Contraceptive Counseling and Education

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This module gives providers comprehensive information about the contraceptive methods and client-centered counseling techniques outlined in *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*. Using the information in this module, providers can help clients identify the contraceptive method that best fits their needs and preferences.

WELCOME

- Navigation tutorial
- Disclosures
- Welcome
- The goal of contraceptive counseling

SECTION 1: CONTRACEPTIVE METHODS

- Characteristics of contraceptive methods
- Hormones in contraception

- Long-acting contraceptive methods
- Sterilization
- Copper IUD
- Long-acting progestin-only methods
- Shorter-acting hormonal methods
- Shorter-acting progestin-only methods
- Combined hormonal contraceptives
- Activity: Match the contraceptive method
- Barrier methods
- Condoms (internal and external)
- Other barrier methods: diaphragm and sponge
- Spermicides
- Activity: Match the contraceptive method
- Knowledge-based methods
- Withdrawal
- Fertility awareness-based methods

- Abstinence
- Lactational Amenorrhea Method
- Activity: Match the contraceptive method
- Emergency contraception
- Explaining contraception
- Client education materials

SECTION 2: GUIDELINES FOR CONTRACEPTIVE USE

- U.S. Medical Eligibility Criteria for Contraceptive Use
- Activity: Explore the U.S. MEC
- Activity: Use the U.S. MEC
- U.S. Selected Practice Recommendations for Contraceptive Use
- Activity: Explore U.S. SPR recommendations
- Scenario 1: Brief contraceptive counseling encounters

SECTION 3: CLIENT-CENTERED CONTRACEPTIVE COUNSELING SKILLS

- Five steps to providing contraceptive services
- What matters to clients
- Counseling skills

Video: Mia’s contraceptive counseling visit

Activity: In your own words

Scenario 2: Contraceptive counseling visit

Quiz

Conclusion

References

Navigation tutorial

For the best experience, use Firefox or Chrome to view this course.

You can leave and come back to this eLearning module at any time. If you exit the module and return to it later, select the lesson where you left off from the menu of lessons on the left. This will bring you back to your place in the course.

To learn how to navigate the module, click the play button below.

PLAY

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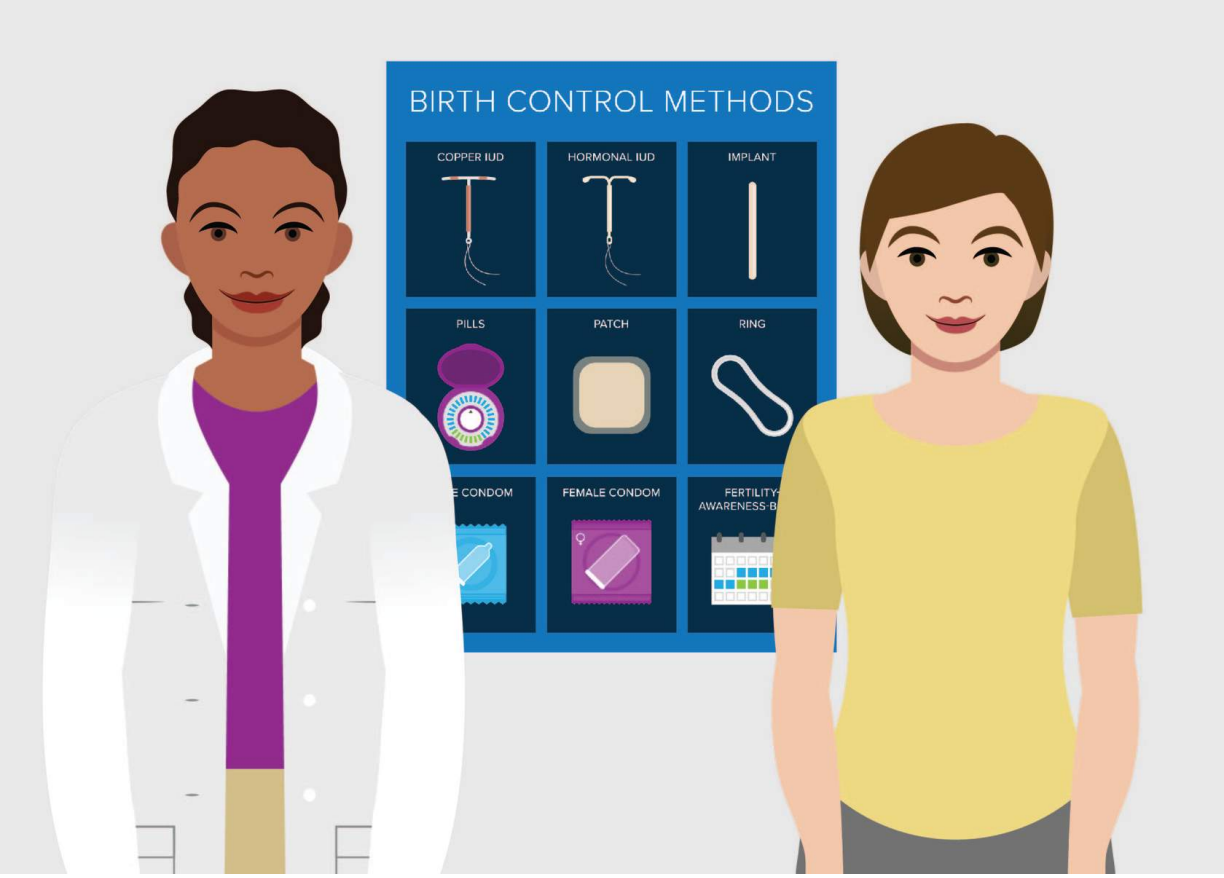
Welcome



Welcome to the *Contraceptive Counseling and Education* eLearning module.

This module includes:

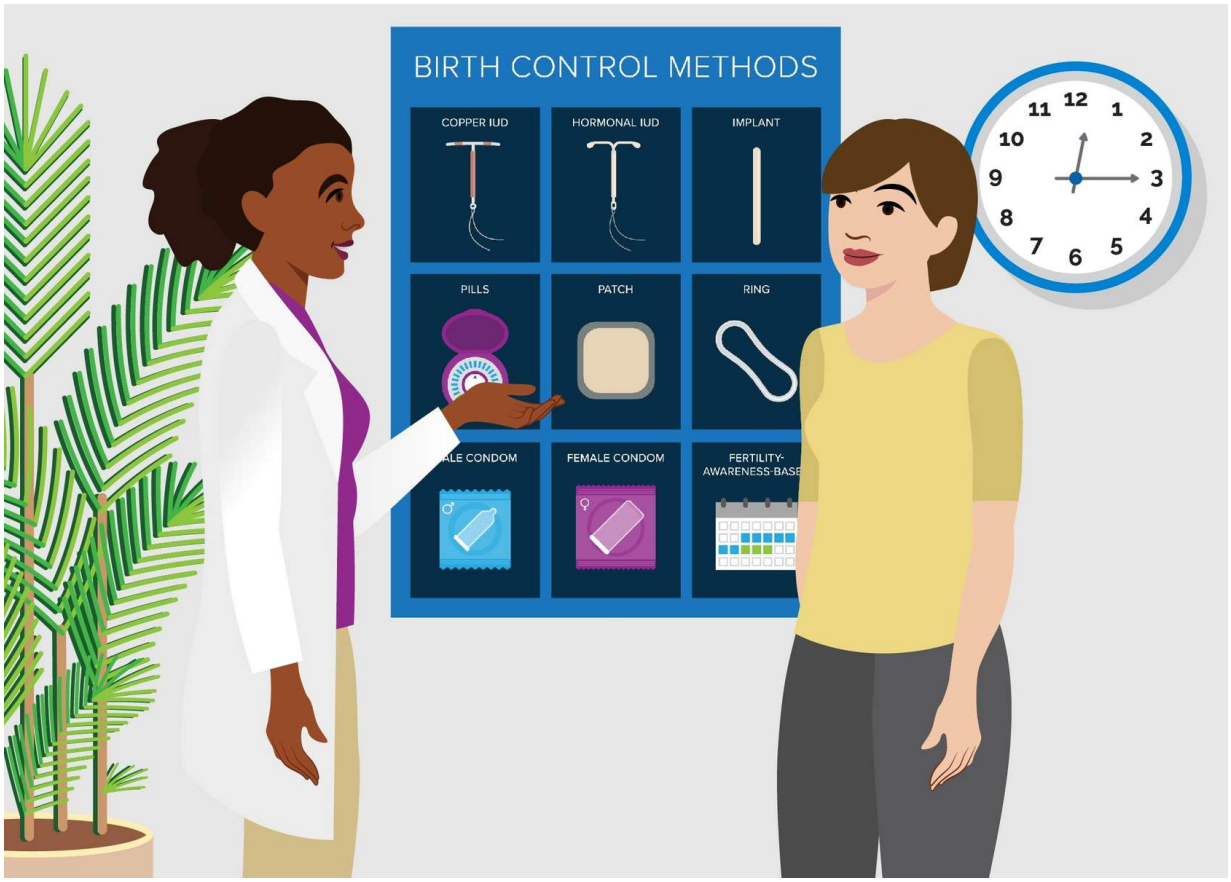
1. Section 1: Contraceptive methods
2. Section 2: Guidelines for contraceptive use
3. Section 3: Client-centered contraceptive counseling skills

Throughout the module, you will be asked to read new information, watch videos, conduct interactive activities, and reflect.

By the end of this module, participants will be able to:

- [ ] Accurately describe the full range of contraceptive methods
- [ ] Elicit client preferences about contraceptive methods
- [ ] Use client-centered counseling techniques to help clients identify a method that best fits their needs and preferences

The goal of contraceptive counseling



The goal of client-centered contraceptive counseling is to support your client seeking to prevent pregnancy in selecting a method that fits their needs and preferences.

What works for one client will not necessarily work for another client. The best method for your client is the method they will use:

- [ ] **Correctly**–the way the method is designed to be used.
- [ ] **Consistently**–for as long as they desire pregnancy prevention.

Characteristics of contraceptive methods

To provide quality contraceptive counseling, you first need accurate, comprehensive information about the full range of contraceptive methods.

This is important because clients may want to understand and consider many characteristics of contraceptive methods before selecting one.

For example, clients may want to know about these characteristics of contraceptive methods:

- How effective the method is at preventing pregnancy
- How safe the method is
- How to use the method and how easy it is to use
- How long the method lasts
- Possible side effects, including menstrual side effects
- How easy it is to become pregnant after stopping the method
- How easy it is to control the method
- How easy it is to keep the method private

When talking with clients, you can describe how effective a method is by sharing the typicalL use effectiveness rate. The typical use effectiveness rate is the number of clients out of everyL 100 clients using the method that will have an unintended pregnancy within the first year of typical use. The typical use effectiveness rate is usually more helpful than the perfect use effectiveness rate because most clients don't use methods 100% correctly all of the time.[1, 2]

Hormones in contraception

Many types of contraception contain hormones.

These methods share many characteristics, including how they prevent pregnancy, non-contraceptive benefits, and possible side effects. The methods differ in how they deliver the hormones, so the client's delivery system preference will help determine which method is the best fit for them.

PROGESTIN-ONLY CONTRACEPTIVES | COMBINED HORMONALS

Some methods contain only the hormone progestin. Progestin is a form of progesterone, a hormone that plays a role in the menstrual cycle and pregnancy.

Methods with progestin prevent pregnancy by thickening the cervical fluid to stop sperm from entering the uterus, and by lowering the chance that the body will release an egg.

Progestin-only methods are safe for clients who cannot use methods that contain estrogen, including women who have hypertension and other risk factors for blood clots (deep vein thrombosis), are immediately postpartum, and are breastfeeding.

PROGESTIN-ONLY CONTRACEPTIVES | COMBINED HORMONALS

Combined hormonal contraceptives (CHC) contain estrogen and progestin, which work together to prevent ovulation, thin the uterine lining to prevent a pregnancy from developing, and thicken the cervical fluid to stop sperm from entering the uterus.

Use of CHCs can increase the risk of blood clots. Therefore, clients at increased risk for blood clots—such as those with migraine headaches, long-standing diabetes, hypertension, and other conditions—should not use CHCs. Because cigarette smoking increases the risk of cardiovascular events, clients who use CHCs are strongly advised not to smoke.

To mitigate the risk of deep vein thrombosis, postpartum women are advised to wait three weeks after delivery to initiate CHCs. Because CHCs may reduce the milk supply, breastfeeding women are advised to wait four weeks, and until breastfeeding is well-established, to start CHCs.

Menstrual periods vs. spotting

Menstrual periods occur when the uterine lining (endometrium) breaks down. They occur once per month and usually last for three to five days.

Spotting refers to light vaginal bleeding or brown discharge that occurs between menstrual periods.

Progestin-only contraceptives and CHCs have several non-contraceptive benefits, including:[3]

- Regular, lighter periods or no periods
- Reduced symptoms of premenstrual syndrome
- Reduced menstrual cramps
- Reduced risk of anemia
- Reduced pain caused by endometriosis
- Reduced risk of ovarian, uterine, and endometrial cancers

In addition, the estrogen in CHCs may improve acne, thinning hair, and excessive hair growth for clients with hormone imbalances.

Some clients experience side effects such as spotting, mild nausea, and breast tenderness, which usually resolve over time.

The progestin-only contraceptives and CHCs that are currently available:

- Do not protect against sexually transmitted diseases (STDs) or HIV
- Can be initiated at any time, as long as the health care provider is reasonably certain the client is not pregnant[5]
- Can be discontinued at any time

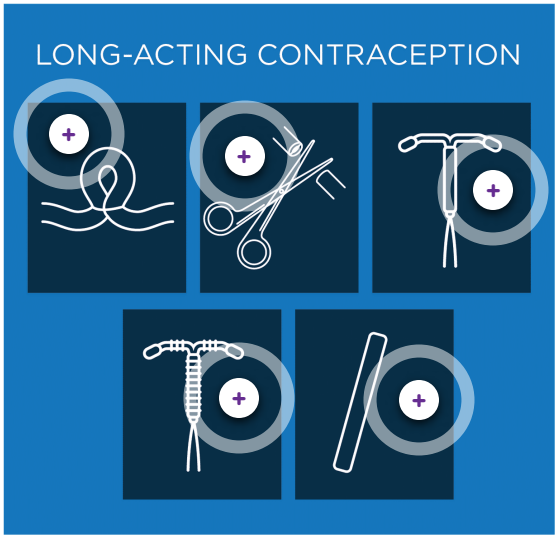
Depending on where the client is in their menstrual cycle when they initiate a hormonal method, the provider may advise using a barrier method of contraception or abstaining from vaginal intercourse for a few days, usually seven, to prevent pregnancy. The number of days a client should use a barrier method or abstain from vaginal intercourse will vary by hormonal method. After discontinuing a hormonal method, the client will usually immediately return to their normal fertility.

Long-acting contraceptive methods

Long-acting contraceptive methods are highly effective and require the client to do little or nothing after starting the method. IUDs and implants are reversible. After discontinuing either of these methods, the client will return to their normal fertility.

These methods can be kept private and do not require partner involvement.

Click on the image below to explore these methods.



Tubal ligation

Tubal ligation or tubal sterilization is the method of sterilization for the female reproductive system. It is considered a permanent method of pregnancy prevention.

Vasectomy

Vasectomy is the method of sterilization for the male reproductive system. It is considered a permanent method of pregnancy prevention.

LNG IUD

The levonorgestrel intrauterine device (LNG IUD) is a progestin-only method that is placed in the uterus. There are several options that provide varying lengths of pregnancy prevention.

Copper IUD

The copper intrauterine device (IUD) is a non-hormonal method that is placed in the uterus for up to 10 years of pregnancy prevention.

Implant

The contraceptive implant is a progestin-only method that provides up to three years of pregnancy prevention.

> **None of the long-acting contraceptive methods protect against STDs or HIV.**

Sterilization

Sterilization procedures are available for females and males. Both procedures are highly effective: within the first year of typical use, fewer than one out of every 100L females will become pregnant and fewer than one out of every 100 males will cause pregnancy.

Tubal ligation or **tubal sterilization**

This method, known as “female sterilization,” is a surgical procedure to cut, block, or tie off the fallopian tubes so the egg cannot move to the uterus and the sperm cannot reach the egg. The procedure involves a small cut in the abdomen through which thin instruments are inserted. Most clients go home the same day as the procedure. The procedure does not change the production of hormones or affect menstruation.

Clients who have a tubal ligation may experience slight pain or soreness in the abdomen for two to three days after the procedure. They may also experience side effects of the anesthesia, including nausea, vomiting, sore throat, dry mouth, dizziness, sleepiness, muscle aches, itching, and shivering.

While many women undergo tubal ligation after childbirth or in combination with another surgery, such as a C-section, it can be done any time. If federal or state funds will pay for the procedure, the client must sign a consent form at least 30 days prior to the procedure.

