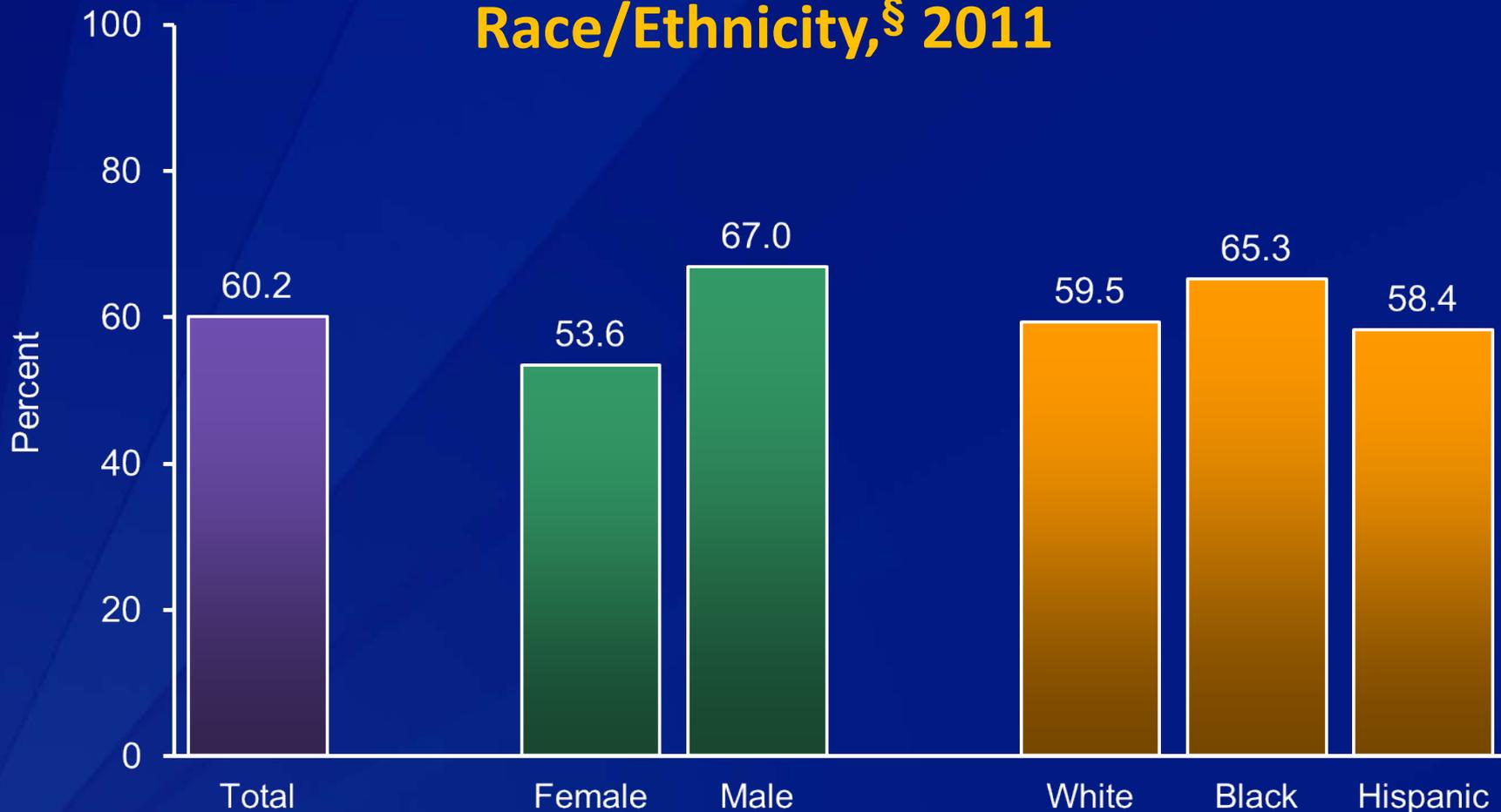


Figure 2. Use of contraception at first sex among females aged 15-19, by method used: United States, 2006-2010

# Use of Contraceptive at Last Sex among Teens

- ❑ Females, 15-19 years old: 86%
- ❑ Males, 15-19 years old: 93%

# Percentage of High School Students Who Used a Condom During Last Sexual Intercourse,\* by Sex† and Race/Ethnicity,§ 2011



\* Among the 33.7% of students nationwide who were currently sexually active.

† M > F

§ B > H

# Impact of inconsistent and non-use of contraception on teen pregnancies

- ❑ 46% due to non-use of contraception
- ❑ 54% due to contraceptive failure
  - Effectiveness of method
  - Consistent and correct use



Santelli et al., 2006

# Declines in Adolescent pregnancy and Unmet Need for contraception

- ❑ Majority of decline attributable to increased contraceptive use among adolescents
- ❑ Among adolescents who become pregnant, about half due to contraceptive failure
  - Failure of method
  - Failure to use correctly and consistently

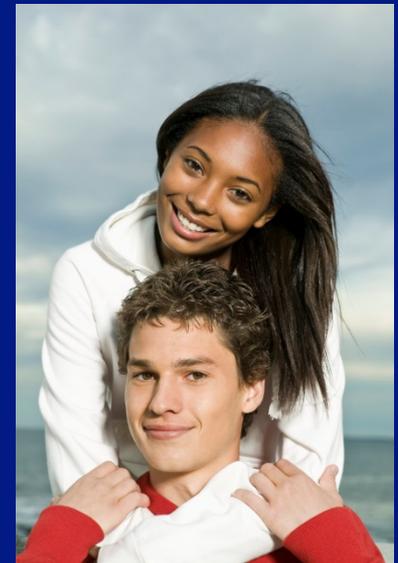
Santelli, Am J Public Health 2007;97:150.

Santelli, Persp Sex Reprod Health, 2006;38:106.

