Provision of Quality Contraceptive Services: Updates From National Guidelines

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In 2024, the Centers for Disease Control and Prevention and the US Department of Health and Human Services Office of Population Affairs updated national guidelines on provision of quality contraceptive services and sexual and reproductive health care. New recommendations systematically promote care that is person-centered and accessible for all people. Contraceptive services may be addressed through a stepwise approach in which the clinician asks about an individual's contraceptive preferences based on their needs, desires, and prior experiences and then collaboratively works with the patient to align methods with their values and preferences. The clinician should discuss all methods that can be used safely based on medical eligibility criteria regardless of method availability and defer the decision to the patient. Physical assessment includes in-office or self-reported blood pressure measurement before starting an estrogen-containing contraceptive or pelvic examination when inserting an intrauterine device. If it is reasonably certain that the patient is not pregnant, any contraceptive may be started immediately; otherwise, a nonintrauterine bridge method may be initiated with follow-up pregnancy testing. To reduce barriers, a 1-year supply of short-acting or injectable contraceptives may be prescribed, and telehealth may be incorporated. The Centers for Disease Control and Prevention supports advance provision of emergency contraceptives. New recommendations include pain control during intrauterine device insertion, management of bleeding irregularities related to contraception, updated eligibility criteria (eg, venous thromboembolism, kidney disease), and new methods (eg, progestin-only formulations). Expanded sexual and reproductive health care services, such as screening for cervical cancer or sexually transmitted infections, should be offered, but patient acceptance of these services is not required during contraception management.

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Access to quality sexual and reproductive health care is fundamental to patient health and quality of life.[1-3] Accordingly, provision of quality contraceptive care requires ongoing incorporation of new evidence and technologies for continuous improvement in delivery of care.[4,5] The Centers for Disease Control and Prevention (CDC) and the US Department of Health and Human Services Office of Population Affairs have released updated, comprehensive, evidence-based contraception recommendations based on systematic literature reviews, expert panels, and patient perspectives that emphasize the principles of equity and person-centeredness[2,4,6,7] (eTable A). These guidelines can be used synergistically. New recommendations include person-centered care strategies, contraceptive services contextualized into broader sexual and reproductive health care, pain control during intrauterine device (IUD) insertion, management of bleeding irregularities related to contraception, updated safety for people with medical conditions (eg, venous thromboembolism, kidney disease), and new contraceptive methods (eg, progestin-only formulations, vaginal pH modulator).[2,6,7] Table 1[2,6,8-12] and Table 2[7,13-19] summarize select

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SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	Comments
Sexual and reproductive health services should be offered to adolescents with assurances of confidentiality in the context of relevant law.[2,29-32]	B	Expert opinion based on studies suggesting confidential care assurances increase adolescent engagement in care
Clinicians should use a patient-centered approach to contraceptive counseling by inquiring about patient preferences based on needs, desires, and prior experiences and align contraceptive methods with their values and goals.[4,5,24,37-39,43]	B	Expert opinion based on high-quality evidence that suggests a patient-centered approach may reduce early method discontinuation and increase satisfaction
Lidocaine gel or a paracervical block may be offered to reduce pain during intrauterine device placement.[7,15,16,19,40]	B	Moderate-quality randomized controlled trials that showed benefit for reducing pain with tenaculum use and intrauterine device placement
If pregnancy status is uncertain, clinicians may consider same day start of a nonintrauterine contraceptive method for immediate coverage and should order follow-up pregnancy testing in 2-4 weeks.[2,7]	C	Expert opinion to decrease barriers to care
Estrogen-containing contraceptives should be deferred until at least 3 weeks (if not 6 weeks) postpartum, because of the risk for venous thromboembolism.[6,7,9,10]	B	Observational studies that showed a risk for venous thromboembolism postpartum with and without the use of estrogen-containing contraceptives; may also affect breast milk supply
Contraceptive use for pregnancy prevention should be considered until menopause or at least until age 50-55 years.[7,44,45]	C	Expert opinion; predicting menopause using laboratory studies may not be accurate
Clinicians should not require screening, such as cervical cytology or for STIs, as a condition of contraceptive prescription because these can introduce unnecessary barriers to contraceptive care.[2,7]	C	Expert opinion to decrease barriers to care
A prescription of nonprocedural contraceptives should cover a 1-year supply to decrease barriers to care.[2,7]	C	Expert opinion to decrease barriers to care
Irregular bleeding may be temporized with ethinyl estradiol–containing combined oral contraceptives for 14-42 days (ie, 20-30 mcg; discarding placebo pills) in patients who use contraceptive implants.[7,17]	B	Randomized controlled trials; bleeding may return when oral contraception is discontinued