Vasectomy

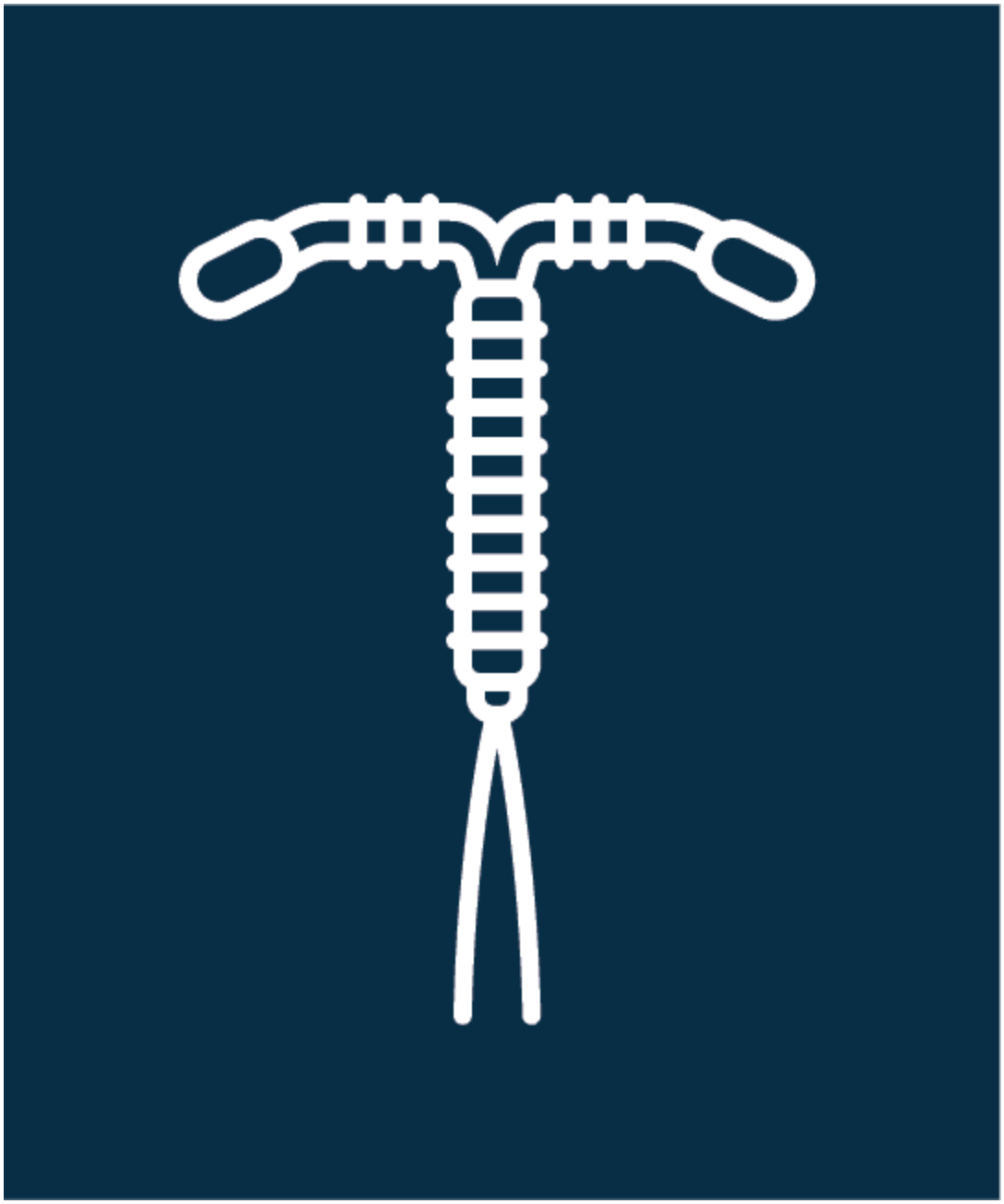
This method, known as “male sterilization,” is a surgical procedure to cut and seal the vas deferens that carry sperm up to the penis, permanently blocking sperm from joining the semen and being ejaculated. In the traditional method, the tubes are pulled through a small opening in the testicles and then sealed. A no-scalpel vasectomy is done by making a small puncture in the testicles through which the tubes are sealed. This procedure is quicker,

generally has fewer side effects, and is less painful than the traditional method. BothL procedures take about 30 minutes.

Clients who have a vasectomy may experience bleeding under the skin, bruising, and discomfort immediately following the procedure. Clients can take mild pain medication and expect the discomfort to go away altogether after a few days. Clients should avoid heavy physical labor for 48 hours after a vasectomy.

Both sterilization procedures are considered permanent and are very difficult and expensive toL reverse. It's also important to let clients know that there are rare but serious risks related to the surgical procedures. They may also experience temporary side effects of the anesthesia.

Copper IUD



The copper IUD is a T-shaped device placed in the uterus that stops sperm from getting toLL the egg. To place the device, a trained health care provider performs a minor, non-surgical procedure through the cervix. To remove the IUD, the provider uses a special tool to pull the strings of the device, which causes its arms fold up and the IUD to slip out through the cervix. There is one brand, Paragard®, and it provides up to 10 years of pregnancy prevention.
The copper IUD is highly effective. Fewer than 1 out of every 100 clients using it will becomeL pregnant within the first year of typical use.

The copper IUD can be initiated at any time, as long as the health care provider is reasonably certain the client is not pregnant. The copper IUD can be placed within five days of unprotected intercourse as emergency contraception.

Non-contraceptive benefits

- Reduced risk of endometrial and cervical cancer

Possible side effects

- Some discomfort associated with placement that goes away within a few days
- Changes in bleeding patterns (some clients may experience longer, heavier menstrual periods and spotting between periods)
- Increased menstrual cramps

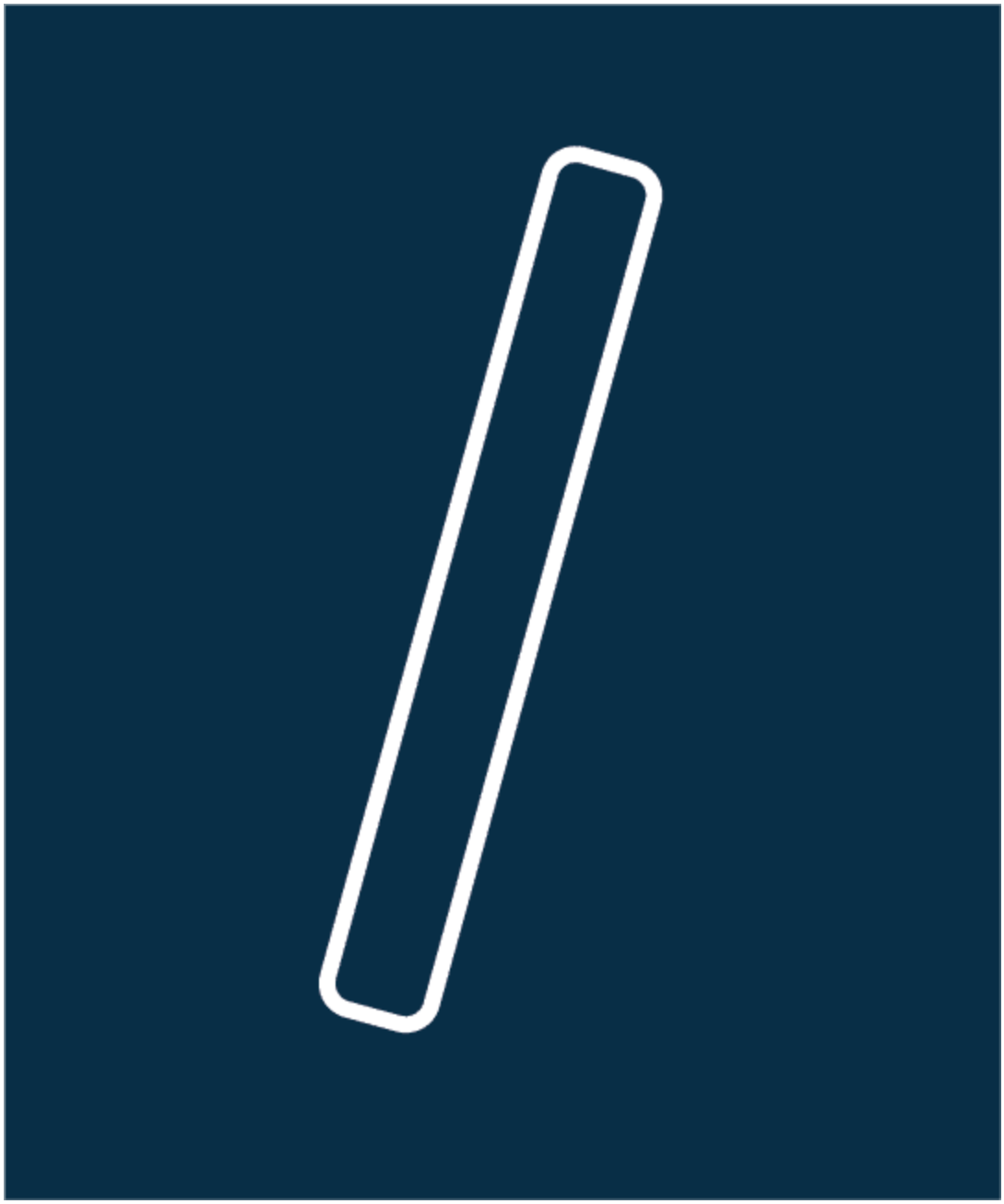
Other considerations

- Can be discontinued at any time and, after removal, the client will immediately return to their normal fertility
- Gonorrhea and chlamydia testing is recommended before or on the day of IUD insertion, to reduce the risk of upper genital tract infection

- Clients should talk to a health care provider if they experience symptoms of pregnancy, suspect their IUD came out, or if they or their partner feels the device in the vagina
- Safe method for clients who are breastfeeding

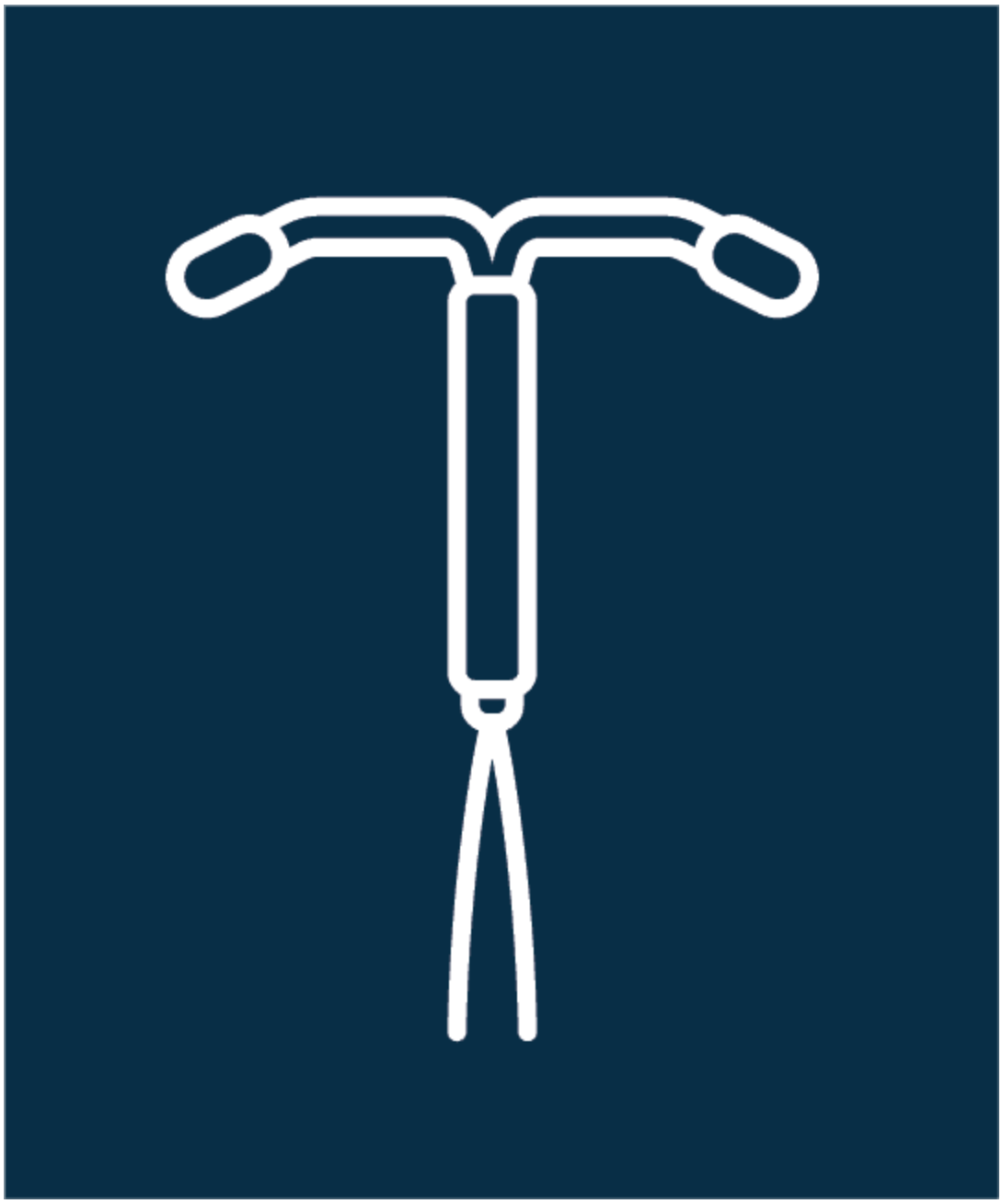
Long-acting progestin-only methods

There are two options for long-acting progestin-only methods. Both methods are highly effective: fewer than one out of every 100 clients will become pregnant within the first year of typical use.



A **contraceptive implant** is a small, flexible rod that is placed under the skin of the upper,L inner arm. A trained health care provider uses local anesthesia and then inserts the device using a special needle. A health care provider follows a similar process to remove the implant, making a small incision and then extracting the implant through the incision.

There is one brand, Nexplanon®, and it is FDA-approved for up to three years of pregnancy prevention.



A **levonorgestrel intrauterine device (LNG IUD)** is a small T-shaped device that releasesL a type of progestin called levonorgestrel. A health care provider will place and remove the LNG IUD in the same way as the copper IUD.

There are several brands of LNG IUDs that are FDA-approved for different periods of pregnancy prevention:

- **Skyla®**: 13.5mg/device, FDA-approved for up to three years

- **Kyleena®**: 19.5mg/device, FDA-approved for up to five years
- **Mirena®**: 52mg/device, FDA-approved for up to five years (Mirena® is also FDA-approved as a therapy for heavy menstrual bleeding)
- **Liletta®**: 52mg/device, FDA-approved for up to six years

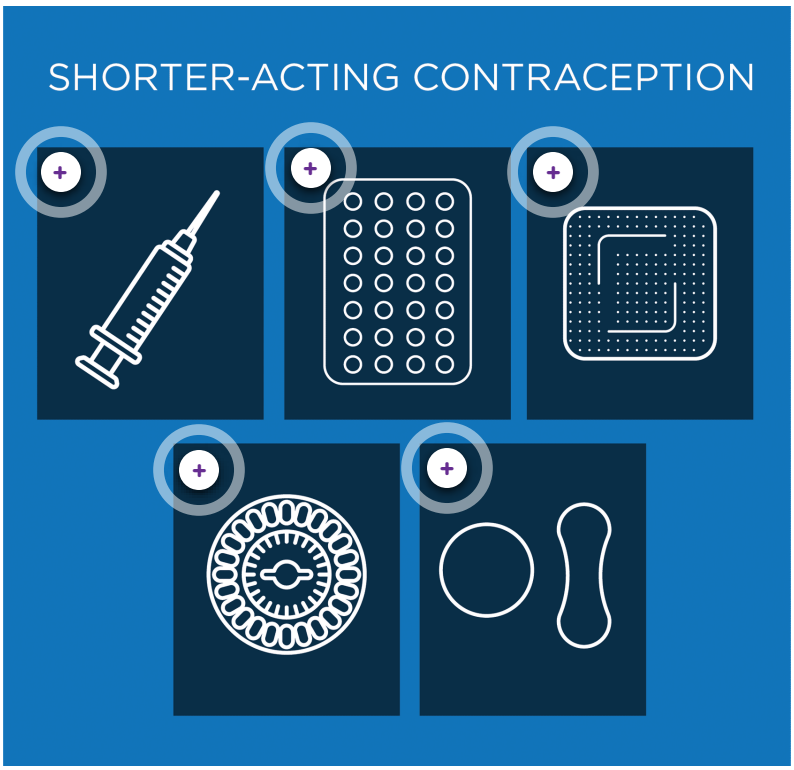
Gonorrhea and chlamydia testing is recommended before or on the day of IUD insertion, to reduce the risk of upper genital tract infection. Clients should talk to a health care provider if they experience symptoms of pregnancy, suspect their IUD came out, or if they or their partner feels the device in the vagina.

For both methods, some clients experience discomfort associated with placement, which goes away within a few days.

Both devises can be discontinued at any time and, after removal, the client will immediately return to their normal fertility.

Shorter-acting hormonal methods

Other hormonal methods, which are considered moderately effective, require the client to do something on a regular schedule–daily, weekly, monthly, or every three months.

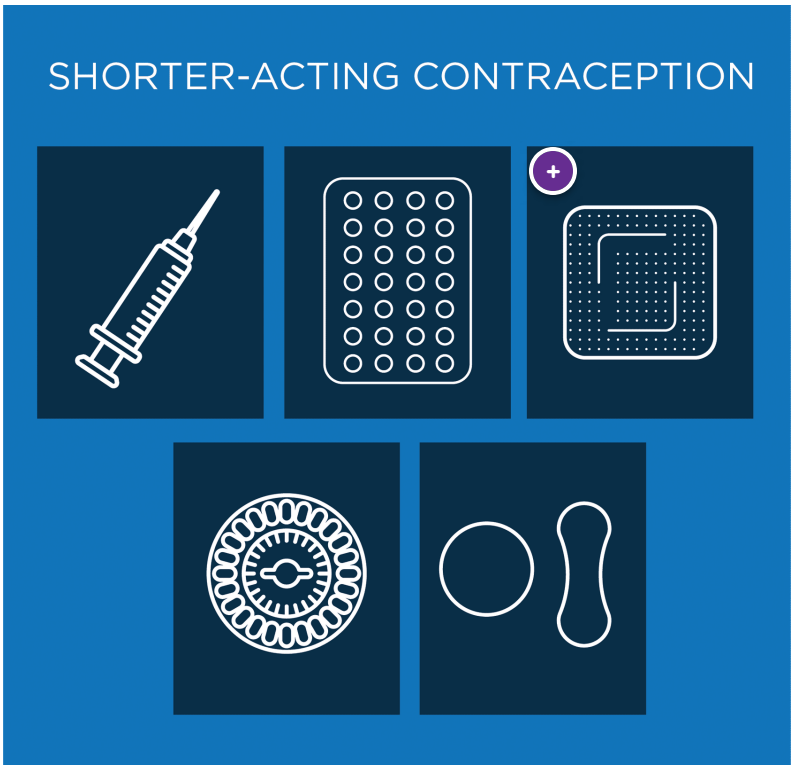


Injectable

The injectable is a progestin-containing shot given every 11-15 weeks.