## Why teen moms did not use contraception

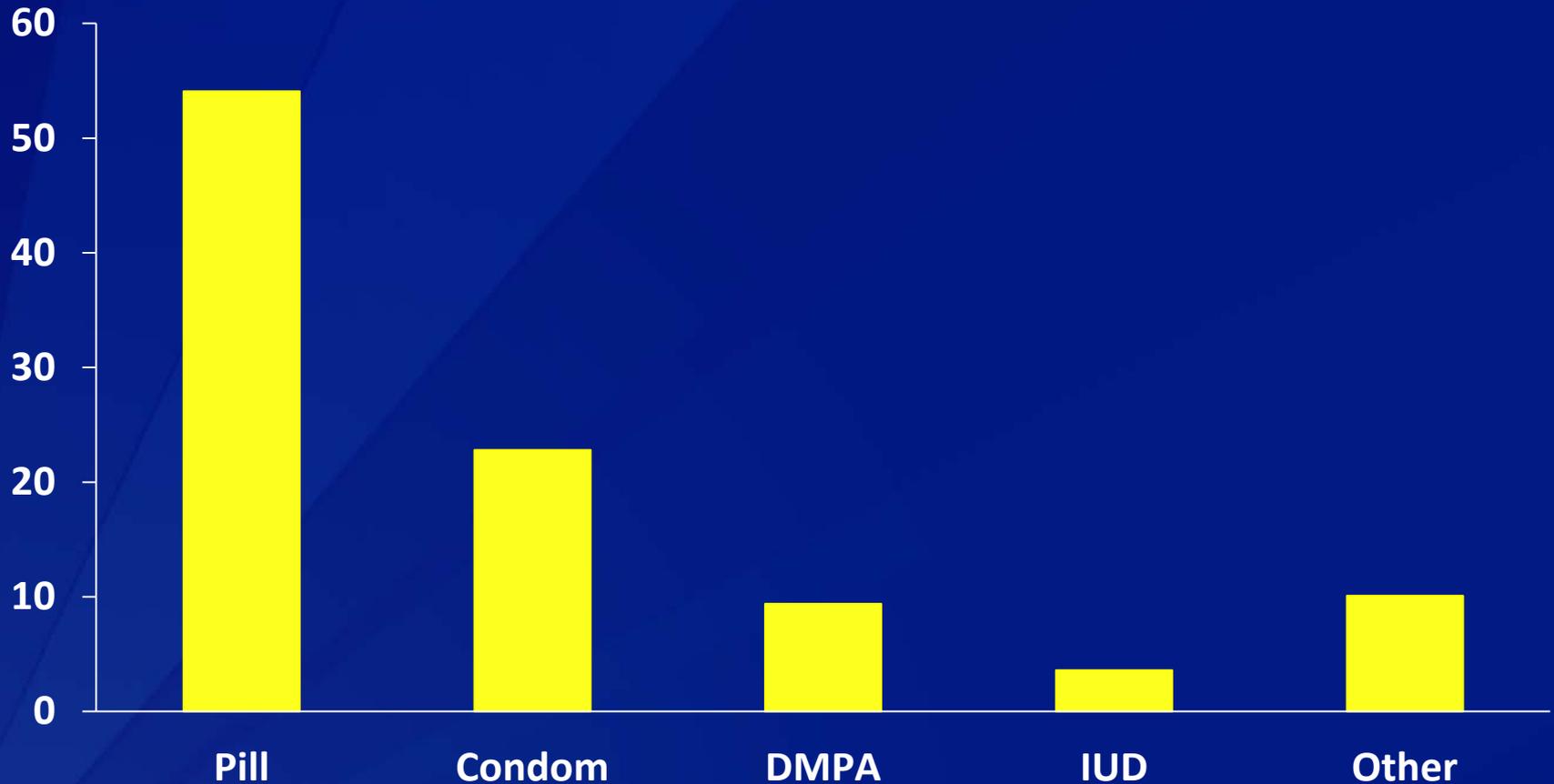
Reason	Percent
Thought could not get pregnant	31.4
Partner did not want to use contraception	23.6
Did not mind if got pregnant	22.1
Trouble getting birth control	13.1
Side effects from contraception	9.4
Thought she or partner was sterile	8.0

**Abstinence is the only 100% effective way to prevent HIV, other sexually transmitted infections (STIs), and pregnancy**



## **SECTION II. CONTRACEPTIVE METHODS**

## Use of Specific Methods by females, 15-19 years old

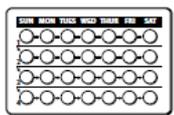
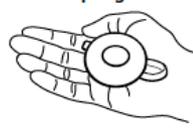
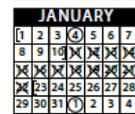
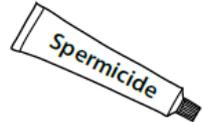


Mosher, National Center for Health Statistics. Vital Health Stat 2010;23:29.

# Effectiveness of family planning methods

## Effectiveness of Family Planning Methods

Most Effective  
 ↑  
 Less than 1 pregnancy per 100 women in a year  
 ↑  
 6-12 pregnancies per 100 women in a year  
 ↑  
 18 or more pregnancies per 100 women in a year  
 ↓  
 Least Effective

Reversible		Permanent		
<b>Implant</b>  0.05%*	<b>Intrauterine Device (IUD)</b>  LNG - 0.2% Copper T - 0.8%	<b>Male Sterilization (Vasectomy)</b>  0.15%	<b>Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic)</b>  0.5%	
<b>Injectable</b>  6%	<b>Pill</b>  9%	<b>Patch</b>  9%	<b>Ring</b>  9%	<b>Diaphragm</b>  12%
<b>Male Condom</b>  18%	<b>Female Condom</b>  21%	<b>Withdrawal</b>  22%	<b>Sponge</b>  24% parous women 12% nulliparous women	
<b>Fertility-Awareness Based Methods</b>  24%	<b>Spermicide</b>  28%			

\*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.

### How to make your method most effective

After procedure, little or nothing to do or remember.

**Vasectomy and hysteroscopic sterilization:** Use another method for first 3 months.

**Injectable:** Get repeat injections on time.

**Pills:** Take a pill each day.

**Patch, Ring:** Keep in place, change on time.

**Diaphragm:** Use correctly every time you have sex.

**Condoms, sponge, withdrawal, spermicides:** Use correctly every time you have sex.

**Fertility awareness-based methods:** Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective.

Tier 1

Tier 2

Tier 3

CS 242797



U.S. Department of Health and Human Services  
 Centers for Disease Control and Prevention

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

### Other Methods of Contraception

**Lactational Amenorrhea Method:** LAM is a highly effective, temporary method of contraception.

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

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397-404.

# Typical Use and Perfect Use

## □ Typical Use

- Failure rate
- Average person
- Not always consistent or correct
- During first year

## □ Perfect Use

- Failure rate
- Use is consistent and correct
- At every sex act
- During the first year

# Reversible Tier 1 Methods: “Most Effective”

## Long Acting Reversible Contraception (LARC)

- ❑ Levonorgestrel-releasing intrauterine system
- ❑ Copper IUD
- ❑ Implant



## **TIER 1 for Adolescents: Long Acting Reversible Contraception (LARC)**

- ❑ “Forgettable contraception”**
- ❑ Not dependent on compliance/adherence**
- ❑ “Expanding access to LARC for young women has been declared a national priority” (IOM)**
- ❑ “Should be considered as first-line choices for both nulliparous and parous adolescents” (ACOG 2007)**

*Finer, et al. Changes in use of long-acting contraceptive methods in the United States, 2007-2009. Fertil Steril 2012.*

## Levonorgestrel IUD

- ❑ Effective for at least 3 or 5 years
- ❑ Side effects: irregular bleeding
- ❑ Reduces dysmenorrhea and menstrual blood loss
- ❑ Does not protect against STIs

Contraceptive Technology, 20<sup>th</sup> edition

<http://www.accessdata.fda.gov/scripts/cder/drugsatfda>

# Copper intrauterine device (IUD)

- ❑ Approved for 10 years
- ❑ Effective for at least 12 years
- ❑ Side effects: irregular bleeding, heavy bleeding
- ❑ Most effective emergency contraception
- ❑ Does not protect against STIs

# Contraceptive implant

- ❑ Effective for at least 3 years
- ❑ Side effects: irregular bleeding
- ❑ Does not protect against STIs



## Correct and consistent use

- ❑ **Methods that require more effort by the user have higher typical failure rates**
- ❑ **Correct and consistent use of pills and condoms may be difficult for all ages**
- ❑ **Women ages 18-24, in last 3 months**
  - 45% missed  $\geq 1$  pill
  - 62% did not use condoms every time

# Depot medroxyprogesterone acetate (DMPA)

- ❑ One injection every 3 months
- ❑ Reliable contraception for 3 months, but effects may last up to 9 months
- ❑ Side effects: irregular bleeding and amenorrhea
- ❑ Does not protect against STIs





# Contraceptive patch

- ❑ Releases estrogen and progestin
- ❑ One patch per week for 3 weeks, then 1 patch-free week
- ❑ Side effects: irregular bleeding
- ❑ Does not protect against STIs



# Contraceptive vaginal ring

- ❑ Releases estrogen and progestin
- ❑ One ring for 3 weeks, then 1 ring-free week
- ❑ Side effects: irregular bleeding
- ❑ Does not protect against STIs



# Quick Start

- ❑ **Initiation of contraception on any day of the cycle**
- ❑ **More reliable and faster protection from unplanned pregnancies**
- ❑ **Advise 7 days of backup or abstinence**
- ❑ **Improves short-term continuation**
- ❑ **No increase in unscheduled bleeding**

# US SPR

## When To Start Using Specific Contraceptive Methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back-up) needed	Examinations or tests needed before initiation <sup>†</sup>
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection <sup>†</sup>
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection <sup>†</sup>
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; HIV = human immunodeficiency virus; IUD = intrauterine device; STD = sexually transmitted disease; U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use, 2010.

