

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

**Division of Reproductive Health
Centers for Disease Control and Prevention**

August 1, 2013

Learning Objectives

Participants will be able to:

- ❑ Describe the US Selected Practice Recommendations for Contraceptive Use, 2013 (US SPR)
- ❑ Identify intended use and target audience Understand how to use the US SPR
- ❑ Apply the guidance in specific situations, based on clinical scenarios

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>.





The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 577 • November 2013

Committee on Gynecologic Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Understanding and Using the U.S. Selected Practice Recommendations for Contraceptive Use, 2013

ABSTRACT: The *U.S. Selected Practice Recommendations for Contraceptive Use, 2013* (U.S. SPR), issued by the Centers for Disease Control and Prevention is a companion piece to the Centers for Disease Control and Prevention's *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010*. The *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010*, provides guidance for which contraceptive methods are safe for women with selected characteristics and medical conditions, whereas the U.S. SPR offers guidance on how to use these methods most effectively. The American College of Obstetricians and Gynecologists endorses the U.S. SPR and encourages its use by Fellows; providers should always consider the specific clinical situation when applying these guidelines to individual clinical care.

US Selected Practice Recommendations for Contraceptive Use, 2013

- ❑ **Follow-up to US Medical Eligibility Criteria for Contraceptive Use, 2010 (US MEC):**
 - ❑ Recommendations for who can safely use contraception
- ❑ **Adapted from World Health Organization (WHO) SPR**
- ❑ **Intent: Evidence-based guidance for common, yet controversial, contraceptive management questions**
 - When to start
 - Missed pills
 - Bleeding problems
 - Exams and tests
 - 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**
- ❑ **Purpose: to assist health care providers when they counsel patients about contraceptive use**
- ❑ **Selected Recommendations**
 - NOT comprehensive textbook
 - NOT the US MEC
 - NOT rigid guidelines
 - NOT well-woman care

US Adaptation of WHO SPR

- ❑ **October, 2010, Small expert meeting**
 - Chose which existing WHO recommendations to adapt
 - Chose new clinical questions to add
- ❑ **Systematic reviews for each topic**
 - Peer reviewed
- ❑ **October 4-7, 2011, Expert meeting**
 - 36 experts from US
- ❑ **For each topic:**
 - Systematic review presentation
 - Discussion
 - Draft recommendation
 - Research gaps

US Adaptation of WHO SPR

- ❑ **Much of the guidance is the same as or very similar to the guidance in the WHO SPR**
- ❑ **Adaptations include:**
 - length of the grace period for progestin-only injectable contraceptives (DMPA),
 - differences in some of the examinations and tests recommended prior to contraceptive method initiation,
 - differences in recommendations for management of bleeding irregularities based on new data and drug availability in the US,
 - simplified missed pill algorithms

US Adaptation of WHO SPR

The US SPR includes additional guidance:

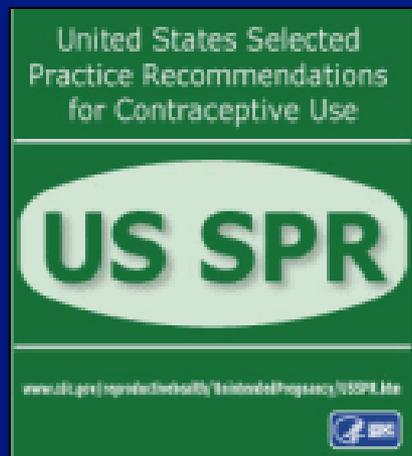
- ❑ Recommendations on patch and ring
- ❑ How to start regular contraception after taking emergency contraceptive pills
- ❑ Management of bleeding irregularities among women using extended or continuous combined hormonal contraceptives (CHCs)
- ❑ When a woman can rely on female sterilization for contraception
- ❑ When a woman can stop contracepting