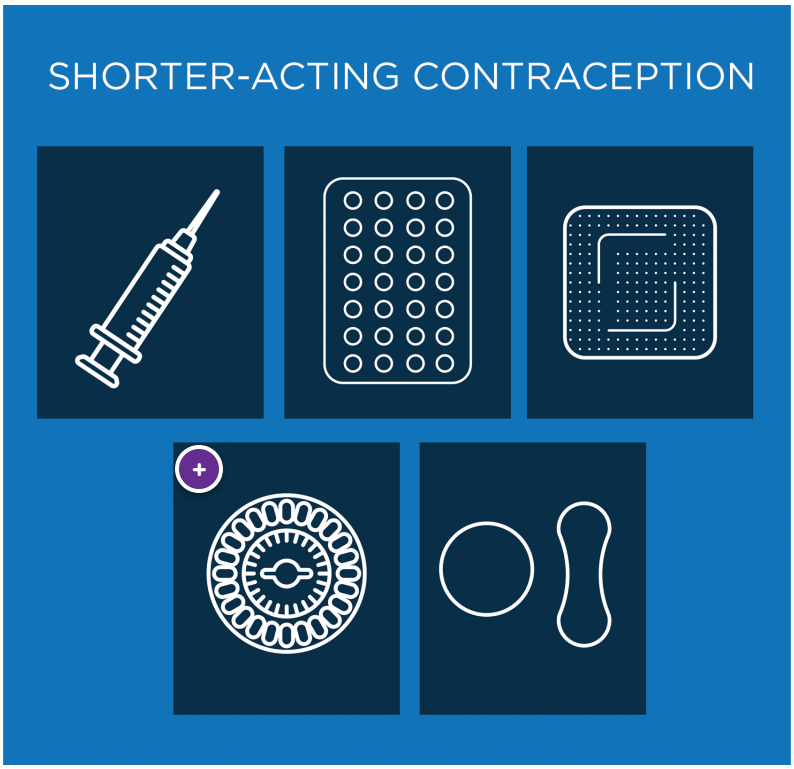
Progestin-only pills

Progestin-only pills are taken orally every day.



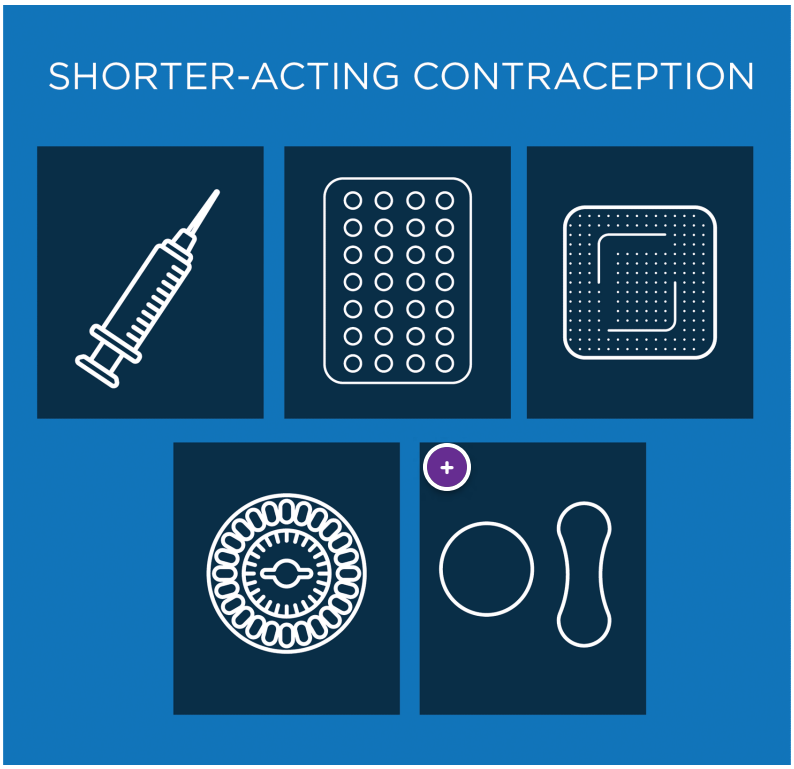
Patch

The patch is a CHC placed on the skin that must be replaced every week.



CHC pills

CHC pills are taken orally every day.



Vaginal ring

The vaginal ring is a CHC placed inside the vagina by the client. Depending on the type, it is replaced once a month or once a year.

> **None of the shorter-acting hormonal methods protect against STDs or HIV.**

Shorter-acting progestin-only methods

There are two options for shorter-acting progestin-only methods.

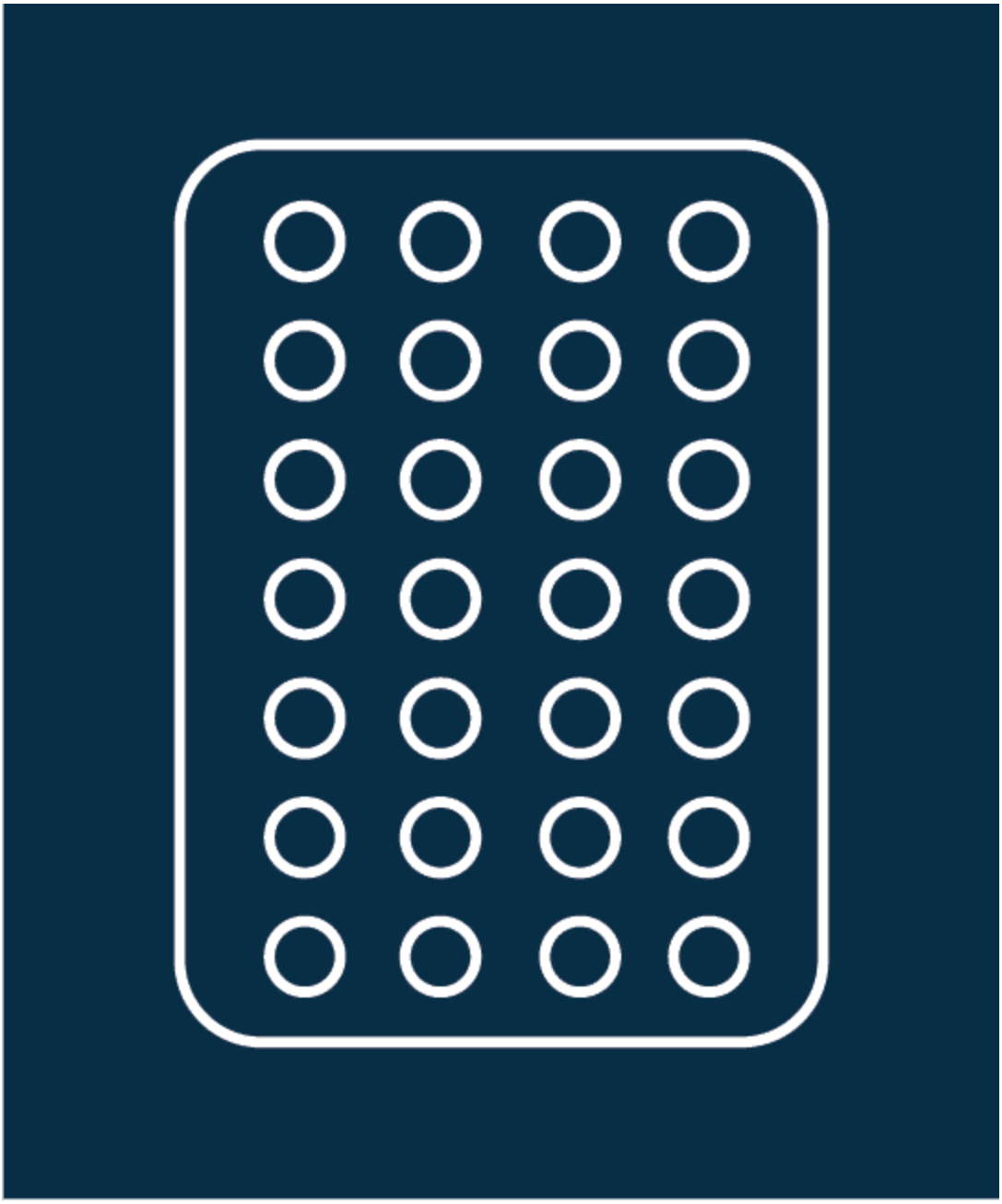
An **injectable** is a shot of depot medroxyprogesterone acetate (DMPA) given in the arm, hip,L or under the skin every three months (11-15 weeks). DMPA can be administered in two ways: 150 mg intramuscularly (IM) or 104 mg subcutaneously (-SQ or sub-Q). DMPA 150 IM is available in both brand name and generic versions; DMPA-SQ is available only as a brand name product (depo-subQ provera 104®).

Four out of every 100 clients using DMPA will become pregnant within the first year of typical use. Effectiveness decreases if the client waits more than three months between shots.

DMPA-IM and DMPA-SQ are equally effective.

Other considerations:

- Clients may experience increased appetite and weight gain, as well as mood changes.
- Clients may experience loss of bone mineral density (BMD); however, evidence suggests that recovery of BMD occurs after discontinuation.
- After discontinuation, clients' return to fertility may be delayed.
- This method can be kept private and does not require a partner’s involvement.



Progestin-only pills (POP) are taken orally. They come in packs of 28 pills, all of whichL contain progestin.

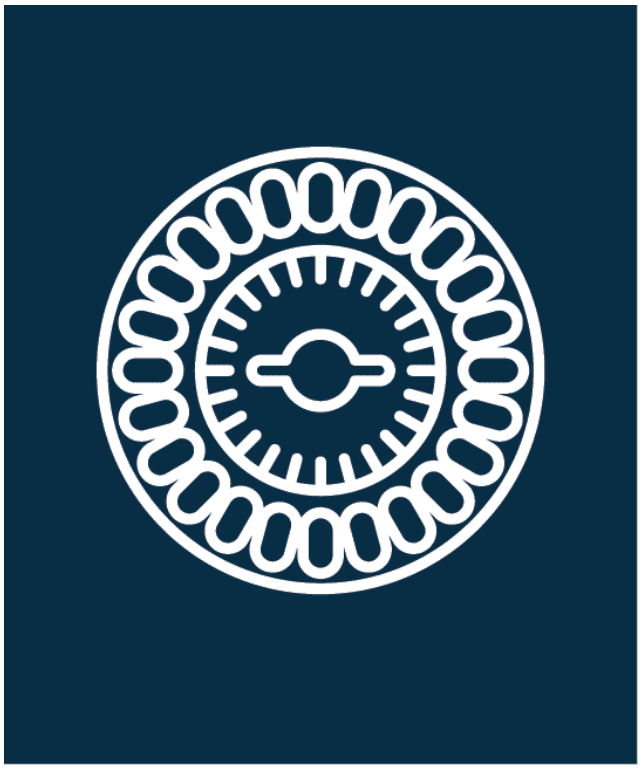
Eight out of every 100 clients using this method will become pregnant within the first year of typical use. Effectiveness decreases if the client does not take the pill at about the same time every day. If the client takes a pill more than three hours outside their usual time, the pill may be less effective. In this case, the client should use a condom or not have vaginal intercourse for the next two days.

Combined hormonal contraceptives

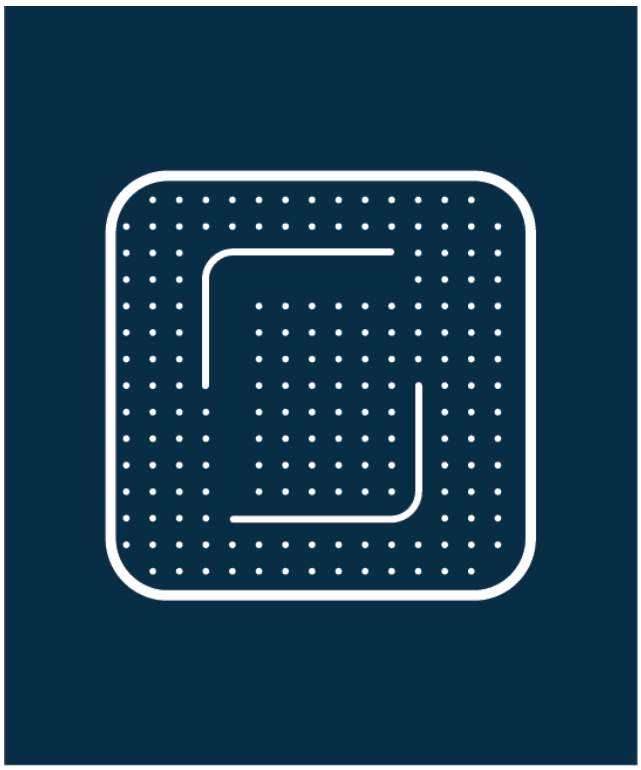
There are three options for CHCs–the pill, patch, and vaginal ring.

PILL | PATCH | VAGINAL RING

CHC pills are taken orally every day. Many CHC pills are packaged to be taken for three weeks, with the fourth week consisting of inert pills during which time the client may menstruate.



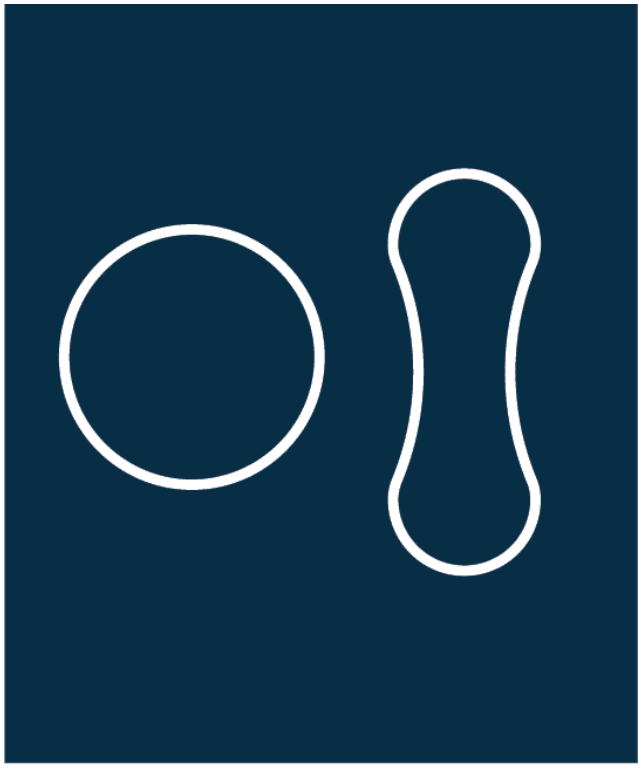
The CHC patch is a thin, stick-on, square 1¾-inch patch placed onto the skin. A client replaces their old patch with a new patch every seven days for three weeks; during the fourth week, the client does not wear a patch and may menstruate. Some clients experience skin irritation around the location of the patch.



A CHC vaginal ring is a small (approximately 2-inch wide, one-size-fits-all) flexible, transparent ring that the client places in their vagina.

There are two versions of the ring available: a one-month ring (the client must insert a new vaginal ring each month for three weeks and remove it for the fourth week, during which time they may menstruate) and a one-year ring (the client uses the same vaginal ring for one year on a rotating schedule of three weeks in the vagina followed by one week out of the vagina). The one-year ring is available in brand name only (Annovera®).

Use of the ring is associated with increased vaginal discharge (but this increased discharge is not unhealthy).



Eight to nine out of every 100 clients using one of these CHC methods will become pregnant within the first year of typical use. Effectiveness decreases with inconsistent use, like missing the pill or being late to replace the patch or ring. The patch may be less effective in preventing pregnancy in women at or above 198 lbs (90kg) and is most effective for women with a body mass index (BMI) less than 30.

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MATCH THE CONTRACEPTIVE METHOD

Match each contraceptive method below to the description of that method.

COPPER IUD ___	a) Surgical procedure to tie, block, or cut the fallopian tubes
LNG IUD ___	b) Surgical procedure to cut and seal the vas deferens
CHC PILL ___	c) Small progestin rod that is placed under the skin in the upper arm and lasts up to 3 years
PATCH ___	d) Small device placed in the uterus that contains no hormones and lasts up to 10 years
VASECTOMY ___	e) Small device placed in the uterus that contains progestin and lasts 3-6 years
RING ___	f) Taken daily by mouth, safe for clients at increased risk of blood clots
INJECTABLE ___	g) Shot in the arm, hip, or under the skin that lasts for three months
TUBAL LIGATION ___	h) Taken daily by mouth, not recommended for clients at increased risk of blood clots
IMPLANT ___	i) The client places a new one on the skin once per week
PROGESTIN-ONLY PILL ___	j) The client places this flexible device into the vagina each month

Correct Responses:
Copper IUD (d); LNG IUD (e); CHC Pill (h); Patch (i); Vasectomy (b); Ring (j); Injectable (g); Tubal ligation (a); Implant (c); Progestin-only pill (f)

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Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Barrier methods

Barrier methods prevent sperm from entering the vagina during sexual intercourse. These methods require the client to do something to prevent pregnancy at or near the time of sexual intercourse.

Some barrier methods are used with spermicides. All barrier methods are free of hormones and safe for clients who are breastfeeding.

External condom

An external condom is a thin sheath that fits over the erect

penis.

Internal condom

An internal condom is a loose-fitting pouch placed inside the

vagina.

Diaphragm

A diaphragm is a dome-shaped rubber (latex) or silicone cup with a stiff rim placed into the vagina and over the cervix.

Vaginal spermicides

Vaginal spermicides contain chemicals that kill sperm.