<sup>\*</sup> Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women (Box 2). However, measuring weight and calculating BMI (weight [kg]/height [m]<sup>2</sup>) at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

<sup>†</sup> Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's *STD Treatment Guidelines* (available at <http://www.cdc.gov/std/treatment>). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. MEC 4). Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion (U.S. MEC 3) (Box 2). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

## Tier 3: “Least Effective”

- ❑ Condoms (male and female)
- ❑ Diaphragms, cervical cap, sponge
- ❑ Fertility awareness-based methods
- ❑ Withdrawal
- ❑ Spermicides



# Emergency Contraception

- ❑ Up to 120 hours after unprotected sex
- ❑ Two methods of delivery
  - Copper IUD
  - Emergency Contraceptive Pills (ECPs)



# Emergency contraceptive pills

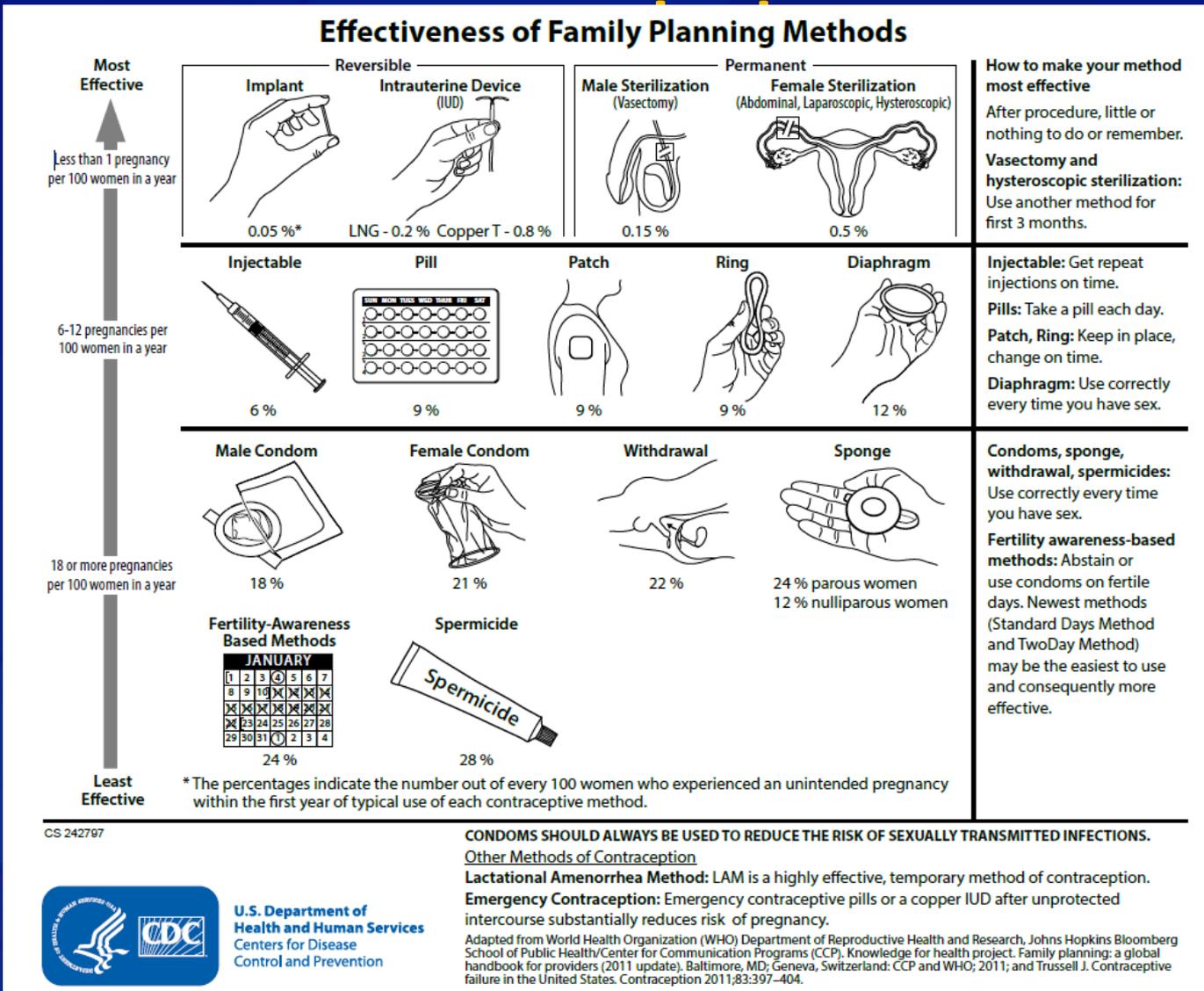
- ❑ Ulipristal acetate
  - Anti-progesterone, single pill
  - More effective than LNG between 3-5 days
  - May be more effective than LNG among obesePrescription only
- ❑ Levonorgestrel
  - Available as one or two pills
  - Progestin-only
- ❑ Yuzpe Method
  - Combined estrogen/progestin pills, multiple pills
  - less effective, more side effects

# Non-contraceptive benefits

- ❑ ***Dysmenorrhea:*** COCs, implant, LNG-IUD
- ❑ ***Cycle Control:*** LNG-IUD, DMPA, OCPs
- ❑ ***Cancer protection:*** COCs protect against ovarian and endometrial cancer
- ❑ ***Ectopic Pregnancy:*** COCs
- ❑ ***Acne:*** COCs and possibly patch and ring
- ❑ ***Menstrual suppression:*** Continuous CHCs, DMPA, implants, LNG-IUD
- ❑ ***Pain from Endometriosis:*** COCs, DMPA, implant, LNG-IUD
- ❑ ***Premenstrual or menstrual-related symptoms:*** extended or continuous use of CHCs, or any menstrual suppression