US Adaptation of WHO SPR

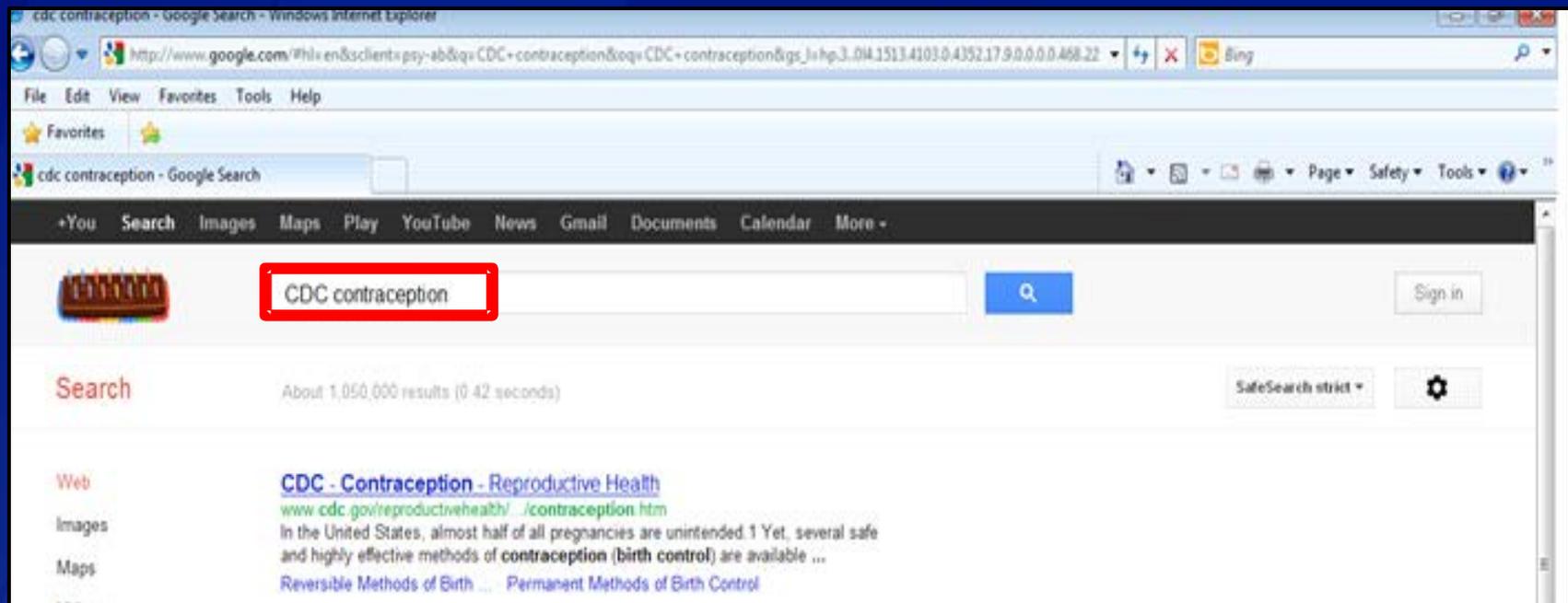
□ Format

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

HOW TO USE THE US SPR



Locating CDC contraception guidance



The screenshot shows a Windows Internet Explorer browser window displaying a Google search for "CDC contraception". The search bar contains the text "CDC contraception" and is highlighted with a red rectangle. The search results show "About 1,050,000 results (0.42 seconds)". The top result is titled "CDC - Contraception - Reproductive Health" with the URL "www.cdc.gov/reproductivehealth/.../contraception.htm". The snippet below the title reads: "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".

cdc contraception - Google Search - Windows Internet Explorer

http://www.google.com/#hl=en&client=psy-ab&q=CDC+contraception&ooq=CDC+contraception&igs_j=hp.3.014.1513.4103.0.4352.17.9.0.0.0.0.468.22

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CDC contraception

Search

About 1,050,000 results (0.42 seconds)

SafeSearch strict

Web

[CDC - Contraception - Reproductive Health](#)

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

CDC CONTRACEPTIVE GUIDANCE FOR HEALTH CARE PROVIDERS

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Reproductive Health

Reproductive Health > Unintended Pregnancy

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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.¹ Unintended pregnancies increase the risk for poor maternal and infant outcomes² and in 2002, resulted in \$5 billion in direct medical costs in the United States.³

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.⁴ 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](#).

More Related Links
Data and Stats

Email page link
Print page

Sign up to receive US MEC and US SPR E-mail Updates.