Sponge

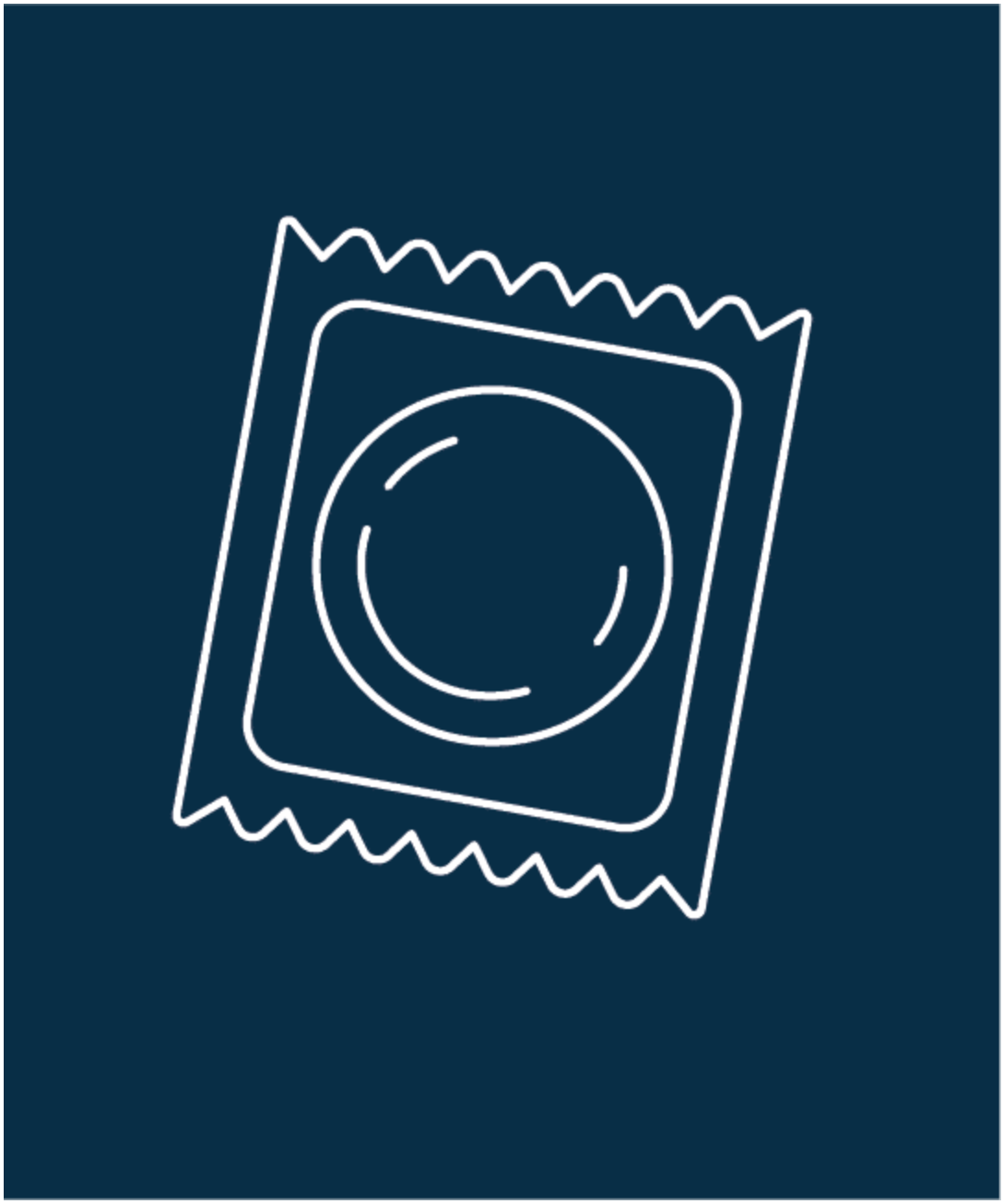
A sponge contains spermicide and is inserted into the vagina and placed in front of the cervix.

Condoms (internal and external)

Condoms act as a physical barrier during sexual intercourse. There are two types of condoms, both available over the counter.

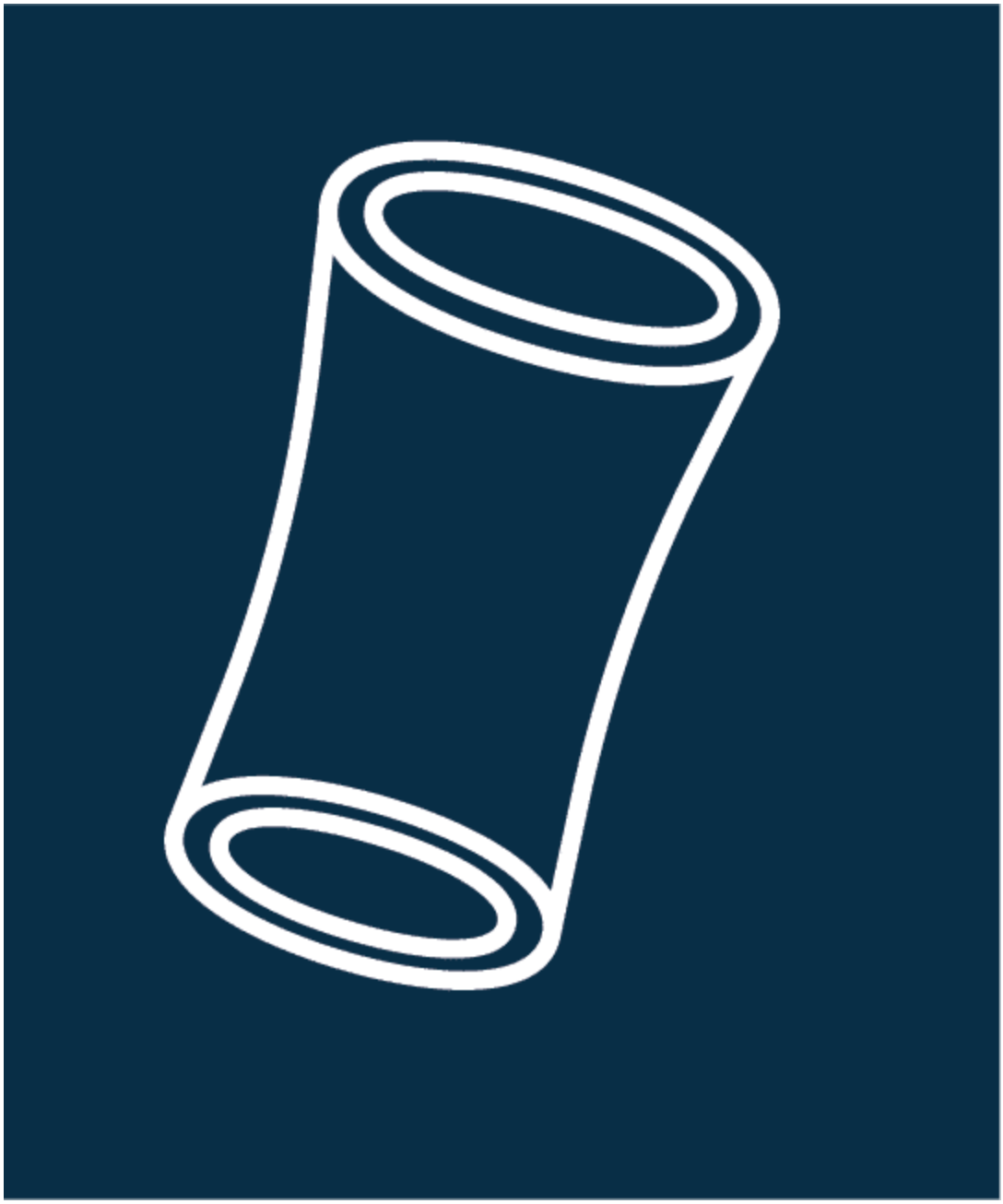
It is important to use only one condom at a time. Clients should never "double up" or use an external condom and an internal condom together.

A new condom should be used for every sexual act.



An **external condom** is a thin sheath made from latex (rubber), polyurethane (syntheticL condoms), or lambskin that fits over the erect penis. The client places the condom on the tip of the erect penis with the rolled side out, leaving a half-inch space for semen to collect, and then unrolls it all the way to the base of the erect penis. The client should put the external condom on immediately before sexual intercourse.

Thirteen out of every 100 clients using the external condom will become pregnant within the first year of typical use.



An **internal condom** is a soft, loose-fitting, single-use sheath (pouch) that is placed insideL the vagina. It has a soft ring at each end of the pouch. The client inserts the closed end of the pouch into the vagina; the ring on the closed end of the pouch helps to hold the condom in place. The open end stays outside of the vagina. The internal condom can be inserted up to 8 hours before sexual intercourse.

Twenty-one out of every 100 clients using the internal condom method will become pregnant within the first year of typical use.

Latex and polyurethane condoms prevent the exchange of body fluids—such as semen, blood, vaginal secretions, and saliva—that cause STDs and HIV infection. They also provide some protection against STDs that are transmitted primarily through skin-to-skin contact, including herpes, genital warts, and syphilis. Lambskin condoms do not provide protection against STDs and HIV.

Some clients experience an allergic reaction or irritation with condom use. Non-latex condoms are less likely to cause an allergic reaction or irritation.

Other barrier methods: diaphragm and sponge

There are two other types of methods that provide a physical barrier during sexual intercourse. These methods are used with spermicide, which kills sperm.

A **diaphragm** is a reusable dome-shaped rubber (latex) or silicone cup with a stiff rim. Before intercourse, the client squeezes spermicidal gel or cream into the diaphragm cup and places it into the vagina and over the cervix. Diaphragms can be placed into the vagina up to 2 hours before intercourse and should be removed within 24 hours. Clients should always use water-based lubricants, never oil-based lubricants, with a diaphragm. Usually, clients must be fitted for a diaphragm by a trained health care provider. The Caya® diaphragm is made of silicone and comes in one size.

Twelve out of every 100 clients using a diaphragm will become pregnant within the first year of typical use.

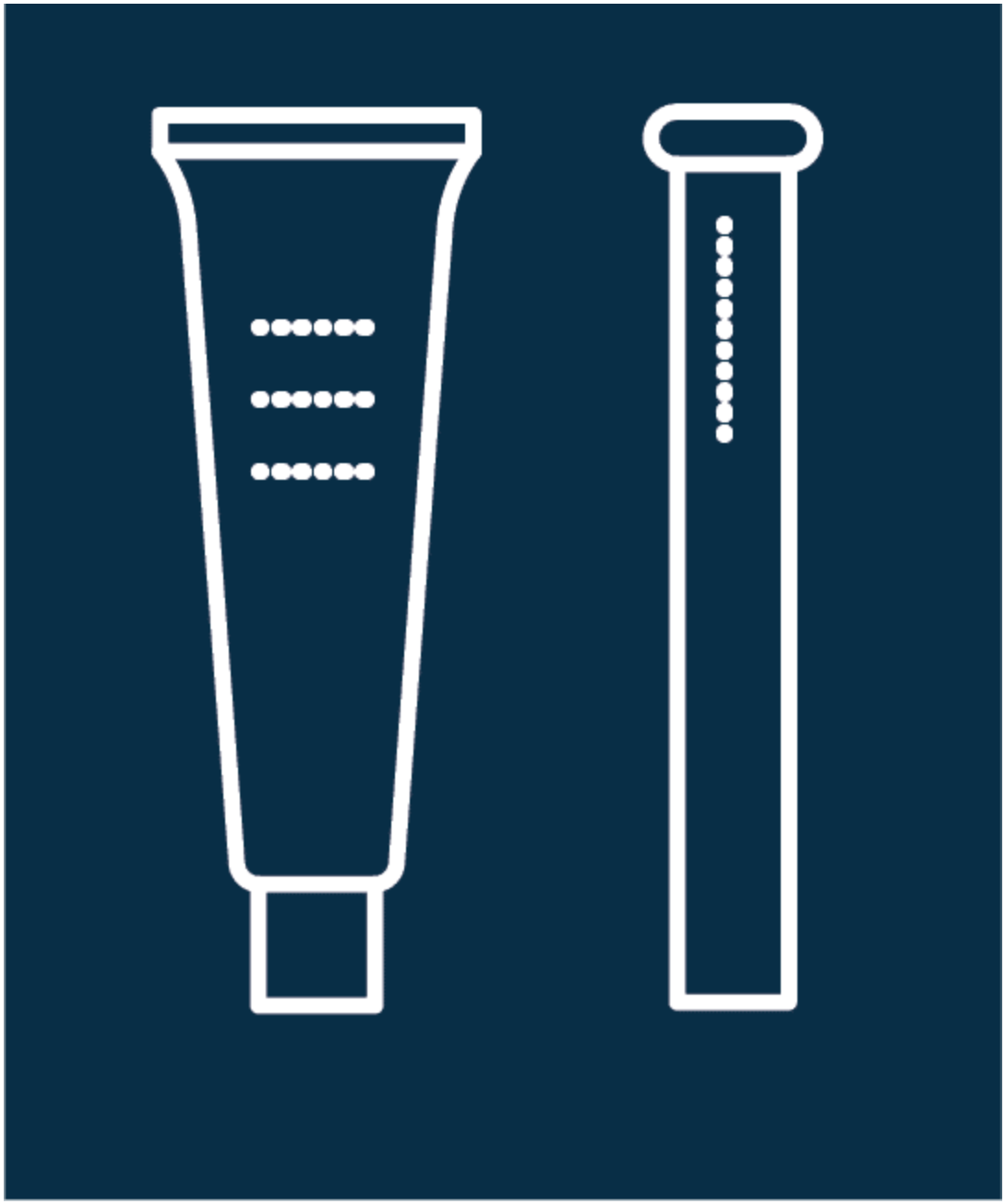
Clients who are allergic to spermicide should not use the diaphragm. Diaphragms cause some clients to experience an allergic reaction or irritation. Diaphragm use is associated with an increased risk of urinary tract infections.

A **sponge** contains spermicide and is inserted into the vagina and placed in front of theL cervix. Sponges come in one size and are single-use. The sponge is effective for 24 hours after insertion. After intercourse, the client must leave the sponge in place for at least six hours before it is removed. They should not leave it in place for more than 24–30 hours. Clients should not use the sponge during a menstrual period or immediately after childbirth, miscarriage, or abortion. There is one brand, Today®.
Twenty-four out of every 100 clients who have experienced childbirth will become pregnant within the first year of typical use. Twelve out of every 100 clients who have not experienced childbirth will become pregnant within the first year of typical use.

Clients who are allergic to spermicide, sulfa drugs, or polyurethane should not use the sponge. Some clients experience an allergic reaction or irritation. There is an increased risk of Toxic Shock Syndrome if worn for more than 24–30 hours after insertion.

Neither the diaphragm nor the sponge protects against STDs or HIV.

Spermicides



Vaginal spermicides contain chemicals that kill sperm. Available over the counter, theyL come in several forms (gel, foam, cream, film, suppository, or tablet). When using a diaphragm, clients must use a gel or cream spermicide. When using a condom, clients may choose to use a spermicide, too. Clients can also use spermicides alone (without any other contraceptive method).
Most spermicides must be in the vagina for no more than one hour before sexual intercourse. Package instructions provide specific guidance about how soon after insertion the spermicide is effective and for how long.

Twenty-eight out of every 100 clients using spermicides will become pregnant within the first year of typical use.

Spermicides do not protect against STDs or HIV. Spermicides containing N9 (nonoxynol-9) can irritate the vagina and rectum, which can actually increase the risk of getting HIV from an infected partner.

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MATCH THE CONTRACEPTIVE METHOD

Match the contraceptive method below to the description of that method.

EXTERNAL CONDOM ___	a) Dome-shaped cup placed inside the vagina and over the cervix
INTERNAL CONDOM ___	b) Thin sheath placed over the penis to prevent sperm from entering the uterus
SPONGE ___	c) Pouch placed inside the vagina to prevent sperm from entering the uterus
DIAPHRAGM ___	d) Single-use method that contains spermicide and is placed over the cervix
SPERMICIDE ___	e) Gel, foam, cream, film, suppository, or tablet that's put inside the vagina to kill sperm

Correct Responses:
External condom (b); Internal condom (c); Sponge (d); Diaphragm (a); Spermicide (e)

This worksheet was supported by Award No. FPTPA006028-04-00 from the Office of Population Affairs (OPA).
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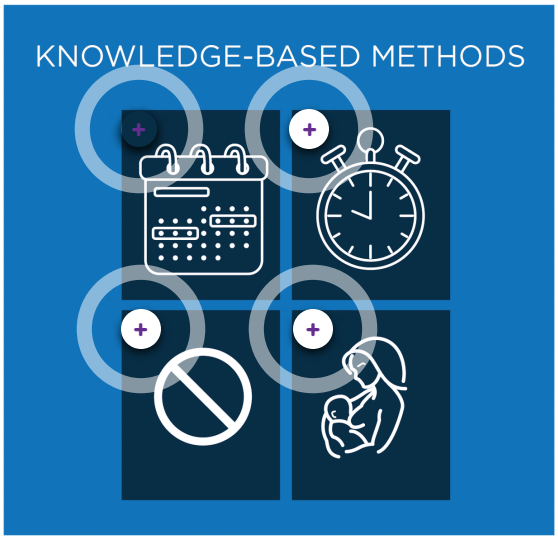
Knowledge-based methods

Some methods require that the client applies certain knowledge and/or adheres to certain practices in order to prevent pregnancy. These methods do not require a prescription and are usually free to use as there is nothing to purchase.



Fertility awareness-based methods

Fertility awareness-based methods involve the identification of “fertile days” and, on those days, either avoiding sexual intercourse or using a barrier method.

Withdrawal

Withdrawal is the practice of pulling the penis out of the vagina before ejaculation.

Abstinence

Sexual abstinence is defined as refraining from all forms of sexual activity and genital contact, including vaginal, oral, and anal sex.

Lactational Amenorrhea Method

Lactational Amenorrhea Method is a short-term birth control method based on the natural effect of breastfeeding on fertility.

Withdrawal

Withdrawal is the practice of pulling the penis out of the vagina before ejaculation in orderL to prevent sperm from getting into the vagina. It is also called coitus interruptus.

Twenty out of every 100 clients using this method will become pregnant within the first year of typical use. Clients who are less experienced with using this method or who have a difficult time knowing when they will ejaculate have a greater risk of failure.

Withdrawal does not protect against STDs or HIV.

Fertility awareness-based methods

Fertility awareness-based methods (FABM) involve the identification of days when intercourse would most likely result in pregnancy, which are often referred to as "fertile days." Use of FABMs can increase clients' awareness of the signs of fertility. Clients can then use this information to prevent or achieve a pregnancy. Clients who wish to prevent pregnancy either avoid sexual intercourse or use a barrier method such as condoms during fertile days.

FABMs are most effective when clients combine multiple strategies for tracking fertility, which include:

Standard Days Method—For clients who have menstrual cycles that are 26-32 days, days 8-19 of the menstrual cycle are considered fertile days. CycleBeads® are a visual aid that clients can use to track days of the menstrual cycle. The Standard Days Method is not recommended for women with irregular periods.

TwoDay Method—Wet, slippery, and clear secretions peak about mid-cycle and are a very reliable sign of increased fertility. Using the TwoDay Method, clients check twice per day for the presence of these vaginal secretions. Clients are considered fertile the day of and the day after they have vaginal secretions.

Symptothermal Method—Basal body temperature decreases slightly just before the ovary releases an egg, then it increases 0.5-1 degree about 24 hours after the egg is released and stays at the higher temperature until around the time of the next period. To use this method, clients use a basal thermometer, which is a very sensitive digital thermometer that shows two decimals (for example 97.74°F). They record their basal body temperature every day so they can identify changes to their temperature. As with the TwoDay method, the client also observes and records vaginal secretions every day. Clients can log basal temperature readings into the FDA-approved Natural Cycles® app to learn when they are fertile.