# DUAL PROTECTION

# Typical effectiveness of family planning



Tier 1

Tier 2

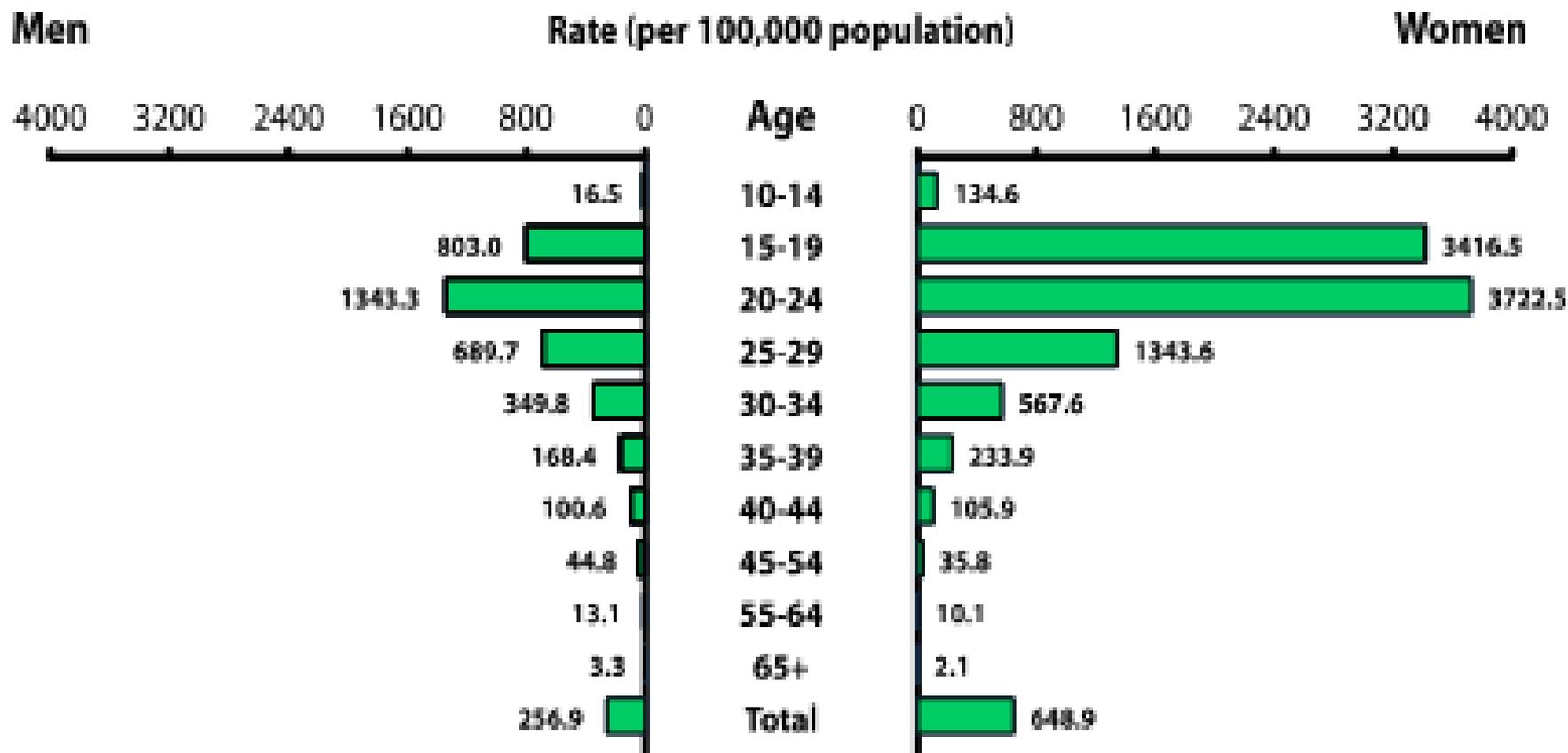
Tier 3

# Condoms

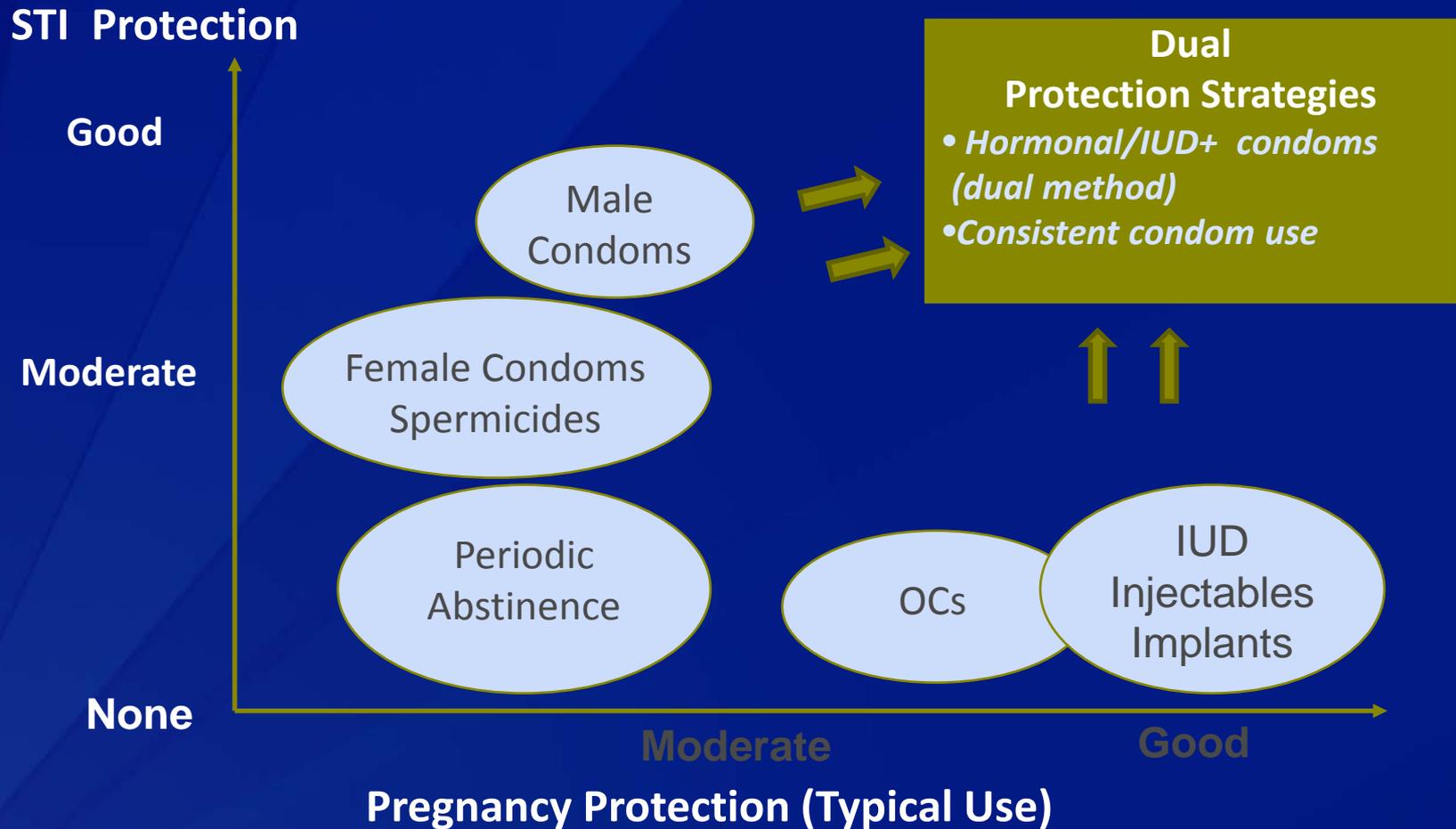
- ❑ Male and female condoms
- ❑ Male latex condoms reduce risk of STIs, including HIV, when used correctly and consistently
- ❑ Female condoms give women shared responsibility of the condom in addition to reducing the risk of STIs and HIV.