United States Medical Eligibility Criteria for Contraceptive Use

www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm
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United States Selected Practice Recommendations for Contraceptive Use

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

Resources

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

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

<http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USSPR.htm>

- Sign up to receive alerts!

- ❑ **WHO evidence-based family planning guidance documents:**

http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

CLINICAL SCENARIOS

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?



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

Other findings

- ❑ Starting CHCs on different days of the cycle does not affect bleeding changes 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

Exposure in early pregnancy

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

Need for back-up contraception

- ❑ Later start days are associated with greater follicular activity, but not ovulation, through day 5 (implications for back up)



US SPR

When to start a contraceptive method

Contraceptive Method	When to start, if provider is reasonably certain woman is not pregnant	Back-up needed
LNG IUD	Any time	If > 7 days of cycle, use back-up method or abstain for 7 days
Copper IUD	Any time	Not needed
Implant (etonogestrel)	Any time	If > 5 days of cycle, use back-up method or abstain for 7 days
Injectable	Any time	If > 7 days of cycle, use back-up method or abstain for 7 days
CHC	Any time	If > 5 days of cycle, use back-up method or abstain for 7 days
Progestin-Only Pills (POPs)	Any time	If > 5 days of cycle, use back-up method or abstain for 2 days

Guidance for Special Considerations

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

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**

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 ≤ 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 ≤ 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:** Lobbok 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

- ❑ **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 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?



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 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**

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

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



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 4: Management of IUD in woman with PID

- ❑ 26 y.o. female has been using a copper-IUD for 6 months. She is now diagnosed with Pelvic Inflammatory Disease (PID).
 - Q: Does her IUD need to be removed?



Clinical scenario 4:

Management of IUD in woman with PID

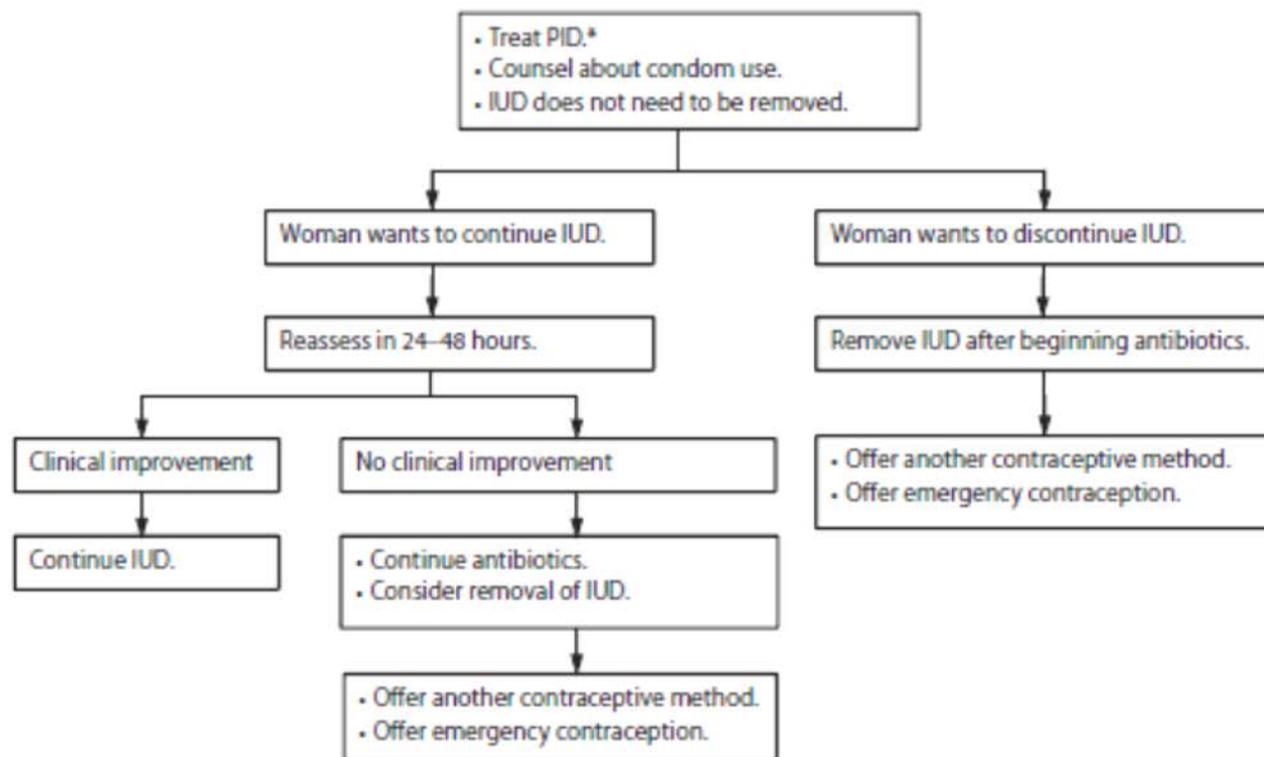
□ Evidence

- 3 RCTs and one cohort study, copper-IUD or non-hormonal IUD
- Compared PID outcomes among women who had the IUD removed compared with those who retained IUD
- Overall, similar outcomes between groups
 - 3 studies found that women with IUD removal had no difference in clinical or lab outcomes
 - 2 of these showed women with IUD removal had longer hospitalization times
 - 1 study found that women with IUD removal experienced improved recovery in clinical signs of PID

US SPR Recommendation

- ❑ **Treat the PID according to the CDC STD Treatment Guidelines.**
- ❑ **Provide comprehensive management for STDs, including counseling about condom use.**
- ❑ **The IUD does not need to be removed immediately**
- ❑ **Reassess in 48-72 hours**
- ❑ **If not improvement, continue antibiotics and consider IUD removal**
- ❑ **If woman does not want to keep the IUD, remove it after antibiotic treatment has been started.**
- ❑ **If the IUD is removed, consider using emergency contraceptive pills and counsel on alternative methods**

Management of the IUD when a Cu-IUD or an LNG-IUD User Is Found To Have Pelvic Inflammatory Disease



Abbreviations: Cu-IUD = copper-containing IUD; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing IUD; PID = pelvic inflammatory disease.

* Treat according to CDC's *STD Treatment Guidelines* (available at <http://www.cdc.gov/std/treatment/>).

Clinical scenario 4: Management of IUD in woman with PID

- ❑ 26 y.o. female has been using a copper-IUD for 6 months. She has been diagnosed with PID.
 - **Q:** Does her IUD need to be removed?
 - **A:** No, unless she wants it removed or if infection does not resolve.



Clinical scenario 5: When to stop contracepting

- ❑ 46 y.o. female with a history of hypertension has been using progestin-only pills and wants to know when she can stop her contraception.
 - Q: When can a woman stop contracepting?



Evidence

- ❑ **There are no reliable tests to confirm a woman's definitive loss of fertility**
- ❑ **FSH levels may not be accurate**
- ❑ **The median age of menopause is approximately 51 years in North America with a range of 40-60 years**

Hillard, American College of Obstetricians and Gynecologists, 2007.
The North American Menopause Society, 2010.
TeVelde, Hum Reprod Update, 2002.

Clinical scenario 5: When to stop contracepting

- ❑ 46 y.o. female with a history of hypertension has been using progestin-only pills and wants to know when she can stop her contraception.
 - **Q:** When can a woman stop contracepting?
 - **A:** Contraceptive protection is still needed in women older than 44 years of age, if the woman wishes to avoid pregnancy.



Clinical scenario 6: When to rely on Female Sterilization

□ A 38 y.o. obese female with three prior cesarean deliveries has completed childbearing and decided she wants hysteroscopic sterilization to replace her DMPA.

- Q: When can she rely on her sterilization for contraception?



Evidence

- ❑ **Most pregnancies after hysteroscopic sterilization occurred when there was deviation from FDA directions:**
 - Early follicular phase placement
 - Imaging at three months
 - Effective alternative contraception until documented occlusion

- ❑ **Hysterosalpingogram confirmation necessary for contraceptive reliance**

- ❑ **Very few pregnancies occurred among women with confirmed bilateral occlusion**

Clinical scenario 6: When to rely on Female Sterilization

- ❑ A 38 y.o. obese female with three prior cesarean deliveries has completed childbearing and decided she wants hysteroscopic sterilization to replace her DMPA.
 - **Q:** When can she rely on her sterilization for contraception?



