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 for the guidance
- Understand how to use the US SPR
- Apply the guidance in specific situations, based on clinical scenarios
Disclosures

- No conflicts of interest
- Some recommendations may be inconsistent with prescribing information
U.S. Selected Practice Recommendations for Contraceptive Use, 2013
Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd Edition

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
- What is NOT included in the US SPR
  - NOT comprehensive textbook
  - NOT the US MEC
  - NOT rigid guidelines
  - NOT well-woman care
US Adaptation of WHO SPR

- **October, 2010, small expert meeting**
  - Existing WHO recommendations to adapt
  - New clinical questions to add

- **Systematic reviews for each topic**
  - Peer reviewed

- **Expert meeting, October 4-7, 2011**
  - 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,
  - changes to the missed pill algorithms to respond to concerns that simplified algorithms are preferable
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
CDC CONTRACEPTIVE GUIDANCE FOR HEALTH CARE PROVIDERS

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/USMEC.htm)
  - [http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USSPR.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.
# US SPR

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

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

## Evidence on Pregnancy Checklist (PC)

<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 (without signs/sx)</td>
<td>1852</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

- A 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

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<th>Examination or test</th>
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<td><strong>Examination</strong></td>
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<td>Blood pressure</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>—†</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><strong>Laboratory test</strong></td>
<td>Glucose</td>
</tr>
<tr>
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<td>C</td>
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<tr>
<td>Lipids</td>
<td>C</td>
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<tr>
<td>Liver enzymes</td>
<td>C</td>
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<td>Hemoglobin</td>
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<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Papanicolaou smear)</td>
<td>C</td>
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<tr>
<td>STD screening with laboratory tests</td>
<td>—§</td>
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## US SPR

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Evidence: BP measurement

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

- **No direct evidence identified for other combined hormonal methods**

Tepper, Contraception, 2012.
## US SPR

### Exams and tests prior to initiation

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STD Screening at IUD placement

- Screen according to CDC’s STD Treatment Guidelines
- Most women do not require additional STD screening
- If no recent screening, screen at time of IUD placement
- Do not delay insertion for test results unless very high likelihood of STD exposure (e.g. current infected partner)
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 exam

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.
Appendix F
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 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 5: 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 6: 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 6: 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 6: 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.
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 Home > Continuing Education

MMWR CEs: 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 Detail

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
Reproductive Health

Reproductive Health > Unintended Pregnancy > Contraceptive Guidance for Providers

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.