Twenty-four out of every 100 clients using this method will have an unintended pregnancy within the first year of typical use.

FABMs do not protect against STDs or HIV.

Abstinence

Sexual abstinence is defined as refraining from all forms of sexual activity and genitalL contact, including vaginal, oral, and anal sex.

To be effective, both partners must agree to avoid all forms of sexual activity. A client who uses abstinence should talk with their partner or partners about this method. Together, they should decide in advance which activities are acceptable and which are not. Abstinence is most effective when partners talk and agree about their reasons to remain abstinent.

Total abstinence is the only method that is 100% effective at preventing pregnancy and preventing transmission of STDs and HIV from sexual contact.

Lactational Amenorrhea Method

Lactational Amenorrhea Method (LAM) is a short-term birth control method based onL the natural effect of breastfeeding on fertility. Exclusive breastfeeding after having a baby may work to prevent pregnancy for up to six months postpartum.
Three necessary conditions for LAM are:

- After having a baby, the client's menstrual periods have not returned.
- The client is only feeding their baby breast milk, not other foods or liquids.
- The baby is less than six months old.

If all three criteria are met, two out of every 100 clients using this method will become pregnant within the first year of typical use. Before the client no longer meets the criteria above, they should initiate another birth control method if they wish to avoid pregnancy.

Exclusive breastfeeding provides optimal nutrition for the baby and is also associated with pregnancy weight loss and reduced risk of breast cancer.

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MATCH THE CONTRACEPTIVE METHOD

Match each contraceptive method below to the description of that method.

WITHDRAWAL ___	a) Avoid intercourse or use a barrier method on days 8-19 of the menstrual cycle
TWODAY METHOD ___	b) Track vaginal secretions and monitor daily temperature to determine fertile days
LACTATIONAL AMENORRHEA METHOD (LAM) ___	c) Check twice per day for the presence of vaginal secretions
ABSTINENCE ___	d) Reduced fertility associated with exclusive breastfeeding for up to six months postpartum
SYMPTOTHERMAL METHOD ___	e) Pull penus out of the vagina before ejaculation
STANDARD DAYS METHOD ___	f) Refrain from all forms of sexual activity and genital contact

Correct Responses:
Withdrawal (e); TwoDay Method (c); Lactational Amenorrhea Method, LAM (d); Abstinence (f); Symptothermal Method (b); Standard Days Method (a)

This worksheet was supported by Award No. FPTPA006028-04-00 from the Office of Population Affairs (OPA).
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Emergency contraception

Emergency contraception (EC) is birth control that clients use after having sexual intercourse to prevent pregnancy. EC is used in situations where either no birth control method was used before or during intercourse or if the birth control method they used had a problem, for example a condom broke or diaphragm slipped.

The three methods of EC are the copper IUD, ulipristal acetate pill, and levonorgestrel pill.

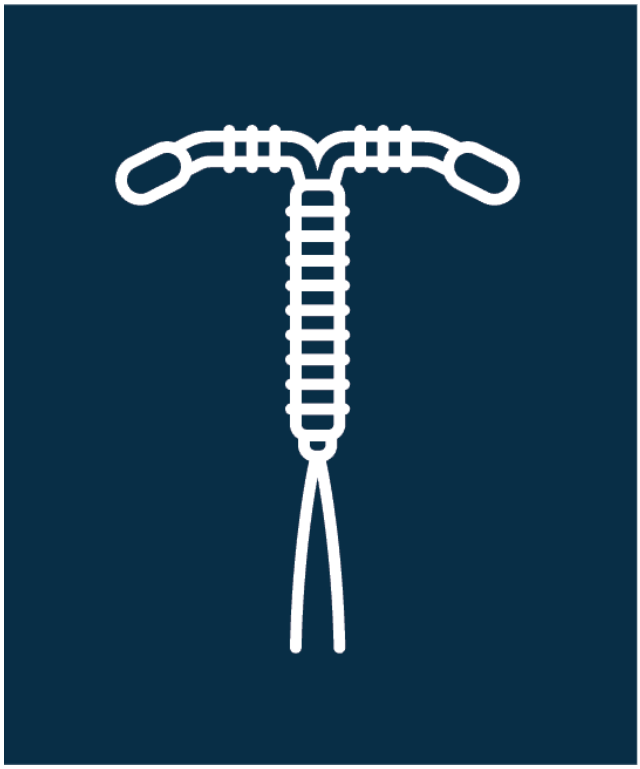
COPPER IUD	ULIPRISTAL ACETATE PILL	LEVONORGESTREL PILL

Brand: Paragard

When: Place within five days (120 hours) of unprotected sexual intercourse **How**: Placed in uterus by a health care provider

Other considerations:

- The most effective method of EC
- Can be used to prevent pregnancy for up to 10 years Does not vary in efficacy based on client's weight Safe for breastfeeding clients
- Not safe for clients who are already pregnant



COPPER IUD | ULIPRISTAL ACETATE PILL | LEVONORGESTREL PILL

Brand: ella

When: Take pill within five days (120 hours) of unprotected sexual intercourse **How**: Prescription medication

Other considerations:

The most effective EC pill

Less effective if the client uses a hormonal method as their usual contraceptive method Less effective if the client weighs 195 pounds or more

Breastfeeding clients must pump and throw away milk for 24 hours after taking ella

Will not stop an already-established pregnancy or harm a developing fetus

COPPER IUD | ULIPRISTAL ACETATE PILL | LEVONORGESTREL PILL

Brands: Plan B One-Step, Next Choice One Dose, After Pill, Take Action, My Way

When: Take pill within three days (72 hours) for maximum effectiveness (but up to five days) after unprotected sexual intercourse

How: Over-the-counter medication

Other considerations:

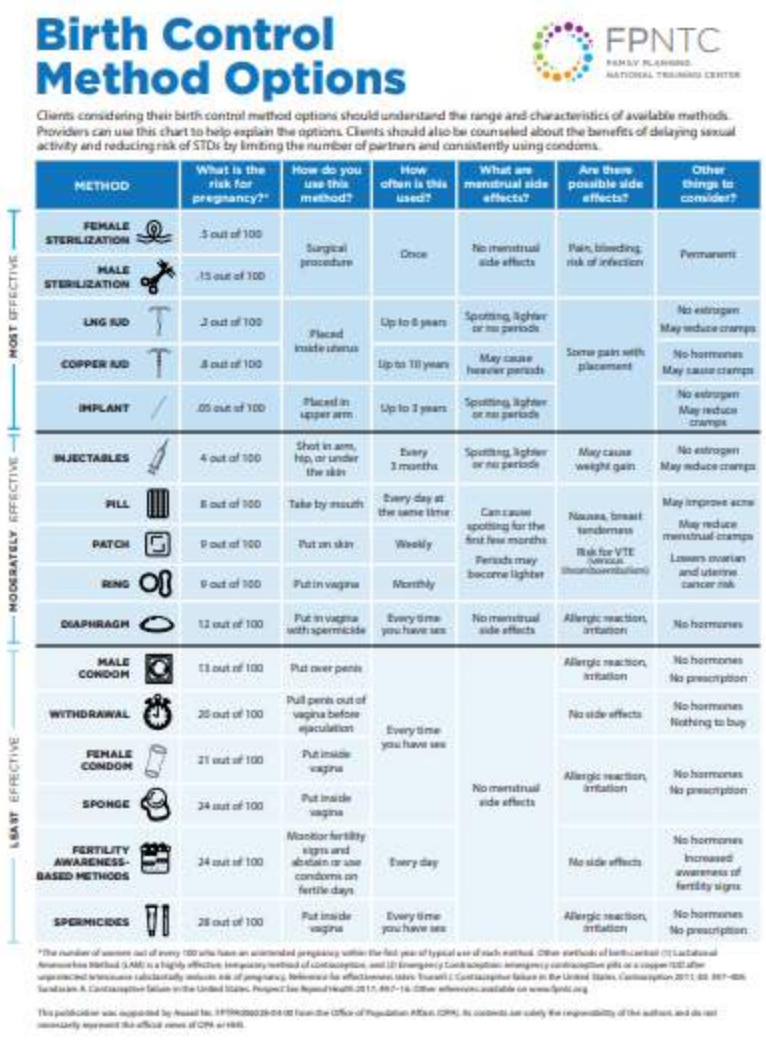
May not work if client weighs 155 pounds or more

Safe for breastfeeding clients

Will not stop an already-established pregnancy or harm a developing fetus

Explaining contraception

When discussing the characteristics of contraceptive methods with clients, it can be helpful to use visual aids.



Birth Control Method Options

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Clients considering their birth control method options should understand the range and characteristics of available methods. Providers can use this chart to help explain the options. Clients should also be counseled about the benefits of delaying sexual activity and reducing risk of STDs by limiting the number of partners and consistently using condoms.

	METHOD	What is the risk for pregnancy?*	How do you use this method?	How often is this used?	What are menstrual side effects?	Are there possible side effects?	Other things to consider?
MOST EFFECTIVE	FEMALE STERILIZATION	.5 out of 100	Surgical procedure	Once	No menstrual side effects	Pain, bleeding, risk of infection	Permanent
	MALE STERILIZATION	.15 out of 100					
	LNG IUD	.2 out of 100	Placed inside uterus	Up to 6 years	Spotting, lighter or no periods	Some pain with placement	No estrogen May reduce cramps
	COPPER IUD	.8 out of 100		Up to 10 years	May cause heavier periods		No hormones May cause cramps
	IMPLANT	.05 out of 100	Placed in upper arm	Up to 3 years	Spotting, lighter or no periods		No estrogen May reduce cramps
MODERATELY EFFECTIVE	INJECTABLES	4 out of 100	Shot in arm, hip, or under the skin	Every 3 months	Spotting, lighter or no periods	May cause weight gain	No estrogen May reduce cramps
	PILL	8 out of 100	Take by mouth	Every day at the same time	Can cause spotting for the first few months Periods may become lighter	Nausea, breast tenderness Risk for VTE (serious thromboembolism)	May improve acne May reduce menstrual cramps Lowers ovarian and uterine cancer risk
	PATCH	9 out of 100	Put on skin	Weekly			
	RING	9 out of 100	Put in vagina	Monthly			
	DIAPHRAGM	12 out of 100	Put in vagina with spermicide	Every time you have sex	No menstrual side effects	Allergic reaction, irritation	No hormones
LEAST EFFECTIVE	MALE CONDOM	13 out of 100	Put over penis	Every time you have sex	No menstrual side effects	Allergic reaction, irritation	No hormones No prescription
	WITHDRAWAL	20 out of 100	Pull penis out of vagina before ejaculation			No side effects	No hormones Nothing to buy
	FEMALE CONDOM	21 out of 100	Put inside vagina			Allergic reaction, irritation	No hormones No prescription
	SPONGE	24 out of 100	Put inside vagina				
	FERTILITY AWARENESS-BASED METHODS	24 out of 100	Monitor fertility signs and abstain or use condoms on fertile days	Every day		No side effects	No hormones Increased awareness of fertility signs
	SPERMICIDES	28 out of 100	Put inside vagina	Every time you have sex		Allergic reaction, irritation	No hormones No prescription

*The number of women out of every 100 who have an unintended pregnancy within the first year of typical use of each method. Other methods of birth control: (1) Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception, and (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy. Reference for effectiveness rates: Trussell J. Contraceptive failure in the United States. Contraception 2011; 83: 397–404. Sundaram A. Contraceptive failure in the United States. Perspect Sex Reprod Health 2017; 49:7–16. Other references available on www.fpntc.org

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The FPNTC **Birth Control Method Options Chart** can help you explain contraceptiveL methods to clients as it includes several method characteristics to consider–including effectiveness, how it is used, and potential side effects.

Consider using this chart together with other client education materials, which should be at a 4th-6th grade reading level.
It can also be helpful to use 3D models—especially for methods that clients may be unfamiliar with, such as the IUD, implant, patch, and ring.

Birth Control Methods Options Chart

Explaining Contraception Job Aids for Health Care Providers

Client education materials

Looking for resources to share with your clients so they can explore their contraceptive options?

In this 15-minute video, developed by the University of California San Francisco (UCSF), young women share their experiences with different birth control methods.

This online decision-making tool, also developed by UCSF, asks clients about their preferences and helps them to explore birth control methods that may be a good fit for them.

The Method Explorer, developed by Bedsider.org, provides client-friendly birth control information and enables side-by-side comparisons.

U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 3
July 29, 2016

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016

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

There are some cases in which it may be unsafe for clients to use a contraceptive method because of certain characteristics or medical conditions.

The *U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), 2016* includes recommendations from the Centers for Disease Control and Prevention (CDC) to assist in the selection of contraceptive methods for clients who have certain characteristics or medical conditions.[4]

The conditions affecting eligibility for the use of each contraceptive method are classified into four categories:

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

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

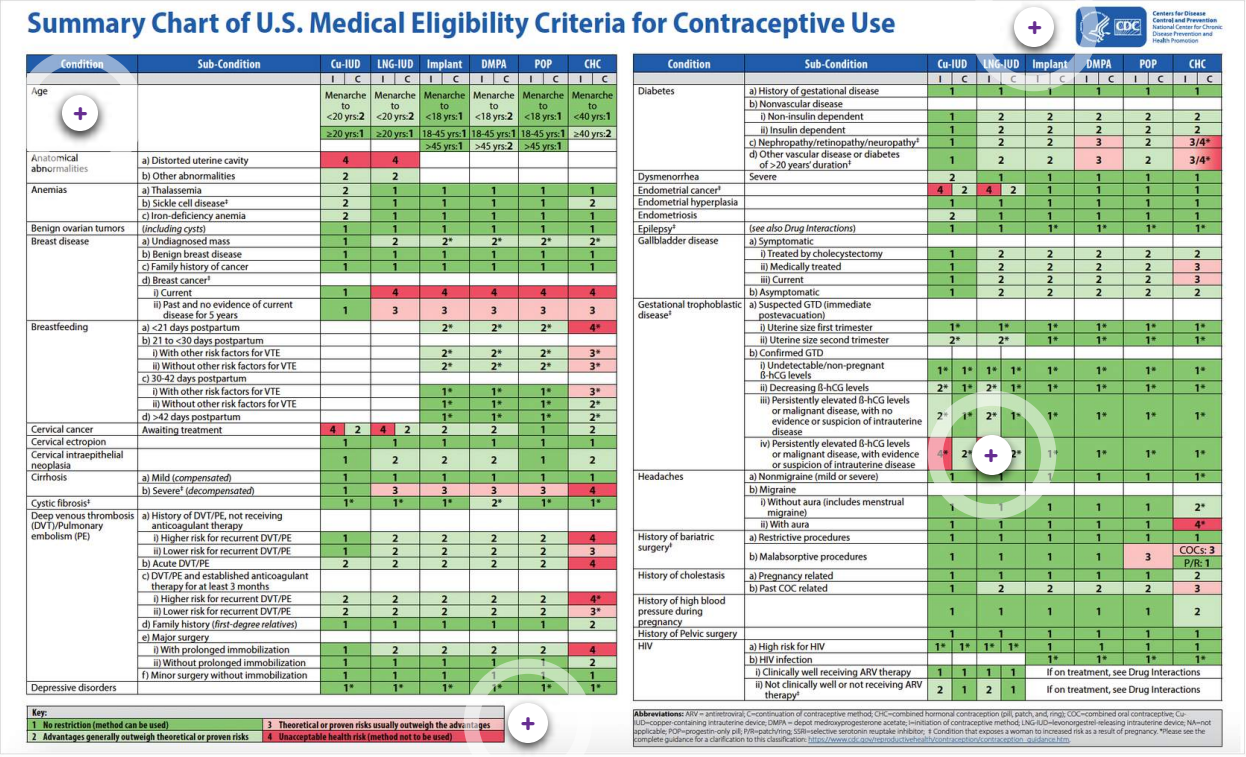
Providers can order limited quantities of the U.S. MEC Wheel and download a phone app using the link below. The app provides quick and easy access to the guidance.

U.S. Medical Eligibility Criteria (USMEC), 2016

Activity: Explore the U.S. MEC

Instructions:

Click on the interactive image below to explore the Summary Chart of U.S. MEC.



Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

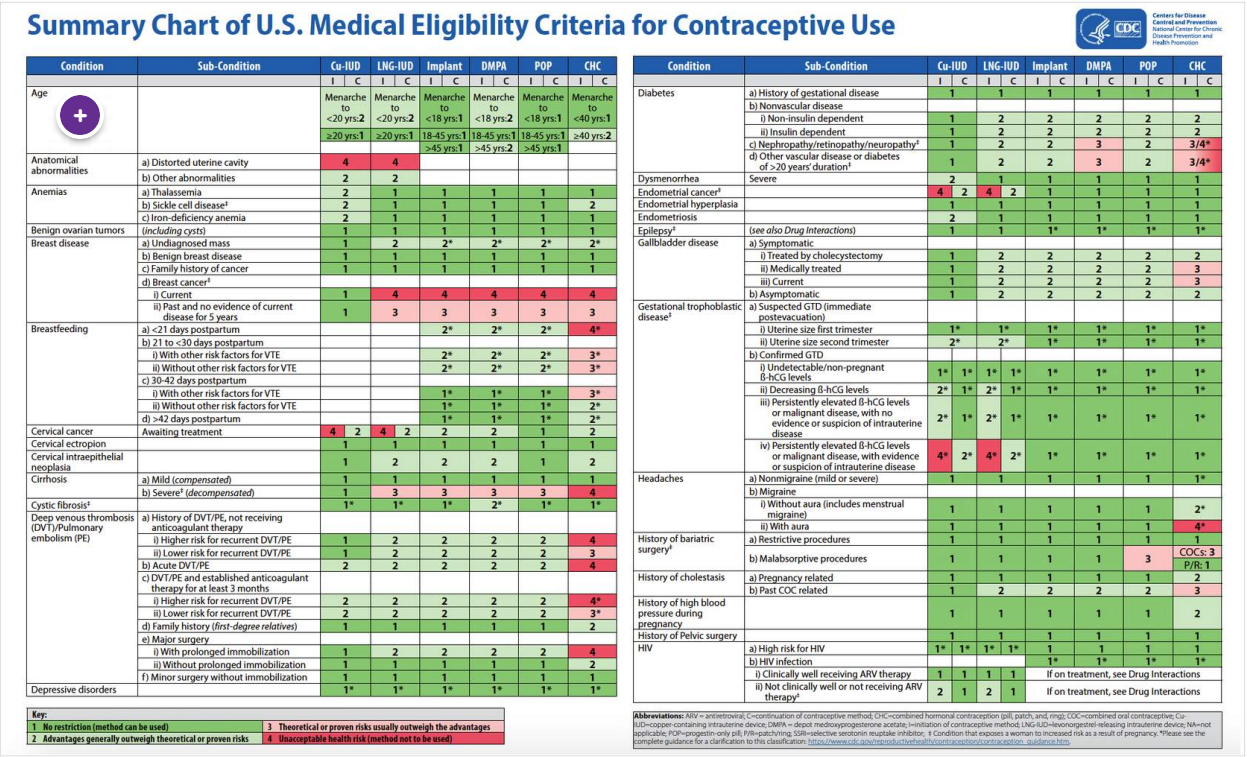
Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:2		Menarche to <18 yrs:1		Menarche to <40 yrs:1	
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1		18-45 yrs:1		18-45 yrs:1		≥40 yrs:2	
						>45 yrs:1		>45 yrs:2		>45 yrs:1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease[3]	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer[3]												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe[3] (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis[3]		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy[3]	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration[3]	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer[3]		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy[1]	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease[3]	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	2*		1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery[4]	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b) HIV infection							1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy[4]	2	1	2	1	If on treatment, see Drug Interactions							

Key:

1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Abbreviations: ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor; ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.