# Chlamydia—Rates by Age and Sex, United States, 2011



# Effectiveness of Contraceptive Methods at Preventing STIs and Pregnancy



# Dual Protection Guidance

- ❑ “{COCs, POC, IUDs} do not protect against STI/HIV. If risk exists for STI/HIV, the correct and consistent use of condoms is recommended either alone or with another contraceptive method. “ ---*U.S. Medical Eligibility Criteria for Contraceptive Use*
- ❑ “Condoms...should be used by all sexually active adolescents regardless of whether an additional method of contraception is used..... When initiating any hormonal contraceptive method, the need for consistent protection against STIs (either male or female condoms) should be reinforced. “ --- *American Academy of Pediatrics, Committee on Adolescence*

U.S. MEC: MMWR Recomm Rep 2010;59:1-86

AAP: Contraception and Adolescents . *Pediatrics* 2007;120;1135-48

# Dual Protection in Healthy People 2020

- ❑ **FP-10** Increase the proportion of sexually active persons aged 15 to 19 years who use condoms to both effectively prevent pregnancy and provide barrier protection against disease
- ❑ **FP-11** Increase the proportion of sexually active persons aged 15 to 19 years who use condoms and hormonal or intrauterine contraception to both effectively prevent pregnancy and provide barrier protection against disease

<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=13>

# Prevalence of Dual Protection among Female Teens in the U.S.

Source	Population	Dual Method (at last sex) (hormonal and condom)	Consistent Condom Use (last 4 weeks)
NSFG, 2006-2008	Ages 15-19, sexually active unmarried females	20.8%	51.6%

Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006–2008 [http://www.cdc.gov/nchs/data/series/sr\\_23/sr23\\_030.pdf](http://www.cdc.gov/nchs/data/series/sr_23/sr23_030.pdf)

**SECTION III.**  
**US FAMILY PLANNING GUIDANCE**

# **US MEDICAL ELIGIBILITY CRITERIA, 2010**

# U.S. Medical Eligibility Criteria for Contraceptive Use, 2010



**MMWR**<sup>TM</sup>

**Morbidity and Mortality Weekly Report**

[www.cdc.gov/mmwr](http://www.cdc.gov/mmwr)

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Recommendations and Reports

June 18, 2010 / Vol. 59 / No. RR-4

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## **U.S. Medical Eligibility Criteria for Contraceptive Use, 2010**

**Adapted from the World Health Organization  
Medical Eligibility Criteria for Contraceptive Use, 4th edition**

## MEC Categories

- 1.** A condition for which there is no restriction for the use of the contraceptive method.
- 2.** A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- 3.** A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
- 4.** A condition which represents an unacceptable health risk if the contraceptive method is used.

# How YOU can use the US MEC



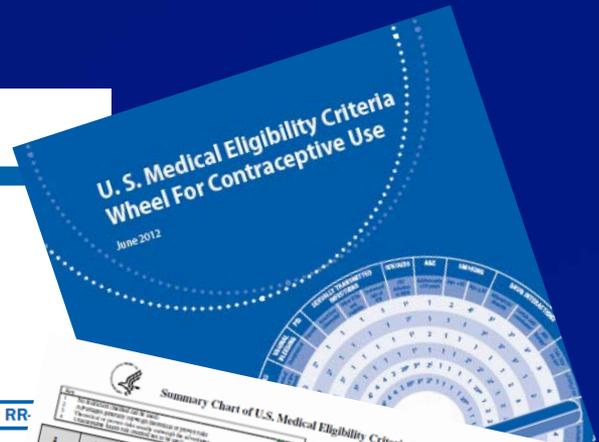
**CDC Contraception 2010**  
5:09 PM  
**Appendix B: Classifications for Combined Hormonal Contraceptives**

**Condition: HYPERTENSION** (For all categories of hypertension, classifications are based on the assumption that no other risk factors exist for cardiovascular disease. When multiple risk factors do exist, risk for cardiovascular disease do increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive.) - [Clarification](#)

**Category:**

- a. Adequately controlled hypertension - **3** (risks usually outweigh advantages)

The cover of the MMWR (Morbidity and Mortality Weekly Report) for June 18, 2010, Vol. 59, No. RR-11. It features the CDC logo and the title "U.S. Medical Eligibility Criteria for Contraceptive Use, 2010".

A detailed "Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use, 2010". It is a large grid with rows for various medical conditions and columns for different contraceptive methods. The cells are color-coded: green for category 1, yellow for category 2, red for category 3, and white for category 4.

Search CDC contraception About 1,050,000 results (0.42 seconds)

**Web** [CDC - Contraception - Reproductive Health](#)  
[www.cdc.gov/reproductivehealth/.../contraception.htm](http://www.cdc.gov/reproductivehealth/.../contraception.htm)  
In the United States, almost half of all pregnancies are unintended.1 Yet, several safe and highly effective methods of **contraception (birth control)** are available ...  
Reversible Methods of Birth ... - Permanent Methods of Birth Control

**Web** [CDC - United States Medical Eligibility Criteria \(USMEC\) for ...](#)  
[www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm](http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm)  
Jun 21, 2012 - In 1996, the World Health Organization (WHO) published the first edition of the Medical Eligibility Criteria for **Contraceptive Use**, which gave ...

## Summary of MEC by age

Method	COC, Patch, Ring	POP	Implant	Barrier	Injection	IUD
Age	< 40	All ages	All ages	All ages	<18	< 20
MEC	1	1	1	1	2	2

1	No restriction
2	Generally can use
3	Generally do not use
4	Do not use

# Contraception: Myths and Misconceptions

- ❑ Myth: IUDs cause pelvic inflammatory disease and infertility
  - Fact: Chlamydia and gonorrhea cause PID and can lead to infertility
- ❑ Myth: DMPA causes fractures
  - Fact: Small amount of bone mineral density lost during use, regained after discontinuation
- ❑ Myth: Contraceptive pills cause cancer
  - Fact: Protects against ovarian and endometrial cancer

# Barriers to LARC provision

- ❑ Patient preference
- ❑ Concern about safety
  - Risk of PID
  - Nulliparous, adolescent, not monogamous
- ❑ Not trained in IUD insertion
- ❑ IUDs not available

# Teen use of LARCs

## ❑ Barriers

- Cost
- Knowledge and attitudes
  - 80% of adolescents never heard of IUD

## ❑ Opportunity

- CHOICE project, St. Louis
- Women educated about LARC
- All methods provided without cost
- 62% of adolescents chose LARC
- 69% of ages 14-17
- 61% of ages 18-20

Whitaker, Contraception 2008;78:211.  
Mestad, Contraception 2011;84:493.

