Contraceptive Use: US Practice Recommendations (2024)

About the Guideline

- These guidelines are a companion document to U.S. Medical Eligibility Criteria for Contraceptive Use 2024 and are intended to provide guidance to health care providers for person-centered contraceptive counseling and services.
- The recommendations address not only the provision of contraceptive methods but also the management of issues and side effects related to specific contraceptive methods.
- A framework is outlined for removing unnecessary medical barriers to using and accessing contraception.
- The recommendations were developed by the Centers for Disease Control and Prevention (CDC) with review by subject-matter experts, invited participants, and external reviewers.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in an acute care setting. Individual circumstances for patients seeking contraceptive services should be considered.

Contraceptive Decision-Making

- When providing contraceptive counseling, health care providers must recognize provider bias, acknowledge structural systems that drive inequities, and work to mitigate harmful impacts.
- Access to the full range of contraceptive methods and information should be given in a noncoercive manner to all persons seeking contraception.
- A person-centered approach should be utilized that gives priority to a person's preferences and reproductive autonomy.
- Since the age a person is no longer at risk for becoming pregnant is not known, all patients should be counseled about contraceptive protection.

Testosterone Use and Risk for Pregnancy

- Transgender, gender-diverse, and nonbinary persons with a uterus should be counseled that the use of testosterone might not prevent pregnancy.
- For those who are at risk and do not desire pregnancy, contraceptive counseling and services should be offered.

Prevention of Sexually Transmitted Infections (STIs)

- Patients should be advised that contraceptives do not protect against STIs, including HIV infection, and thus other contraceptive methods and pre-exposure prophylaxis (PrEP) should be discussed.
- Counseling about the use of condoms and the risk for STIs, including HIV infection, should be provided to all patients regardless of contraceptive choice.
- Patients should be advised that the correct use of male external latex condoms reduces the risk for STIs and HIV infection, and internal (female) condoms can provide protection from the acquisition and transmission of STIs.
- Patients should be counseled that when taken as prescribed, PrEP is highly effective in preventing HIV infection.

How to Be Reasonably Certain That a Patient Is Not Pregnant

- Prior to starting contraceptive methods, a detailed history provides the most accurate assessment of pregnancy risk.
- If the patient has no symptoms or signs of pregnancy and meets the following criteria, the provider can be reasonably certain the patient is not pregnant and can initiate contraceptives:
    - It is 7 days or less after the start of normal menses or after spontaneous or induced abortion.
    - There has been no sexual intercourse since the start of last normal menses.
    - There has been correct and consistent use of a reliable method of contraception.
    - It is within 4 weeks postpartum.
    - The patient is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority of feeds are breastfeeds), amenorrheic, and less than 6 months postpartum.
- An additional urine pregnancy test may be considered based on the provider's clinical judgment.

Examinations and Tests Needed Before Initiation of a Contraceptive

- Few tests or examinations are needed before initiation of a contraceptive method if the patient is healthy.
- Examinations and tests, if needed, should include the following:
    - Bimanual examination and cervical inspection
    - Baseline weight and body mass index
    - Screening for STIs according to STI screening guidelines
    - Any additional test or examinations based on the patient's medical problems or special conditions, such as anemias, dyslipidemia, liver dysfunction, breast disease, cervical dysplasia, hypertension, diabetes, or thrombophilia
    - Blood pressure and glucose level (patients with severe hypertension, vascular disease, or uncontrolled diabetes should not use progestin-only injectable contraceptives [DMPA])
- Special consideration before the initiation of a copper IUD (Cu-IUD) or levonorgestrel IUD (LNG-IUD), implant, or injectable should be given to patients who:
    - have amenorrhea (not postpartum).
    - are postpartum (including cesarean delivery, breastfeeding or non-breastfeeding).
    - are postabortion (spontaneous or induced).
    - are switching from another contraceptive method.