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Age		Menarche to <20 yrs: 2		Menarche to <20 yrs: 2		Menarche to <18 yrs: 1		Menarche to <18 yrs: 2		Menarche to <18 yrs: 1		Menarche to <40 yrs: 1	
		≥20 yrs: 1		≥20 yrs: 1		18-45 yrs: 1		18-45 yrs: 1		18-45 yrs: 1		≥40 yrs: 2	
						>45 yrs: 1		>45 yrs: 2		>45 yrs: 1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe‡ (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy‡	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy‡	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease‡	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3	
												P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b) HIV infection							1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy‡	2	1	2	1	If on treatment, see Drug Interactions							

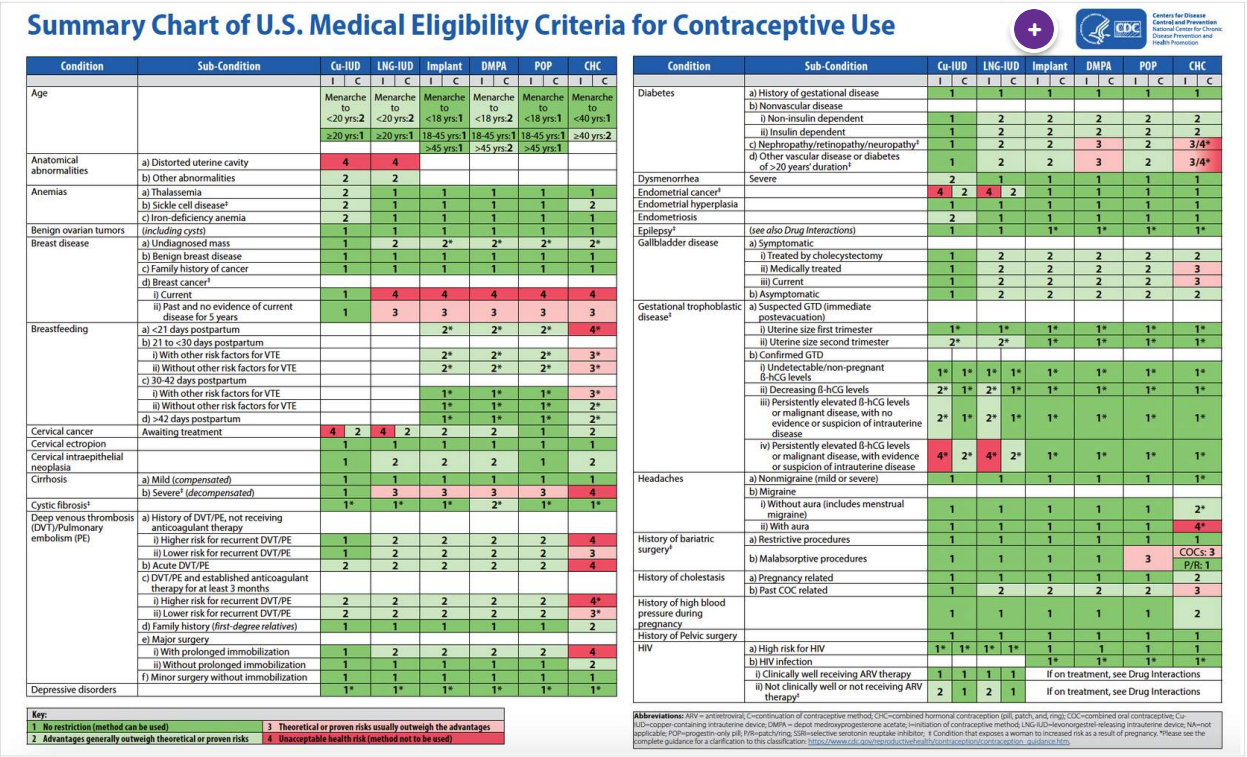
Key:

1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Abbreviations: ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor. ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.

Condition

Conditions are listed on the left.



Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:2		Menarche to <18 yrs:1		Menarche to <40 yrs:1	
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1		18-45 yrs:1		18-45 yrs:1		≥40 yrs:2	
						>45 yrs:1		>45 yrs:2		>45 yrs:1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease[3]	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer[3]												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe[4] (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis[3]		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy[3]	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration[3]	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer[3]		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy[3]	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease[3]	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery[4]	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3	
												P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b) HIV infection							1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy[4]	2	1	2	1	If on treatment, see Drug Interactions							

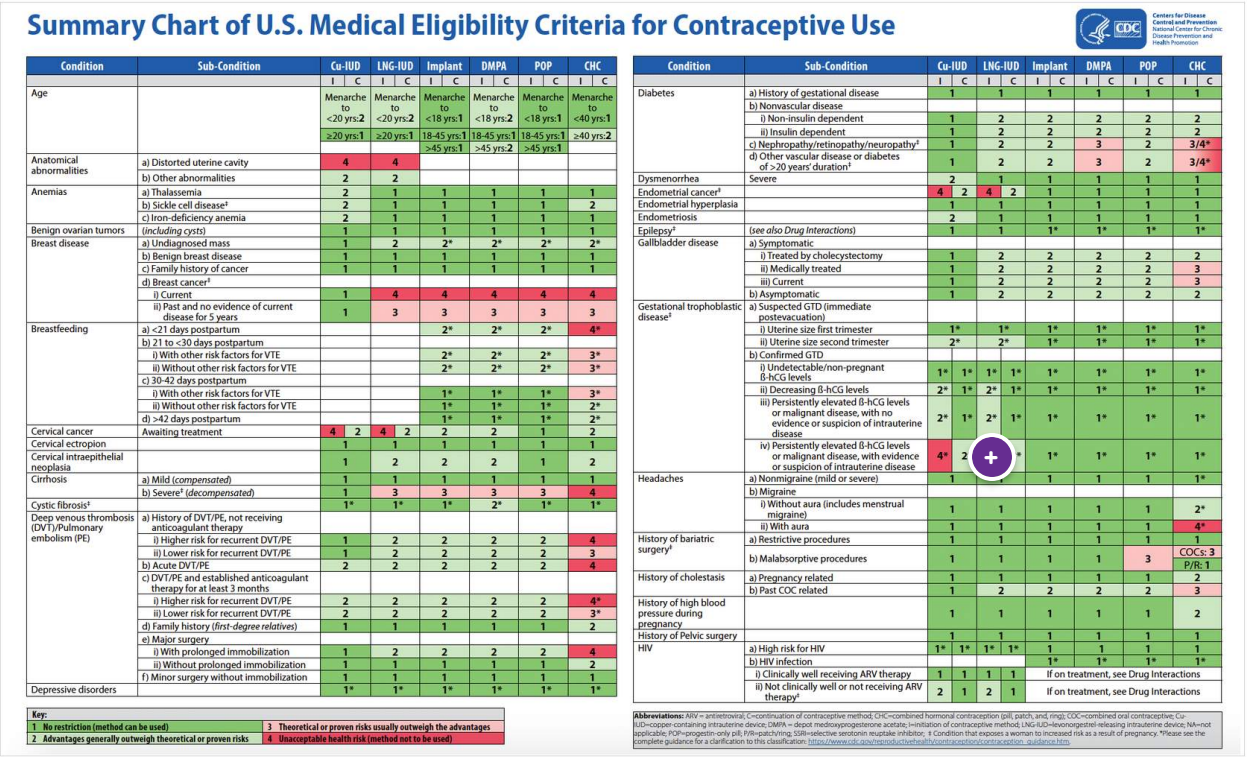
Key:

1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Abbreviations: ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor; ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.

Contraceptive methods

Contraceptive methods are listed at the top.



Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age		Menarche to <20 yrs: 2		Menarche to <20 yrs: 2		Menarche to <18 yrs: 1		Menarche to <18 yrs: 2		Menarche to <18 yrs: 1		Menarche to <40 yrs: 1	
		≥20 yrs: 1		≥20 yrs: 1		18-45 yrs: 1		18-45 yrs: 1		18-45 yrs: 1		≥40 yrs: 2	
						>45 yrs: 1		>45 yrs: 2		>45 yrs: 1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease[3]	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer[3]												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe[4] (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis[3]		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy[3]	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration[3]	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer[3]		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy[3]	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease[3]	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2	2*	1*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery[4]	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3	
												P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b) HIV infection							1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy[4]	2	1	2	1	If on treatment, see Drug Interactions							

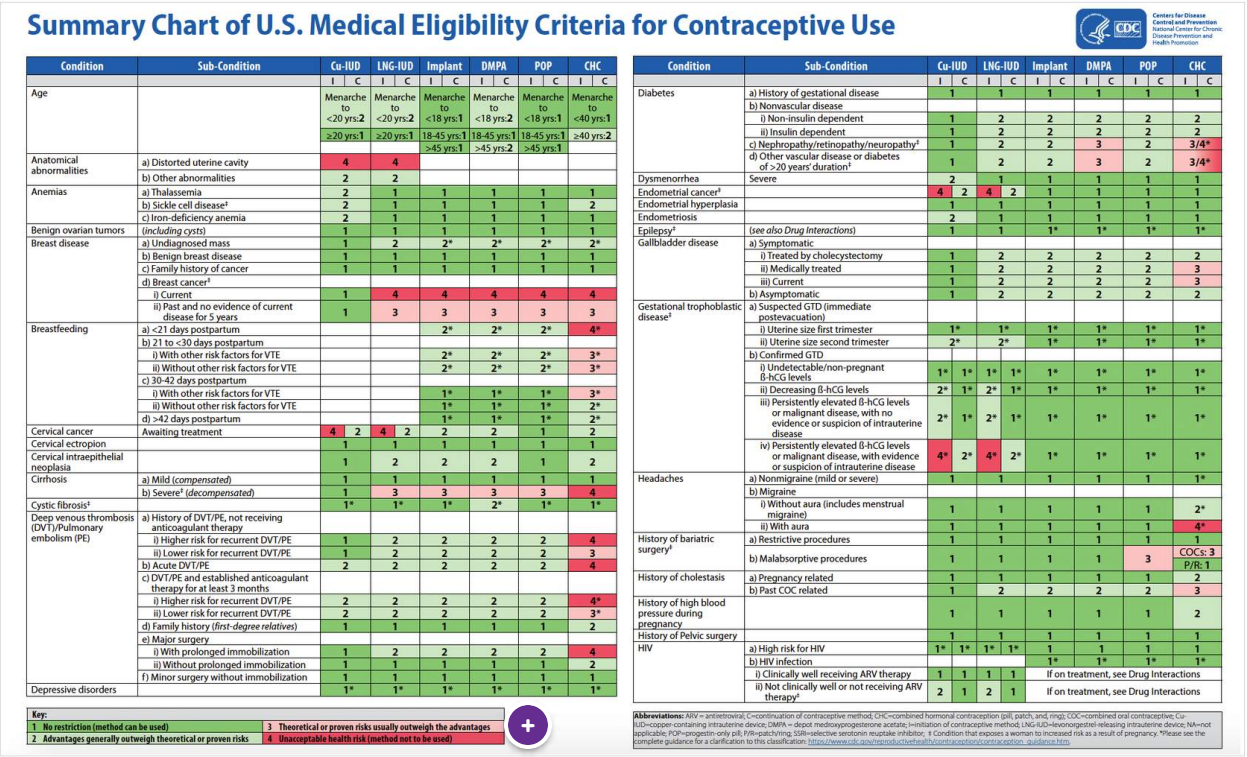
Key:

1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Abbreviations: ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor; ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.

Categories

Health care providers can use this chart to identify eligibility categories when assessing the safety of contraceptive method use for women and men with specific medical conditions or characteristics.



Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs: **2**		Menarche to <20 yrs: **2**		Menarche to <18 yrs: **1**		Menarche to <18 yrs: **2**		Menarche to <18 yrs: **1**		Menarche to <40 yrs: **1**	
		≥20 yrs: **1**		≥20 yrs: **1**		18-45 yrs: **1**		18-45 yrs: **1**		18-45 yrs: **1**		≥40 yrs: **2**	
						>45 yrs: **1**		>45 yrs: **2**		>45 yrs: **1**			
Anatomical abnormalities	a) Distorted uterine cavity	**4**		**4**									
	b) Other abnormalities	**2**		**2**									
Anemias	a) Thalassemia	**2**		**1**		**1**		**1**		**1**		**1**	
	b) Sickle cell disease[‡]	**2**		**1**		**1**		**1**		**1**		**2**	
	c) Iron-deficiency anemia	**2**		**1**		**1**		**1**		**1**		**1**	
Benign ovarian tumors	(*including cysts*)	**1**		**1**		**1**		**1**		**1**		**1**	
Breast disease	a) Undiagnosed mass	**1**		**2**		**2***		**2***		**2***		**2***	
	b) Benign breast disease	**1**		**1**		**1**		**1**		**1**		**1**	
	c) Family history of cancer	**1**		**1**		**1**		**1**		**1**		**1**	
	d) Breast cancer[‡]												
	i) Current	**1**		**4**		**4**		**4**		**4**		**4**	
	ii) Past and no evidence of current disease for 5 years	**1**		**3**		**3**		**3**		**3**		**3**	
Breastfeeding	a) <21 days postpartum					**2***		**2***		**2***		**4***	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					**2***		**2***		**2***		**3***	
	ii) Without other risk factors for VTE					**2***		**2***		**2***		**3***	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					**1***		**1***		**1***		**3***	
	ii) Without other risk factors for VTE					**1***		**1***		**1***		**2***	
	d) >42 days postpartum					**1***		**1***		**1***		**2***	
Cervical cancer	Awaiting treatment	**4**	**2**	**4**	**2**	**2**		**2**		**1**		**2**	
Cervical ectropion		**1**		**1**		**1**		**1**		**1**		**1**	
Cervical intraepithelial neoplasia		**1**		**2**		**2**		**2**		**1**		**2**	
Cirrhosis	a) Mild (*compensated*)	**1**		**1**		**1**		**1**		**1**		**1**	
	b) Severe[‡] (*decompensated*)	**1**		**3**		**3**		**3**		**3**		**4**	
Cystic fibrosis[‡]		**1***		**1***		**1***		**2***		**1***		**1***	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	**1**		**2**		**2**		**2**		**2**		**4**	
	ii) Lower risk for recurrent DVT/PE	**1**		**2**		**2**		**2**		**2**		**3**	
	b) Acute DVT/PE	**2**		**2**		**2**		**2**		**2**		**4**	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	**2**		**2**		**2**		**2**		**2**		**4***	
	ii) Lower risk for recurrent DVT/PE	**2**		**2**		**2**		**2**		**2**		**3***	
	d) Family history (*first-degree relatives*)	**1**		**1**		**1**		**1**		**1**		**2**	
	e) Major surgery												
	i) With prolonged immobilization	**1**		**2**		**2**		**2**		**2**		**4**	
	ii) Without prolonged immobilization	**1**		**1**		**1**		**1**		**1**		**2**	
	f) Minor surgery without immobilization	**1**		**1**		**1**		**1**		**1**		**1**	
Depressive disorders		**1***		**1***		**1***		**1***		**1***		**1***	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes	a) History of gestational disease	**1**		**1**		**1**		**1**		**1**		**1**	
	b) Nonvascular disease												
	i) Non-insulin dependent	**1**		**2**		**2**		**2**		**2**		**2**	
	ii) Insulin dependent	**1**		**2**		**2**		**2**		**2**		**2**	
	c) Nephropathy/retinopathy/neuropathy[‡]	**1**		**2**		**2**		**3**		**2**		**3/4***	
	d) Other vascular disease or diabetes of >20 years' duration[‡]	**1**		**2**		**2**		**3**		**2**		**3/4***	
Dysmenorrhea	Severe	**2**		**1**		**1**		**1**		**1**		**1**	
Endometrial cancer[‡]		**4**	**2**	**4**	**2**	**1**		**1**		**1**		**1**	
Endometrial hyperplasia		**1**		**1**		**1**		**1**		**1**		**1**	
Endometriosis		**2**		**1**		**1**		**1**		**1**		**1**	
Epilepsy[‡]	(*see also Drug Interactions*)	**1**		**1**		**1***		**1***		**1***		**1***	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	**1**		**2**		**2**		**2**		**2**		**2**	
	ii) Medically treated	**1**		**2**		**2**		**2**		**2**		**3**	
	iii) Current	**1**		**2**		**2**		**2**		**2**		**3**	
	b) Asymptomatic	**1**		**2**		**2**		**2**		**2**		**2**	
Gestational trophoblastic disease[‡]	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	**1***		**1***		**1***		**1***		**1***		**1***	
	ii) Uterine size second trimester	**2***		**2***		**1***		**1***		**1***		**1***	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	**1***	**1***	**1***	**1***	**1***		**1***		**1***		**1***	
	ii) Decreasing ß-hCG levels	**2***	**1***	**2***	**1***	**1***		**1***		**1***		**1***	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	**2***	**1***	**2***	**1***	**1***		**1***		**1***		**1***	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	**4***	**2***	**4***	**2***	**1***		**1***		**1***		**1***	
Headaches	a) Nonmigraine (mild or severe)	**1**		**1**		**1**		**1**		**1**		**1***	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	**1**		**1**		**1**		**1**		**1**		**2***	
	ii) With aura	**1**		**1**		**1**		**1**		**1**		**4***	
History of bariatric surgery[‡]	a) Restrictive procedures	**1**		**1**		**1**		**1**		**1**		**1**	
	b) Malabsorptive procedures	**1**		**1**		**1**		**1**		**3**		COCs: **3** P/R: **1**	
History of cholestasis	a) Pregnancy related	**1**		**1**		**1**		**1**		**1**		**2**	
	b) Past COC related	**1**		**2**		**2**		**2**		**2**		**3**	
History of high blood pressure during pregnancy		**1**		**1**		**1**		**1**		**1**		**2**	
History of Pelvic surgery		**1**		**1**		**1**		**1**		**1**		**1**	
HIV	a) High risk for HIV	**1***	**1***	**1***	**1***	**1**		**1**		**1**		**1**	
	b) HIV infection							**1***		**1***		**1***	
	i) Clinically well receiving ARV therapy	**1**	**1**	**1**	**1**	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy[‡]	**2**	**1**	**2**	**1**	If on treatment, see Drug Interactions							

Key:

1 No restriction (method can be used)	**3** Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	**4** Unacceptable health risk (method not to be used)

Abbreviations: ARV = antiretroviral; C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring; SSRI=selective serotonin reuptake inhibitor; ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm.