# Clinical Scenario 1

- **16 year old female, healthy, nulliparous, currently using condoms, but wants more reliable method. Which of the following options are available to her?**
  - A. IUD (copper or levonorgestrel)**
  - B. Implants**
  - C. DMPA**
  - D. Combined hormonal methods (pill, patch, ring)**



# Safety of IUDs for Teens

- ❑ **IUDs and age <20: US MEC 2**
- ❑ **IUDs and Expulsion**
  - Evidence shows slightly increased risk of expulsion in younger women
- ❑ **IUDs and infertility**
  - No evidence that IUDs cause later infertility
  - Infertility associated with gonorrhea and Chlamydia
- ❑ **IUDs and STIs**
  - No evidence that IUDs increase risk of STI acquisition
  - Women with current cervicitis, chlamydial infection, gonorrhea should not start an IUD (US MEC 4)
  - Women with a very high individual likelihood of exposure to chlamydial infection or gonorrhea generally should not start an IUD (US MEC 3)

# Safety of DMPA for Teens

- ❑ **DMPA and age <18: US MEC 2**
- ❑ **DMPA and Bone mineral density**
  - Small amounts of BMD lost using DMPA
  - BMD regained after discontinuation
  - Unclear how BMD relates to fracture risk in adolescents
  - No evidence that DMPA increases fracture in adolescents
- ❑ **DMPA and Obesity**
  - Obese adolescents who use DMPA may be more likely to gain weight than non-obese DMPA users and obese users of other methods

# Clinical Scenario 1

- 16 year old female, healthy, nulliparous, currently using condoms, but wants more reliable method. What options are available to her?
  - A. IUD (copper or levonorgestrel) (US MEC 2)
  - B. Implants (US MEC 1)
  - C. DMPA (US MEC 2)
  - D. Combined hormonal methods (pill, patch, ring) (US MEC 1)

**ALL OF THE ABOVE! Plus...**

**Encourage continued condom use for dual protection**

## Clinical Scenario 2

- **18 year old G1P0, 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)**



# Postpartum: Hormonal Contraception

Condition	Combined methods	Progestin-only methods
Postpartum (non-breastfeeding women)		
a) < 21 days	4	1
b) 21 days to 42 days		
i) With other risk factors for VTE	3	1
ii) Without other risk factors for VTE	2	1
c) > 42 days	2	1

1	No restriction
2	Generally can use
3	Generally do not use
4	Do not use

# Postpartum IUD Insertion

Condition	Sub-Condition	LNG-IUD	Cu-IUD
Postpartum (In breastfeeding and non-breastfeeding women, including post-caesarian women)	a) <10 minutes after delivery of placenta	2	1
	b) 10 minutes after delivery of placenta to <4 weeks	2	2
	c) ≥ 4 weeks	1	1
	d) Puerperal sepsis	4	4

1	No restriction
2	Generally can use
3	Generally do not use
4	Do not use

## Clinical Scenario 2

- **18 year old G1P0, 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) (US MEC 2)**
  - B. Progestin-only methods (pill, injectable, implant) (US MEC 1)**
  - C. Combined hormonal methods (pill, patch, ring) (US MEC 4)**  
(Wait until 21-42 days postpartum, depending on VTE risk factors)

**Encourage Dual protection with condom use**

## Clinical Scenario 3

- **16yo nulliparous female with heavy cycles and dysmenorrhea presents with her mother since she is missing school at the start of most periods. She is sexually active with her boyfriend using condoms. What options are available to her?**
  - A. IUD (copper or levonorgestrel)**
  - B. Implants**
  - C. DMPA**
  - D. Combined hormonal methods (pill, patch, ring)**



## Clinical Scenario 3

- 16yo nulliparous female with heavy cycles and dysmenorrhea presents with her mother since she is missing school at the start of most periods. She is sexually active with her boyfriend using condoms. What options are available to her?
  - A. IUD (copper or levonorgestrel) (US MEC 2)
  - B. Implants (US MEC 1)
  - C. DMPA (US MEC 2)
  - D. Combined hormonal methods (pill, patch, ring) (US MEC 1)
  - E. **All of the above**

**Encourage continued condom use for dual protection**

# **US SELECTED PRACTICE RECOMMENDATIONS**

# U.S. Selected Practice Recommendations for

Centers for Disease Control and Prevention

# MMWR

Morbidity and Mortality Weekly Report

Recommendations and Reports / Vol. 62 / No. 5

June 21, 2013

## U.S. Selected Practice Recommendations for Contraceptive Use, 2013

Adapted from the World Health Organization Selected Practice  
Recommendations for Contraceptive Use, 2nd Edition



Continuing Education Examination available at <http://www.cdc.gov/mmwr/cme/conted.html>.



U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention

# **US Selected Practice Recommendations for Contraceptive Use, 2013**

- **Follow-up to US Medical Eligibility Criteria for Contraceptive Use, 2010**
- **Adapted from World Health Organization**
- **Intent: Evidence-based guidance for common, yet controversial contraceptive management questions**
  - **When to start**
  - **Missed pills**
  - **Bleeding problems**
  - **Exams and test**
  - **Follow-up**
  - **How to be reasonably certain that a woman is not pregnant**

# **US Selected Practice Recommendations for Contraceptive Use, 2013**

- **Target audience: health-care providers**
- **Guidance intended to assist health care providers when they counsel patients about contraceptive use**
- **Applies to women of all ages, including adolescents**
- **What is NOT included in the US SPR**
  - **NOT the Medical Eligibility Criteria**
  - **NOT comprehensive textbook**
  - **NOT rigid guidelines**
  - **NOT well-woman care**

## Format of US SPR

- ❑ Arranged by contraceptive method
- ❑ For each recommendation:
  - Recommendation itself
  - Comments and evidence summary
- ❑ Simplified text of actual recommendations
- ❑ Bullets, tables, flowcharts, algorithms

# How YOU can use the US SPR

Centers for Disease Control and Prevention

# MIMWR

Morbidity and Mortality Weekly Report

Recommendations and Reports / Vol. 62 / No. 4

June 7, 2013

CDC Home



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

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## Reproductive Health

### Reproductive Health

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## U.S. Selected Practice Recommendations for Contraceptive Use, 2013

The [U.S. Selected Practice Recommendations for Contraceptive Use, 2013 \(US SPR\)](#) provides recommendations for health care providers. The guidance addresses a select group of common, yet sometimes complex, management issues around the initiation and use of specific contraceptive methods. The *US SPR* is a companion document to CDC's previously published

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www.cdc.gov/reproductivehealth/.../contraception.  
In the United States, almost half of all pregnancies and highly effective methods of **contraception (bir**  
Reversible Methods of Birth ... - Permanent Method

Videos [CDC - United States Medical Eligibility Criteria \(USMEC\) for ...](#)  
www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm  
Jun 21, 2012 - In 1996, the World Health Organization (WHO) published the first edition of the Medical Eligibility Criteria for **Contraceptive** Use, which gave ...

## U.S. Selected Practice Recommendations for Contraceptive Use, 2013

Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd edition



Continuing Education Examination available at <http://www.cdc.gov/ceem>

United States Selected Practice Recommendations for Contraceptive Use

# US SPR

www.uspr.gov/reproductivehealth/unintendedpregnancy/USPR.htm

# **CLINICAL SCENARIOS**

## Clinical Scenario 1: When to start a contraceptive method?

- **16 y.o. female comes to office desiring contraception and decides she wants the implant.**

Q: When can she start?



# When can a woman start a contraceptive method

## ❑ Barriers to starting any method

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

## ❑ Starting when woman requests contraception (“Quick start”)

- May reduce time woman is at risk for pregnancy
- May reduce barriers to starting

# US SPR

## When To Start Using Specific Contraceptive Methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back-up) needed	Examinations or tests needed before initiation <sup>†</sup>
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection <sup>†</sup>
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection <sup>†</sup>
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; HIV = human immunodeficiency virus; IUD = intrauterine device; STD = sexually transmitted disease; U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use, 2010.

\* Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women (Box 2). However, measuring weight and calculating BMI (weight [kg]/height [m]<sup>2</sup>) at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

† Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's *STD Treatment Guidelines* (available at <http://www.cdc.gov/std/treatment/>). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. MEC 4). Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion (U.S. MEC 3) (Box 2). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

## **When to start a contraceptive method: Other situations**

- **Amenorrheic**
- **Postpartum**
  - Breastfeeding
  - Not breastfeeding
- **Postabortion**
- **Switching from another contraceptive method**

## **Clinical Scenario 1: When to start a contraceptive method?**

- **16 y.o. female comes to office desiring contraception and decides she wants the implant.**

**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**

- **16 y.o. female comes to office desiring  
contraception and decides she wants the implant.**

**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**

Cervinski, Clin Chem Lab Med. 2010;48:935-42.  
Cole LA, Expert Rev Mol Diagn. 2009;9:721-47.  
Wilcox, JAMA. 2001;286:1759-61.  
Korhonen, Clin Chem. 1997;43:2155-63.  
Reyes, Am J Obstet Gynecol. 1985;153:486-9.  
Steier, Obstet Gynecol. 1984;64:391-4.

# US SPR

## BOX 1. 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

---

\* **Source:** Labbok M, Perez A, Valdez V, et al. The Lactational Amenorrhea Method (LAM): a postpartum introductory family planning method with policy and program implications. *Adv Contracept* 1994;10:93–109.

# Evidence on Pregnancy Checklist (PC)

Study, year, country	# Women	Positive preg test	Sensitivity of PC	Specificity of PC	PPV of PC	NPV of PC
Stanback, 1999, Kenya	1852	1%	64%	89%	6%	99%
Stanback, 2006, Kenya	1852 (without signs/sx)	1%	55%	90%	6%	99%
Stanback, 2008, Nicaragua	263	1%	100%	60%	3%	100%
Torpey, 2010, Africa	535 HIV+	4%	90.9%	38.7%	6%	99%

Stanback, Lancet, 1999;354:566.

Stanback, J Fam Plann Reprod Health Care, 2006;32:27.

Stanback, Rev Panam Salud Publica, 2008;23:116.

Torpey, BMC Public Health, 2010;10:249.

## **Clinical scenario 2: How to be reasonably certain that a woman is not pregnant**

- **16 y.o. female comes to office desiring contraception and decides she wants the implant.**

**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 criteria, a provider can be reasonably certain that the women is not pregnant.**

## Clinical Scenario 3: Exams and tests

- **16 y.o. female comes to office desiring contraception and decides she wants the implant.**

**Q: Do you need to do any exams or test before she starts?**



# US SPR

## Exams and tests prior to initiation

- **Unnecessary tests may be barrier to starting**
  - 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 test 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**





## Pelvic Exam before Initiating Contraception

- ❑ Is not necessary before starting implant
- ❑ No US MEC 3 or 4 conditions will be detected by pelvic
- ❑ Evidence:
  - Two case-control studies
  - Delayed versus immediate pelvic exam before contraception



## Clinical Scenario 3: Exams and tests

- 16 y.o. female comes to office desiring contraception and decides she wants the implant.

**Q: Do you need to do any exams or test before she starts?**

**A: No**



## **Clinical Scenario 3: Exams and tests**

- **16 y.o. female comes to office desiring contraception and now decides she wants the levonorgestrel IUD.**

**Do any of the previous steps change?**

**Q1: When can she start?**

**Q2: How can you be reasonably certain she is not pregnant?**

**Q3: Do you need to do any exams or test before she starts?**



## **Clinical scenario 3: Exams and tests**

- **16 y.o. female comes to office desiring contraception and now decides she wants the levonorgestrel IUD.**

**Q3: Do you need to do any exams or test before she starts?**

**A: Pelvic exam and STI screening as appropriate.**

## Clinical Scenario 4 : Emergency Contraception

- ❑ 17 y.o. female had unprotected intercourse 4 days ago and is worried about pregnancy.
  - Q: What are her emergency contraception options?



## Four options 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 dose combined
- 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

- ❑ 17 y.o. 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



## Clinical Scenario 4 : Initiation of regular contraception after emergency contraception pills

- ❑ 17 y.o. female had unprotected intercourse 4 days ago and is worried about pregnancy. She has chosen to take UPA
  - Q: When can she start regular contraception after ECPs?



## Evidence

- ❑ **Data limited to expert opinion and product labeling.**
- ❑ **Theoretical concerns for decreased effectiveness of systemic hormonal contraception after UPA use.**
- ❑ **The resumption or initiation of regular hormonal contraception following ECP use involves consideration of the risk of pregnancy if ECPs fail.**

## **US SPR Recommendation: When to initiate regular contraception after emergency contraception pills**

- ❑ Any regular contraceptive method can be started immediately after the use of ECPs.
- ❑ Advise the woman to have a pregnancy test, if she does not have a withdrawal bleed within 3 weeks.
- ❑ **UPA**
  - The woman will need to abstain from sex or use barrier contraception for 14 days or her next menses, whichever comes first.
- ❑ **LNG and combined estrogen/progestin formulations**
  - The woman will need to abstain from sex or use barrier contraception for 7 days.

## **Clinical Scenario 4 : Initiation of regular contraception after emergency contraception pills**

- ❑ **17y.o. female had unprotected intercourse 4 days ago and is worried about pregnancy.**
  - **Q: When can she start regular contraception after ECPs?**
  - **A: She can start contraception immediately but she will need to abstain from sex or use barrier contraception for 7 days if she uses LNG or 14 days if she uses UPA or until her next menses, whichever comes first.**

# Take Home Messages

- ❑ Rates of adolescent pregnancy in the US are decreasing, but remain high
- ❑ Adolescents who are at risk of unintended pregnancy need access to highly effective contraceptive methods
- ❑ Adolescents are eligible to use all methods of contraception
  - ❑ there is no contraceptive method that an adolescent cannot use based on age alone
- ❑ Long-acting, reversible contraception (LARCs) may be particularly suitable for many adolescents
  - IUDs
  - Implants
- ❑ Dual protection should be encouraged for adolescents

## Take Home Messages

- ❑ Most women of any age can start methods anytime
- ❑ Few, if any, exams or tests are needed
- ❑ Anticipatory counseling for potential bleeding problems and proper management provided
- ❑ Routine follow-up generally not required
- ❑ Discuss emergency contraception often
- ❑ Regular contraception should be started after EC

# How to find Teen Pregnancy information?

The screenshot shows the CDC website in a Windows Internet Explorer browser. The address bar displays <http://www.cdc.gov/>. The page features the CDC logo and the text "Centers for Disease Control and Prevention" with the tagline "CDC 24/7: Saving Lives, Protecting People, Saving Money through Prevention.™". A search bar is located in the top right corner. Below the header, there is a navigation menu with letters A-Z and a hash symbol, which is highlighted with a red box. The main content area includes several sections: "STD Prevention" with a sub-header "Adolescents and young adults are increasingly impacted by STDs.", "New Autism Data" with a sub-header "CDC estimates 1 in 88 children has been identified with an autism spectrum disorder.", "Minority Health" with a sub-header "Health Equity Can't Wait. Act Now in Your Community!", and "Autism: New Training for Health Professionals". A "HEALTH & SAFETY TOPICS" section lists various categories such as "Diseases & Conditions", "Healthy Living", "Emergency Preparedness & Response", "Injury, Violence & Safety", "Environmental Health", and "Workplace Safety & Health". There are also promotional banners for "Making Health Care Safer", "CDC 24/7", and "Smoking Causes Immediate Damage to Your Body".