- **A:** She can rely on her hysteroscopic sterilization when hysterosalpingogram at 3 months confirms bilateral tubal occlusion. Continue DMPA till then.

Clinical scenario 7: What if a woman has menstrual abnormalities using CHCs

- ❑ **28 y.o. female has been using continuous combined OCPs for the last 6 months but has had persistent spotting for the last month.**
 - **Q: What can she do if she wants treatment?**



Evidence

- ❑ Anticipatory counseling decreases method discontinuation from bleeding irregularities with DMPA
- ❑ Hormone-free Interval (HFI) of 3-4 days improves bleeding after 2 weeks
- ❑ Doxycycline has not been shown to improve bleeding

Clinical scenario 7:

What if a woman has menstrual abnormalities using CHCs

- ❑ 28 y.o. female has been using continuous oral contraceptive pills (OCPs) but has had persistent spotting for the last month.
 - Q: What can she do if she wants treatment?
 - A:
 - Emphasize importance of correct use and timing
 - Discuss HFI for 3-4 days if taking OCPs >21 days



Clinical scenario 8 : 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 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 8 : 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

Clinical scenario 8 :

Initiation of regular contraception after emergency contraception pills

- ❑ 38 y.o. obese 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 8 :

Initiation of regular contraception after emergency contraception pills

- ❑ 38 y.o. obese 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.



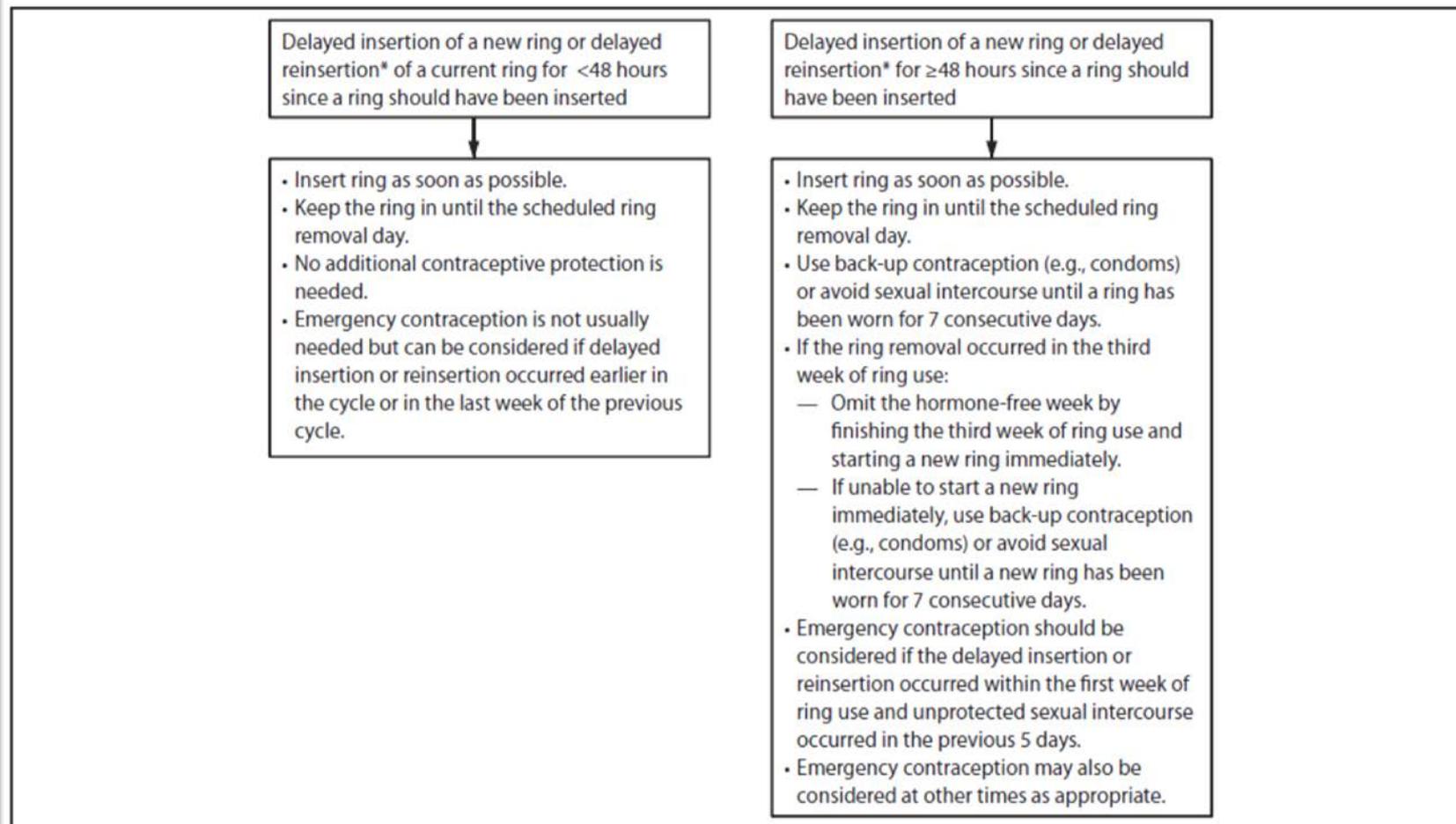
Clinical scenario 9 : Delayed Insertion of Vaginal Ring