Key

A key that defines the four categories is at the bottom.

Activity: Use the U.S. MEC

Instructions:

Use the U.S. MEC to identify which of the scenarios below is safe (MEC Category 1 or 2) or not safe (MEC Category 3 or 4).

MEC Category 1 or 2

An implant for a client who uses selective serotonin reuptake inhibitors (SSRIs)

A copper IUD for a client with current breast cancer

DMPA for a client with endometriosis

An LNG IUD for a client with systolic blood pressure ≥160

DMPA for a client with adequately controlled hypertension

The ring for a client who has a BMI of 30 or higher

MEC Category 3 or 4

CHC pills for a client who experiences migraines with aura

An LNG IUD for a client with current breast cancer

DMPA for a client with systolic blood pressure ≥160

The patch for a client who is fewer than 21 days postpartum

The ring for a client with adequately controlled hypertension

CHC pills for a client ≥35 years old who smokes fewer than 15 cigarettes per day

PDF

UsetheU.S.MEC.pdf

34.5 KB

U.S. Selected Practice Recommendations for Contraceptive Use

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 4
July 29, 2016

U.S. Selected Practice Recommendations for Contraceptive Use, 2016

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

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

Also developed by the CDC, the *U.S. Selected Practice Recommendations for Contraceptive Use (US SPR), 2016* provides guidance about common issues related to initiating and using certain contraceptive methods.[5]

This set of recommendations is designed to give health care providers evidence-based guidance that they can use to reduce medical barriers to contraception access and use.

The US SPR provides recommendations for:

- When to start hormonal methods
- How to be reasonably certain a client is not pregnant
- How to manage irregular bleeding
- What to do if the client misses a pill, is late to replace their patch or ring, or is late to obtain a DMPA injection

Health care providers should always consider the individual clinical circumstances of each client seeking family planning services.

Providers can download printable summaries and a phone app to quickly and easily access the guidance via the link below.

U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR), 2016

Activity: Explore U.S. SPR recommendations

Instructions:

Explore the U.S. SPR recommendations using the flash cards below. Use the purple arrows to move between topics and click on the flash cards to review the U.S. SPR guidance for each topic.

When to start hormonal methods

It's typical to start a client on a hormonal contraceptive method at the beginning of their

1 of 4

A provider can be reasonably certain a client

How to be reasonably certain a client is not pregnant

is not pregnant if the client
h t i

2 of 4

How to manage irregular bleeding

When a client has a copper IUD, implant, or uses DMPA and experiences irregular bleeding, a provider can

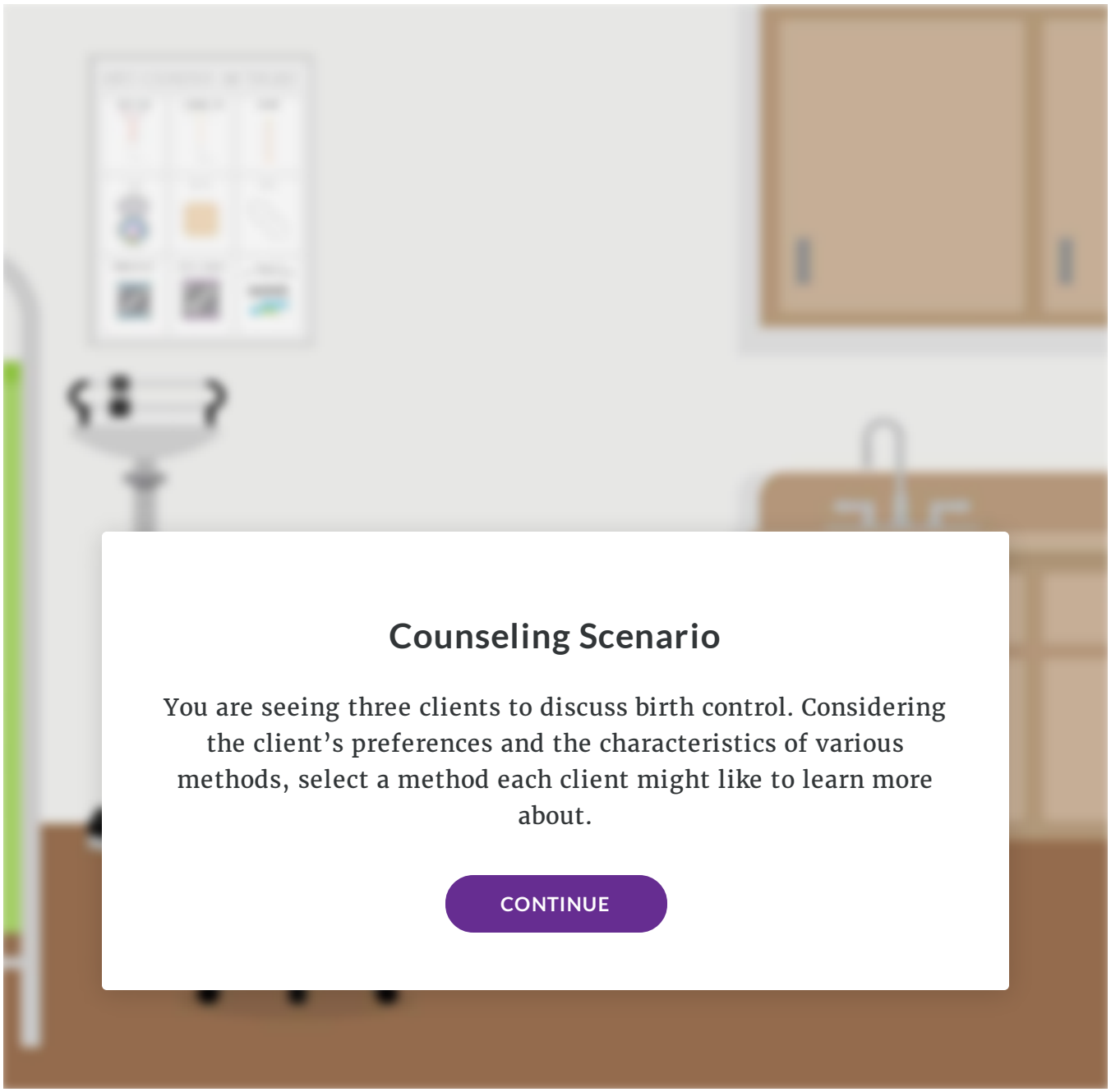
3 of 4

What to do if a client misses a contraceptive pill

If a client misses a pill, they should:

- Take the most recent missed pill as soon as

Scenario 1: Brief contraceptive counseling encounters



Scene 1 Slide 1

Continue → Next Slide

Scene 1 Slide 2

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Scene 1 Slide 3

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Scene 1 Slide 4

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Scene 1 Slide 5

Continue → End of Scenario

Five steps to providing contraceptive services

It is important to use client-centered counseling techniques to tailor the contraceptive method information you provide and help your clients identify a method that works for them.

Tailoring counseling enables providers to focus the conversation on what's most important to the client, instead of trying to cover information that isn't relevant to their needs or

preferences. Many providers find that tailoring counseling to a client's needs and preferences actually takes less time than providing a comprehensive list of contraceptive options.

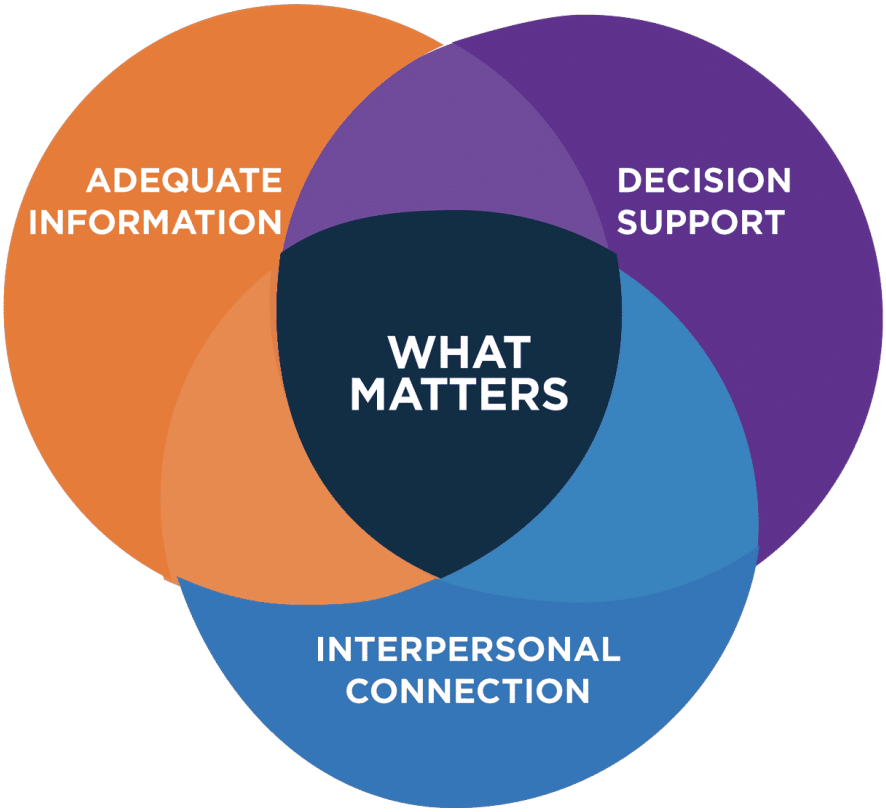
There are five steps to Providing Contraceptive Services outlined in QFP.[6] These steps alignL with the five principles of quality counseling described in the *Introduction to the QFP* eLearning module.

The five steps are:

1. Establish and maintain rapport with the client.
2. Obtain clinical and social information from the client.
3. Work with the client interactively to select the most effective and appropriate contraceptive method for the client.
4. Conduct a physical assessment related to contraceptive use (only when warranted).
5. Provide the contraceptive method along with instructions about correct and consistent use, help the client develop a plan for using the selected method and for follow-up, and document understanding.

Introduction to the QFP eLearning

What matters to clients



What makes clients feel like they had a good experience with contraceptive counseling?

Researchers at UCSF interviewed clients and health care providers to find out. Clients described a positive contraceptive counseling experience to be one where they 1) had an interpersonal connection with the provider, 2) received adequate information about contraceptive methods, and 3) received support to make their decision about selecting a method.

UCSF researchers developed the *Person-Centered Contraceptive Counseling* survey which providers can use to assess how clients felt about their counseling experience.[7] Drawing from the domains above, the *Person-Centered Contraceptive Counseling* survey asks clients to say whether the provider:

- Respected them as a person
- Let them say what mattered to them about their birth control method
- Took their preferences about birth control methods seriously
- Gave them enough information to make the best decision about their birth control method

You can use this survey too.

Person-Centered Contraceptive Counseling

Counseling skills

Expand each box below to learn about a counseling skill and understand what the skill sounds like in practice.

Start with small talk.

To build rapport and learn about your client's goals, aim to start every visit with small talk about your client's life. This can happen during otherwise unused time, such as when bringing your client to the exam room or while logging into the electronic health record. You can use what you learn later in the discussion to tailor the counseling to their needs.

This sounds like:

> "How are you doing today?"
>
> "Tell me a little bit about what's going on in your life. Are you working or in school?"
>
> "What kinds of things do you do for fun?"

Ask about contraceptive preferences.

Rather than asking which contraceptive methods your client is interested in, ask open-ended questions about what they're looking for from their contraceptive method. Asking about which methods your client is interested in limits their response to the methods they are already aware of and assumes they have correct information about those methods. An open-ended question about characteristics creates space for further discussion about which methods may meet your client's needs.

This sounds like:

> "Do you have a sense of what is important to you in a birth control method?"

Remember to pause to allow your client to think about the question.

Use open-ended probing questions.

After opening up the conversation about what's important to your client in a contraceptive method, ask probing questions to explore those preferences. The goal is to elicit as much information as you can about which characteristics of methods—such as side effects, bleeding pattern, and control over discontinuation—matter most to your client.

This sounds like :

> "It sounds like you're looking for a method that is really effective at preventing pregnancy and doesn't require regular action from you. **Do you have a sense of what else is important to you?**"
>
> "Some methods cause some clients to stop having a period altogether, which is completely safe. **How would you feel about that?**"
>
> "Some methods require you to take action daily, weekly, monthly, or every three months. **Could you imagine yourself doing that?**"

Watch the video to below to see how probing questions can be used to explore client preferences.

Explain effectiveness using easy-to-understand terms.

When explaining the effectiveness of contraceptive methods, use natural frequencies, which are generally easier for clients to understand than percentages. Always use common denominators when comparing effectiveness or risk so your client can easily understand the comparison.

This sounds like:

> "Four out of every 100 women who use the injectable contraceptive will get pregnant within the first year of typical use."
>
> "If 100 women have unprotected sex for a year, 85 of them will get pregnant, as compared to maybe 0 or 1 out of 100 using an IUD."

Use "Yes, and..." to provide clarifying information.

When discussing your client's preferences and understanding about their contraceptive method options, you may discover that your client has misinformation. Try to find something your client says to agree with, empathize with, or validate before giving additional clarifying information. This builds trust and rapport, and helps avoid making your client feel wrong or defensive. Instead of "No" or "But," try to start with "Yes! And_____."

This sounds like:

Agreement: "Yes, you're absolutely right, and..."

Display of empathy: "I can see this is concerning to you, and..."

Validation: "Yes, many of my clients say that, and..."

Acknowledge positive behavior.

Pointing out the health-supporting behaviors or knowledge your client demonstrates can help to build trust and rapport, and can also help the client identify—and continue—the strategies that they are already using to promote their health. Examples of positive behaviors to reinforce include risk reduction, condom use and consistent use of their contraceptive method, as well as healthy eating, physical activity, and smoking cessation.

This sounds like:

> "**You ask really great questions** about ways to reduce risks and achieve optimal health."
>
> "**I wish all of my patients knew that** hormonal birth control is safe and effective."
>
> "I can tell by the fact that you are using condoms to protect against STDs and the pill for pregnancy prevention **you are clearly interested in protecting yourself**."

Paraphrase to show you are listening.

Paraphrase what your client says so they know you have heard them, they can correct or confirm your understanding, and you can redirect the conversation in a client-centered way.

This sounds like:

> "It sounds like **on the one hand** you are saying you'd prefer to wait to be pregnant until you are finished with your degree, yet on the other hand you are saying you'd also be happy if you were to become pregnant before then. **Do I have that right?**"
>
> "**I hear you saying** that you are looking for a birth control method that is really effective. Do I have that right?"
>
> "**It sounds like** it is really important to you that you have control over using your birth control method. Is that right?"
>
> "I think what I hear you saying is that you are concerned about the possible health consequences of not having a period while using a hormonal method. **Is that what you mean?**"

Reflect and validate feelings.

Let clients know that you heard them and that their feelings are normal. Demonstrating empathy builds trust with your client and can help them feel comfortable sharing their concerns with you. When your client shares their concerns, you can most effectively tailor your counseling to their needs.

This sounds like:

> "I am so sorry to hear that you lost your job. **I think most people would find that really hard to deal with.**"
>
> "I hear in your voice how stressed you are with balancing school and childcare. **It sounds like an incredibly difficult situation.**"
>
> "**A lot of my clients have the same concern** about becoming pregnant before they feel ready to be a parent."

Explain that your client can change their mind.

Once your client has selected a method, make sure they know that they can always change their mind for any reason. If your client chooses an IUD or implant, be sure they know they can have the IUD or implant removed at any time. Also, be sure your client knows that you are available to manage side effects and that you will work with them to identify another method if the one they selected does not satisfy their needs.

This sounds like:

> "It's completely okay to change your mind if the method you've chosen today doesn't end up working for you. You may want to try a few methods before you find the one that works best for you. We can work together to avoid any gaps in your contraceptive coverage as you try other methods."

> "This implant is good for up to 3 years, but if you want to get pregnant before then, or if you would like it removed for any reason, we can remove it any time you want."

Confirm client understanding.

Confirm the client's understanding by asking them to phrase information you've discussed in their own words. Phrase the request in a way that you take responsibility for needing clarification so that your client doesn't feel like they are on the spot to give a correct answer. Before ending the visit, always give the client an opportunity to ask additional clarifying questions.

This sounds like:

> "We covered a lot of information. What do we need to go over again?"
>
> "We have discussed many different things today, I would like to be sure I was clear. Can you tell me what you will be doing to manage heavy periods with your copper IUD?"
>
> "What questions do you have about _____?"

Client-Centered Reproductive Goals and Counseling Flow Chart and Efficient Questions for Client-Centered Contraceptive Counseling Palm Card

Client-Centered Reproductive Goals and Counseling Flow Chart

Video: Mia’s contraceptive counseling visit

As you watch Mia's counseling session, reflect on which of the counseling skills you see the provider demonstrate.

