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 https://www.cdc.gov/mmwr/cme/conted.html.
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
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:
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

Brahmi, Contraception, 2013.
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.

Brahmi, Contraception, 2013.
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)

Brahmi, Contraception, 2013.
# When to start a contraceptive method

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

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 [≥85%] of feeds are breastfeeds),* amenorrheic, and <6 months postpartum

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

Stanback, J Fam Plann Reprod Health Care, 2006;32:27.
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
## US SPR
Exams and tests prior to initiation

<table>
<thead>
<tr>
<th>Examination or test</th>
<th>Contraceptive method and class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LNG and Cu-IUD</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>_<code>†</code></td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
</tr>
<tr>
<td>Laboratory test</td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>C</td>
</tr>
<tr>
<td>Lipids</td>
<td>C</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Papanicolaou smear)</td>
<td>C</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td>_<code>§</code></td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
</tr>
</tbody>
</table>
### US SPR
**Exams and tests prior to initiation**

<table>
<thead>
<tr>
<th>Examination or 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>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>
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| Laboratory test                            |                |         |            |     |     |        |                           |            |
|--------------------------------------------|                |         |            |     |     |        |                           |            |
| Glucose                                    | C              | C       | C          | C   | C   | C      | C                         | C          |
| Lipids                                     | C              | C       | C          | C   | C   | C      | C                         | C          |
| Liver enzymes                              | C              | C       | C          | C   | C   | C      | C                         | C          |
| Hemoglobin                                 | C              | C       | C          | C   | C   | C      | C                         | C          |
| Thrombogenic mutations                     | C              | C       | C          | C   | C   | C      | C                         | C          |
| Cervical cytology (Papanicolaou smear)     | C              | C       | C          | C   | C   | C      | C                         | C          |
| STD screening with laboratory tests        | _§             | C       | C          | C   | C   | C      | C                         | C          |
| HIV screening with laboratory tests        | C              | C       | C          | C   | C   | C      | C                         | C          |
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.
# US SPR

## Exams and tests prior to initiation

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<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
</tr>
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</table>
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

Tepper et al., Contraception 2013.
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.

http://www.cdc.gov/std/treatment
Management of the IUD when a Cu-IUD or an LNG-IUD User Is Found To Have Pelvic Inflammatory Disease

- Treat PID.*
- Counsel about condom use.
- IUD does not need to be removed.

Woman wants to continue IUD.
- Reassess in 24–48 hours.
  - Clinical improvement
    - Continue IUD.
  - No clinical improvement
    - Continue antibiotics.
    - Consider removal of IUD.
    - Offer another contraceptive method.
    - Offer emergency contraception.

Woman wants to discontinue IUD.
- Remove IUD after beginning antibiotics.
  - Offer another contraceptive method.
  - Offer emergency contraception.

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

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

Cleary et al, Contraception 2012.
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?
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

**Delayed insertion of a new ring or delayed reinsertion* of a current ring for <48 hours since a ring should have been inserted**

- Insert ring as soon as possible.
- Keep the ring in until the scheduled ring removal day.
- No additional contraceptive protection is needed.
- Emergency contraception 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.

**Delayed insertion of a new ring or delayed reinsertion* for ≥48 hours since a ring should have been inserted**

- Insert ring as soon as possible.
- Keep the ring in until the scheduled ring removal day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until a ring has been worn for 7 consecutive days.
- If the ring removal occurred in the third week of ring use:
  - Omit the hormone-free week by finishing the third week of ring use and starting a new ring immediately.
  - If unable to start a new ring immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until a new ring has been worn for 7 consecutive days.
- Emergency contraception should be considered if the delayed insertion or reinsertion occurred within the first week of ring use and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

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*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/

Morbidity and Mortality Weekly Report (MMWR)

MMWR CE: Serial Publications

For more information on MMWR's Continuing Education, select General Information.

To view and select from the list of Serial MMWR courses available at TCEO, please go to http://www.cdc.gov/TCEOnline and follow the instructions below:

1. Click on "Search" from the main menu
2. Go to box 2 under "Search Options: 2) Keyword Search", type in "MMWR"
3. Click the "View" button under box 2

Available Courses

U.S. Selected Practice Recommendations for Contraceptive Use, 2013: Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd Edition

Course Details

View MMWR Vol.62 No. RRO

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
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.