Bleeding Irregularities Associated with Contraceptive Use

- Provide counseling before IUD implant placement, initiation of injectables, extended or continuous use of combined hormonal contraceptive (CHC), or progestin-only pills (POPs) about potential changes in bleeding patterns during contraceptive use.
- If there is a new onset of heavy or prolonged bleeding, an underlying health condition should be considered.
- Counsel the patient that amenorrhea does not require medical treatment, and that spotting or light bleeding is expected during the first 3 to 6 months of IUD implant use, with a usual decrease over time; however, a new onset of heavy or prolonged bleeding is uncommon, and an underlying health condition should be considered.
- Consider the patient's goals regarding contraceptive use or removal.
- Consider short-term use (5 to 7 days) of nonsteroidal anti-inflammatory drugs if treatment for bleeding is warranted and aligned with the patient's preferences, goals, and medical history.

- Counsel the patient that spotting or light bleeding is expected during the first 3 to 6 months of LNG-IUD use with a usual decrease over time; however heavy or prolonged bleeding is uncommon, and amenorrhea does not require any medical treatment.
- If removal of the IUD or implant, or discontinuation of the CHCs or POPs is desired, offer counseling on alternative contraceptive methods.

Intrauterine Contraception

- **Routine Follow-Up after IUD or Implant Placement**
  - More frequent follow-up visits might benefit specific populations such as adolescents, persons with certain medical conditions or characteristics, and persons with multiple medical conditions.
  - Patients should be advised that no routine follow-up visit is required, but they may contact their provider to discuss side effects or other concerns, when it is time to remove or replace the contraceptive method, or if they want to change the method being used.
  - Providers who see IUD or implant users at other routine visits should assess the patient's satisfaction with the contraceptive method, any associated concerns, and any changes in health status or medications; providers should consider performing an examination to check for the presence of the IUD strings, and they should assess whether any weight changes are related to the contraceptive method.
- **IUD Type**
  - Patients should be advised that there are four brands of IUDs available in the United States that are long-acting, reversible, and intended for use by patients of all ages, including adolescents, parous, and nulliparous patients.
  - If it is determined that the patient is reasonably not pregnant, the Cu-IUD or LNG-IUD may be placed at any time.
  - The Cu-IUD may be placed as an emergency contraceptive within 5 days of the first act of unprotected sexual intercourse. It can also be placed more than 5 days after unprotected intercourse, as long as placement is no more than 5 days after ovulation. No additional contraceptive is needed.
  - If the LNG-IUD is placed more than 7 days since menstrual bleeding stared, the patient needs to abstain from sexual intercourse or use barrier methods for the next 7 days.
  - There is no need for additional contraceptive protection after LNG-IUD placement.
  - Misoprostol can be useful in selected circumstances, but it is not recommended for routine use with IUD placement.
  - To reduce pain upon insertion, lidocaine (paracervical block or topical) may be useful.
  - For Cu-IUD or LNG-IUD insertion, prophylactic antibiotics are generally not recommended.
- **Management of the IUD When There Are Complications**
  - Pelvic inflammatory disease
    - Treat the patient according to CDC Sexually Transmitted Infections Treatment Guidelines; reassess in 48 to 92 hours and continue antibiotics if needed; counsel on alternative contraceptive methods if the IUD is removed.
  - Pregnancy
    - Evaluate the patient for possible ectopic pregnancy. Advise on the increased risk for spontaneous abortion. Counsel about options if the patient wants to discontinue the pregnancy. If the patient wants to keep the pregnancy, provide

information about where to seek care if heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever occurs.
    - Cu-IUD strings are visible and can be safely retrieved from the cervical canal
        - Advise the patient to have the IUD removed as soon as possible and seek care if there is heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.
    - Cu-IUD strings not visible and cannot be safely retrieved
        - Consider an ultrasound examination, and if the IUD cannot be located, advise the patient to seek care if there is heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.

Implants

- The etonogestrel (ENG) implant, available in the United States, is long-acting, reversible, and can be used by patients of all ages including adolescents.
- Patients should be advised that the ENG implant does not protect against STIs, including HIV infection, and other contraception methods and PrEP should be discussed.
- Note that implants may be implanted at any time if the provider is reasonably certain the patient is not pregnant.
- When the implant is placed within the first 5 days after menstrual bleeding starts, no additional contraception protection is needed.
- If the implant is placed more than 5 days after menstrual bleeding starts, the patient is required to use the barrier method or abstain from sexual intercourse for the next 7 days.