Click the play button below to start the video.

PLAY

This video is a clip from the Envision Sexual & Reproductive Health video compilation demonstrating PATH counseling skills. The full compilation is available here: envisionsrh.com/counseling-movies

Activity: In your own words

Instructions:

Reflect on the skills you just learned. Download the worksheet below and in your own words, write the ways you would apply the skills you learned to the counseling encounter described.

CONTRACEPTION COUNSELING AND EDUCATION: **WORKSHEET**

IN YOUR OWN WORDS

FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER

Nadia is visiting your clinic today to discuss changing her contraceptive method. She currently uses the injectable. She is starting school in the fall and is concerned about trying to make time in her schedule to visit the clinic every three months for her shot. She tells you she really wants to prevent pregnancy until after she finishes school, and she consistently uses condoms for dual protection against STDs. She's heard about the implant and IUD but she's worried about negative side effects.

Reflect on the skills you just learned about. **In your own words, what are ways you would apply the following skills while counseling Nadia?**

Use open-ended probing questions

Acknowledge positive behavior

Use "Yes, and..." to provide clarifying information

Paraphrase to show you are listening

Explain that your client can change their mind

Confirm client understanding

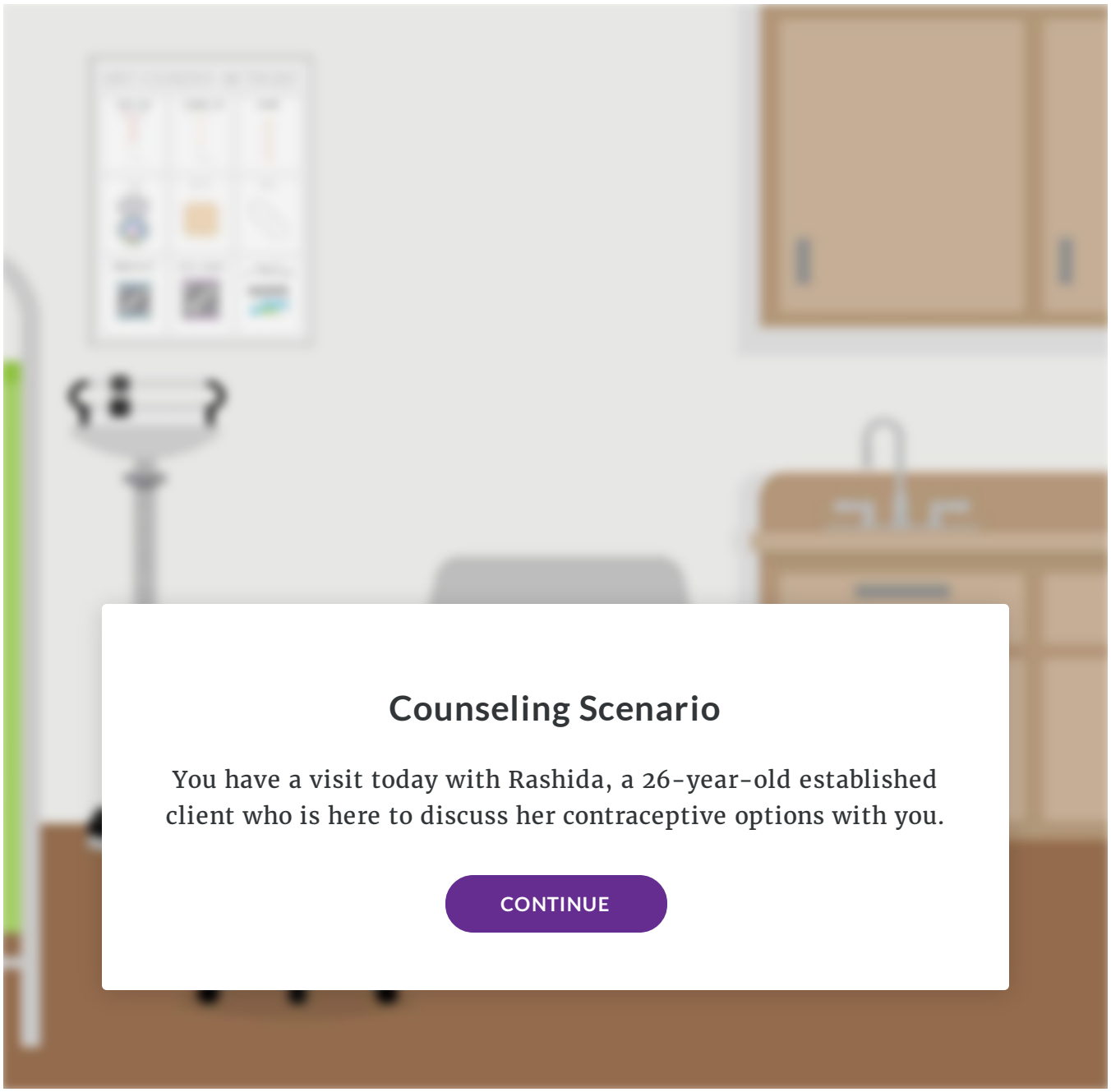
This worksheet was supported by Award No. FPTPA006028-04-00 from the Office of Population Affairs (OPA).
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

PDF

InYourOwnWords.pdf

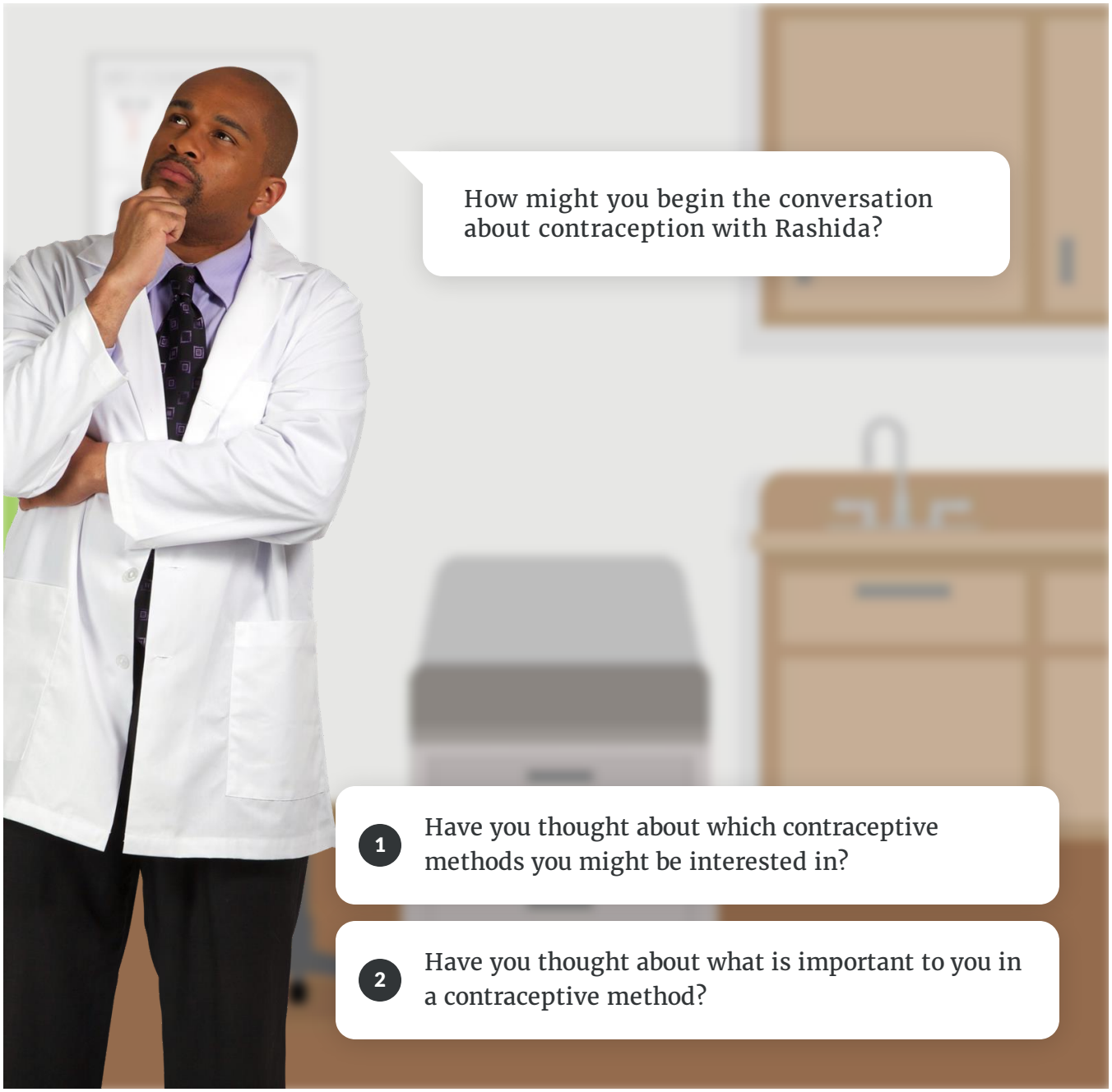
473.2 KB

Scenario 2: Contraceptive counseling visit



Scene 1 Slide 1

Continue → Next Slide



Scene 1 Slide 2

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Scene 1 Slide 3

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Scene 1 Slide 4

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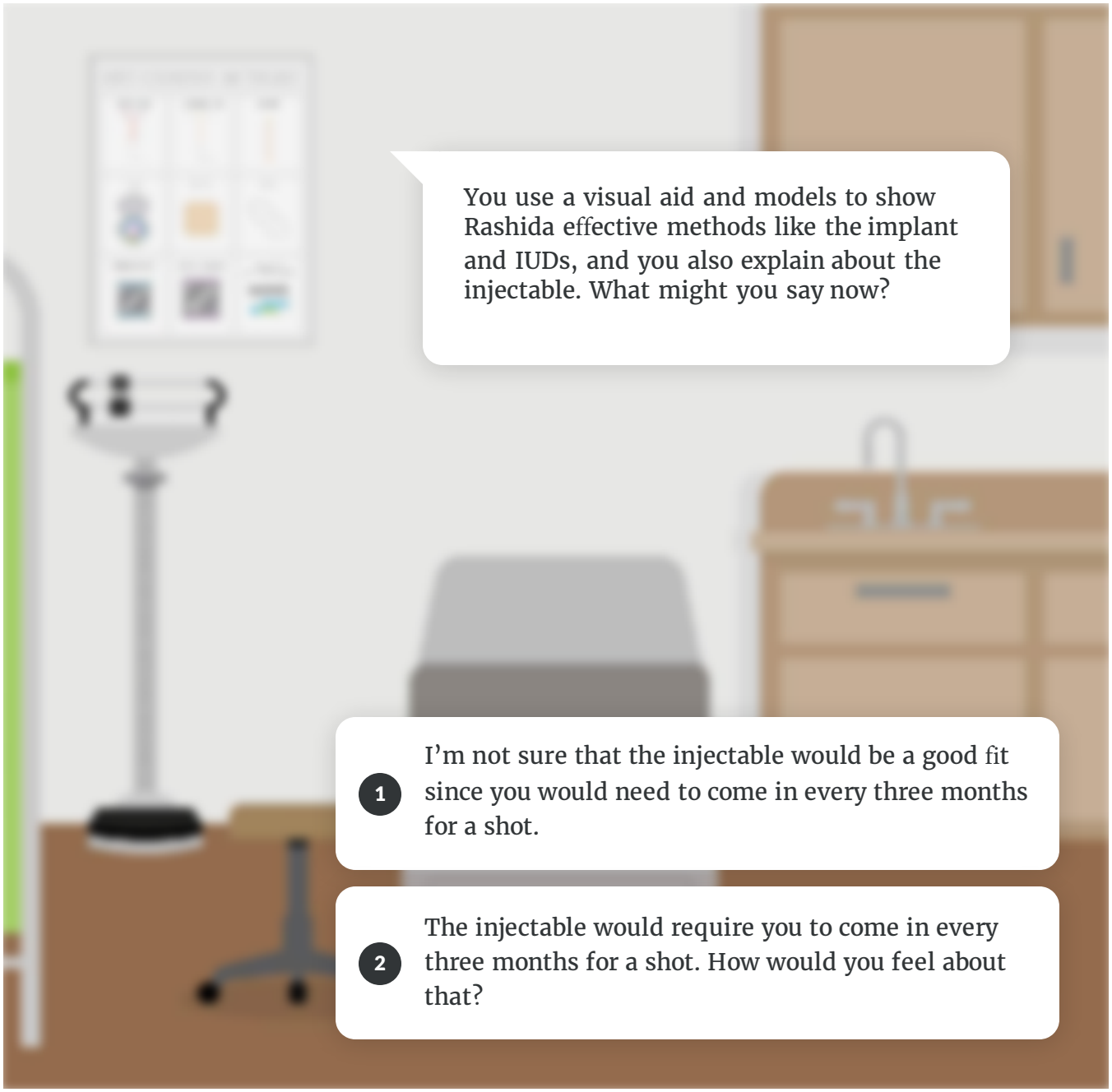

Scene 1 Slide 5

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Scene 1 Slide 6

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Scene 1 Slide 7

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Scene 1 Slide 8

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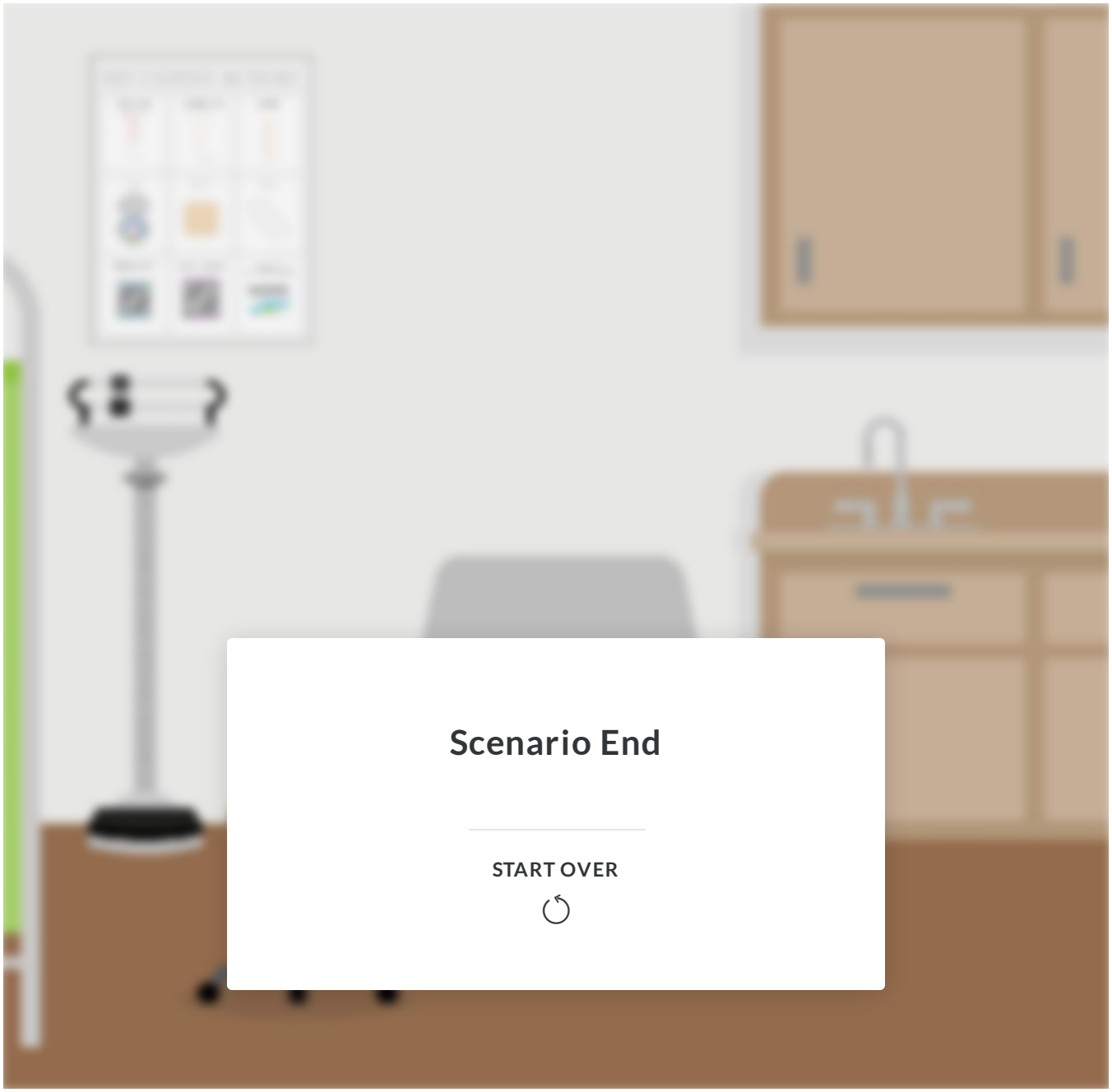

Scene 1 Slide 9

Continue → End of Scenario

Quiz

Now we will review the information we have covered during this module. For each question, select the response option you think is correct.

Question

01/05

Which of the following methods are not recommended for clients who are at increased risk of cardiovascular events?

CHC Pill

Ring

Implant

All of the above

A and B

Question

02/05

A client discloses that they've had a bad experience using a method in the past. Which of the following statements is **NOT** empathetic to the client's past experience?

It would be normal to be concerned about that again.

I am sorry that happened to you.

That probably won't happen again.

It sounds like that was really tough to deal with.

Question

03/05

The goal of contraceptive counseling is to help the client...

Have correct information about all contraceptive methods available

Select a method they will use correctly and consistently

Prevent pregnancy for the longest amount of time

Choose the most effective method possible

Question

04/05

Which of the following methods can also prevent the transmission of STDs and HIV?

Condoms

Spermicide

Abstinence

All of the above

A and C

Question

05/05

Which guidance document can providers use to determine if a contraceptive method may be safe for a client?

U.S. Selected Practice Recommendations for Contraceptive Use (US SPR)

Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (QFP)

U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC)

STD Treatment Guidelines

Conclusion

This is the end of the *Contraceptive Counseling and Education* module.

Thank you for joining us. Your feedback is important to us!

Please complete a brief evaluation of this module. After completing the evaluation, you can download your certificate of completion from your FPNTC training account.

Course Evaluation

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References

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