Centers for Disease Control and Prevention - Windows Internet Explorer  
http://www.cdc.gov/

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CDC 24/7: Saving Lives, Protecting People, Saving Money through Prevention.™

En español

A-Z Index A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

**STD Prevention**  
Adolescents and young adults are increasingly impacted by STDs. Providers can make a difference by educating their young patients about sexual health and STD prevention.  
[Learn more](#)

**New Autism Data**  
CDC estimates 1 in 88 children has been identified with an autism spectrum disorder. Track your child's development and act early if you are concerned.  
[Learn more](#)

**Minority Health**  
Health Equity Can't Wait. Act Now in Your Community! CDC is working to improve targeted interventions for minority populations.  
[Learn more](#)

**Autism: New Training for Health Professionals**

**Have Diabetes? Daily Care Can Save Your Feet**

**HEALTH & SAFETY TOPICS**

**Diseases & Conditions**  
ADHD, Birth Defects, Cancer, Diabetes, Fetal Alcohol Syndrome, Flu, Hepatitis, HIV/AIDS, STDs...

**Healthy Living**  
Food Safety, Bone Health, Physical Activity, Immunizations, Genetics, Smoking Prevention...

**Emergency Preparedness & Response**  
Bioterrorism, Chemical & Radiation Emergencies, Severe Weather...

**Injury, Violence & Safety**  
Motor Vehicle Safety, Traumatic Brain Injury & Concussion, Falls, Child Abuse, Prescription Drug Overdose, Suicide, Injury Data...

**Environmental Health**  
Air Pollution, Biomonitoring, Carbon Monoxide, Lead, Toxic Substances, Mold...

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TIPS FROM FORMER SMOKERS

[www.cdc.gov](http://www.cdc.gov)

# www.cdc.gov/teenpregnancy/

The screenshot shows the CDC Teen Pregnancy Home page in a Windows Internet Explorer browser. The address bar displays <http://www.cdc.gov/teenpregnancy/>. The page features the CDC logo and the text "Centers for Disease Control and Prevention" with the tagline "CDC 24/7: Saving Lives. Protecting People. Saving Money through Prevention." Below this is an alphabetical index from A to Z. The main heading is "Teen Pregnancy".

The primary article is titled "The Importance of Prevention" and contains the following text: "In 2010, a total of 367,752 infants were born to women aged 15-19 years, for a live birth rate of 34.3 per 1,000 women in this age group. This is a record low for U.S. teens in this age group, and a drop of 9% from 2009. Birth rates fell 12% for women aged 15-17 years, and 9% for women aged 18-19 years. In addition, teen birth rates declined for all races and for Hispanics in 2010. While reasons for the declines are not clear, teens appear to be less sexually active, and more of those who are sexually active appear to be using contraception than in previous years."

A prominent banner reads: "Half of teen mothers don't graduate from high school". To the right of the banner are navigation options: "Replay", "Teen Pregnancy", "Vital Signs", and "CDC-TV". Below the banner is the text "A Message to Health Care Professionals" and a "GO" button.

On the right side of the page, there are utility links: "Text size: S M L XL", "Email page", "Print page", and "Bookmark and share". Below these is a "Get email updates" section with a text input field and a "Submit" button.

The "Teen Pregnancy Prevention Topics" section includes:

- About Teen Pregnancy:** Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.
- Parent and Guardian Resources:** Your teen needs your help in understanding his or her feelings, peer pressure, and how to say no if he or she does not want to have sex.
- Success Stories:** Programs that work from states and community partners funded through the Promoting Science-Based Approaches (PSBA) programs.
- Teen Pregnancy Prevention 2010-2015:** As part of the President's Teen Pregnancy Prevention Initiative, CDC is partnering with the Office of the Assistant Secretary for Health to reduce teenage pregnancy and address disparities in teen pregnancy and birth rates.

At the bottom, the "Related Links" section includes: "Prepregnancy Contraceptive Use Among Teens with Unintended Pregnancies".

Additional content on the right includes a "CDC Expert Commentary" video thumbnail, a link to "CDC Medscape Commentary: Teen Pregnancy and Reproductive Health", and a "Prevent Teen Pregnancy" video thumbnail. A "At A Glance 2011" report is also featured, titled "Improving the Lives of Young People and Strengthening Communities by Reducing Teen Pregnancy".

<http://www.cdc.gov/vitalsigns/teenpregnancy/>

# CDC Contraceptive Guidance

CDC Home  
 Centers for Disease Control and Prevention  
CDC 24/7: Saving Lives. Protecting People.™

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### CDC Contraceptive Guidance for Health Care Providers

Unintended pregnancy rates remain high in the United States. About 50% of all pregnancies are unintended, with higher proportions among adolescent and young women, women who are racial/ethnic minorities, and women with lower levels of education and income.<sup>1</sup> Unintended pregnancies increase the risk for poor maternal and infant outcomes<sup>2</sup> and in 2002, resulted in \$5 billion in direct medical costs in the United States.<sup>3</sup>

About half of unintended pregnancies are among women who were not using [contraception](#) (birth control) at the time they became pregnant. The other half are among women who became pregnant despite reported use of contraception.<sup>4</sup> Strategies to prevent [unintended pregnancy](#) include removing unnecessary medical barriers to contraceptive use, and helping women and men at risk for unintended pregnancy choose appropriate contraceptive methods and use them correctly and consistently to prevent pregnancy.

In 2010, CDC adapted global guidance from the World Health Organization (WHO) to help health care providers counsel women, men, and couples about contraceptive method choice. The [U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 \(US MEC\)](#), focuses on who can safely use specific methods of contraception, and provides recommendations for the safety of contraceptive methods for women with various medical conditions (such as hypertension and diabetes) and characteristics (such as age, parity, and smoking status).

The [U.S. Selected Practice Recommendations for Contraceptive Use, 2013 \(US SPR\)](#) provides guidance on how contraceptive methods can be used and how to remove unnecessary barriers for patients in accessing and successfully using contraceptive methods. The *US SPR* includes recommendations on when women can start contraceptive methods, what exams and tests are needed before starting a method, what follow-up is appropriate, and how to address side effects and other problems with contraceptive method use.

#### How to Use the *US MEC* and *US SPR*

Health care providers can use these documents when counseling patients about contraceptive choice, how to use contraceptive methods, and how to manage problems with contraceptive use. CDC has developed [several provider tools](#), including summary charts, a *US MEC* wheel, and mobile tools for easy access to this guidance.

CDC is committed to keeping this clinical guidance up to date and based on the best available scientific evidence. CDC will continue to work with WHO to identify and assess all new relevant evidence and determine whether changes in the recommendations are warranted. Updates to the guidance will be posted on this Web site or can be received by signing up for [E-mail Updates](#).

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United States Medical Eligibility Criteria for Contraceptive Use  
  
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[www.cdc.gov/reproductivehealth/UnintendedPregnancy/Contraception\\_Guidance.htm](http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/Contraception_Guidance.htm)

# Resources

- **US MEC published in CDC's Morbidity and Mortality Weekly Report (MMWR):**

[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s\\_cid=rr5904a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s_cid=rr5904a1_w)

- **US SPR published in CDC's Morbidity and Mortality Weekly Report (MMWR):**

[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s\\_cid=rr6205a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s_cid=rr6205a1_w)

**CDC evidence-based family planning guidance documents:**

<http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm>

- **CDC Vital Signs:**

<http://www.cdc.gov/vitalsigns/teenpregnancy>

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