- ❑ 26 y.o. female calls your nursing line because she is 30 hours late for her vaginal ring reinsertion.
 - Q: What should she do?



Recommended Actions after Delayed Insertion/Reinsertion with Ring

FIGURE 4. Recommended actions after delayed insertion or reinsertion with combined vaginal ring



* If removal takes place but the woman is unsure of how long the ring has been removed, consider the ring to have been removed for ≥48 hours since a ring should have been inserted or reinserted.

Delayed Insertion or Reinsertion of Vaginal Ring up to 48 hours

- ❑ Insert ring as soon as possible
- ❑ Keep the ring in until the scheduled ring removal day
- ❑ No additional contraceptive protection is needed
- ❑ Emergency contraception (EC) is not usually needed, but can be considered if delayed insertion or reinsertion occurred earlier in the cycle or in the last week of the previous cycle.



Provider tools and learning aids

- ❑ Summary tables and clinical algorithms**
- ❑ E-book and other electronic versions**
- ❑ Continuing Education Activities**
- ❑ Speaker-ready slides**
- ❑ Contraceptive Effectiveness Chart**

Continuing Education

<http://www.cdc.gov/mmwr/>

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[View MMWR Vol.62 No. RR5](#) 
Course Number: WB2272
CE Origination Date: June 21, 2013
CE Expiration Date: June 21, 2015
[CE available at TCEO](#)

Take Home Messages

- ❑ Most women can start most methods anytime
- ❑ Few, if any, exams or tests are needed
- ❑ Recommendations for anticipatory counseling for potential bleeding problems and proper management provided
- ❑ Routine follow-up generally not required
- ❑ Many circumstances call for consideration of emergency contraception use
- ❑ Regular contraception should be started after EC

Why the US SPR is important

- ❑ Evidence-based guidance
- ❑ Quality family planning care
- ❑ Help individuals use methods correctly and consistently
- ❑ Decrease medical barriers to contraceptive use

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SEARCH

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U.S. Selected Practice Recommendations (US SPR) 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 contraceptive guidance document, [U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 \(US MEC\)](#). While the *US MEC* provides guidance on who can use various methods of contraception, the *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. Several medical barriers to initiating and continuing contraceptive methods may exist, such as—

- Unnecessary screening exams and tests before starting the method.
- Inability to receive the method on the same day as the visit.
- Difficulty obtaining continued contraceptive supplies.

These recommendations have been adapted from global family planning guidance provided by the World Health Organization (WHO). Although many of the recommendations are the same as those provided by WHO, they have been adapted to be more specific to U.S. practices or have been modified because of new evidence. In addition, new topics of interest to U.S. health care providers have been added to the guidance.

These recommendations are meant to serve as a source of clinical guidance for health care providers. Health care providers should always consider the individual clinical circumstances of each person seeking family planning services.

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United States Medical Eligibility Criteria for Contraceptive Use



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