Other Non-Intrauterine Contraceptives

- **Injectables**
    - In the United States, progestin-only injectable contraceptives (DMPA [depot medroxyprogesterone], 150 mg intramuscularly [DMPA-IM] or 104 mg subcutaneously [DMPA-SC]), are available.
    - DMPA may be started at any time if it is reasonably certain the patient is not pregnant.
    - If started within the first 7 days after menstrual bleeding began, this method requires no additional contraceptive protection.
    - If started more than 7 days after menstrual bleeding began, the patient should use a barrier method or abstain from sexual intercourse for the next 7 days.
    - An additional approach, self-administered DMPA-SC, should be made available.
    - DMPA injections may be repeated every 3 months (13 weeks) or earlier, if needed, or up to 2 weeks late after the last injection.
    - For bleeding irregularities
        - provide counseling before the use of injectables, about potential changes in bleeding patterns during DMPA use; advise the patient that amenorrhea, spotting, or light bleeding are common, and that heavy or prolonged bleeding can occur.
        - consider underlying health conditions or medications if there is heavy or prolonged bleeding.
        - consider the patient's goals regarding continued implant use or discontinuation of DMPA.

- **Combined Hormonal Contraceptives (CHCs)**
  - CHCs contain progestin and estrogen and exist in various formulations such as transdermal patches and combined vaginal rings; CHCs are reversible and are generally used for 21 to 24 consecutive days followed by 4 to 7 hormone-free days.
  - If CHCs are to be started less than 5 days since menstrual bleeding began, no additional contraceptive is needed; however, if initiated more than 5 days after menstrual bleeding started, the patient should use a barrier method or abstain from sexual intercourse for the next 7 days.
  - Postpartum patients who are breastfeeding should not use CHCs before 30 days postpartum and not before 42 days if risk factors exist.
  - Up to one year of prescription refills should be made available based on the patient's preferences and anticipated use.
  - Directions should be given for late or missed doses as well as for the side effects from CHC use such as vomiting or severe diarrhea.
- **Progestin-Only Pills (POPs)**
  - POPs can be started any time, including immediately postpartum, postabortion, and when breastfeeding.
  - If POPs are started less than 5 days after menstrual bleeding began, no additional contraceptive is needed; however, if started more than 5 days after menstrual bleeding began, the patient should use a barrier method or abstain from sexual intercourse for the next 2 days.
  - Directions should be given for late or missed doses as well as for the side effects from POP use such as vomiting or diarrhea for any reason occurring within 3 hours after taking a pill.
- **Standard Days Method (SDM)**
  - Fertility awareness is the basis for SDM, and users of this method must avoid unprotected intercourse on days 8 through 19 of the menstrual cycle.
  - Counseling should be provided for the use of SDM when patients have various durations of the menstrual cycle.
- **Emergency Contraception**
  - Cu-IUD and 3 types of emergency contraceptive pills (ECPs) can be used as emergency contraception, and all are approved in the United States for use within 5 days of the first act of unprotected sexual intercourse; however, these do not protect against STIs, including HIV infection.
  - Patients should be advised that correct use of male external latex condoms reduces the risk for STIs and HIV infection, and the use of internal (female) condoms can provide protection from acquisition and transmission of STIs.
  - Patients should be counseled when emergency contraception is taken as prescribed, noting that emergency contraception does not protect against STIs (including HIV infection). PrEP is highly effective in preventing HIV infection.
  - An advanced supply of ECPs can be provided.
  - Patients should be advised to start or resume the regular contraceptive method as needed.
  - Counseling should be given for preventing and managing nausea and vomiting after ECP use.

- **Permanent Contraception**
  - Laparoscopic and abdominal tubal surgery and vasectomy are methods of permanent contraception available in the United States.
  - No additional contraceptive protection is needed after laparoscopic and abdominal approaches.
  - A semen analysis should be performed at 8 to 16 weeks after a vasectomy, and the patient should abstain from sexual intercourse or use a barrier method until success is determined.
  - The patient should abstain from ejaculation for 1 week to allow for healing of the surgical site.

Reference

Curtis, K. M., Nguyen, A. T., Tepper, N. K., Zapata, L. B., Snyder, E. M., Hatfield-Timajchy, K., Kortsmit, K., Cohen, M. A., Whiteman, M. K., & Contributors (2024). U.S. Selected Practice Recommendations for Contraceptive Use, 2024. *MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports*, *73*(3), 1–77. https://doi.org/10.15585/mmwr.rr7303a1