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to https://www.aafp.org/afpsort.

changes from the 2024 US Medical Eligibility Criteria for Contraceptive Use and US Selected Practice Recommendations for Contraceptive Use.

PROVISION OF CONTRACEPTION

Patients should be screened for their reproductive desires and related needs at the initial visit and on a regular basis.[2] A clinician should routinely ask, "Do you want to talk about contraception or pregnancy prevention during your visit today?" This should be followed up with personalized, clarifying questions.[2,20,21] Requested services should be provided or referrals established.[20] A stepwise approach to contraception in primary or specialty care settings can be helpful for conceptualizing person-centered contraceptive care in a broad sexual and reproductive health care framework to optimize patient-oriented outcomes and wellbeing[2] (Figure 1[2,22]).

Step 1: Establish and Maintain Rapport

Discussion about sexual and reproductive health care should be normalized as part of a person's general health and well-being. Power dynamics in clinician-patient relationships can create subtle patient pressures.[23,24] Simple deliberate acts such as providing a warm welcome, asking permission before talking about sensitive topics, matching the patient's tone, prioritizing respectful listening instead of explaining, and ensuring confidentiality can facilitate trust and foster safe discussions.[2,25] An inclusive environment allows a person's unique circumstances to be addressed in an unbiased and nonjudgemental manner; therefore, diverse cultural practices should be welcomed, services in the patient's preferred language should be offered, and conversations about sexual orientation and gender identity without making assumptions about sexual behavior or pregnancy risk should be normalized.[2] This is particularly important for people from historically marginalized and excluded groups (eg, based on race or sexual orientation).[26] Care should

TABLE 1

Summary of Select Changes: 2024 US Medical Eligibility Criteria for Contraceptive Use

Condition	Contraceptive	Category change	Clinical relevance
Chronic kidney disease			
Current nephrotic syndrome, hemodialysis, or peritoneal dialysis	Depot medroxyprogesterone acetate	— 3	Increased risk of thrombosis and fracture
	Progestin-only pill	— 2	Progestin-only pill drospirenone (Slynd) is category 4 if known hyperkalemia; all other progestin-only pills are category 2
	Combined hormonal contraceptives	— 4	Thrombosis risk
Liver disease			
Decompensated cirrhosis or hepatocellular adenoma	Levonorgestrel-releasing IUD, implant, or progestin-only pill	3 → 2	No increased risk of worsening disease state
Peripartum			
Peripartum cardiomyopathy: normal or mildly impaired cardiac function	Depot medroxyprogesterone acetate	1 → 2	Increased risk of VTE; category 3 if impaired cardiac function is moderate to severe
Postpartum: < 10 minute after delivery of placenta	Copper IUD or levonorgestrel-releasing IUD	1 → 2	Increased expulsion rate
Thrombosis and thrombophilia			
History of or current DVT or PE: receiving anticoagulation treatment	Combined hormonal contraceptives	4 → 3	No increased risk of VTE; may be of benefit for heavy menses related to anticoagulation
Thrombophilia or history of DVT or PE: higher risk for recurrence; not taking a treatment or prophylactic dose of anticoagulant	Depot medroxyprogesterone acetate	2 → 3	Increased risk of VTE

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Note: Categories of medical eligibility criteria for contraceptive use are: 1 = a condition for which there is no restriction on 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.

DVT= deep venous thrombosis; IUD = intrauterine device; PE = pulmonary embolism; VTE = venous thromboembolism.

TABLE 1 (continued)

Summary of Select Changes: 2024 US Medical Eligibility Criteria for Contraceptive Use

Condition	Contraceptive	Category change	Clinical relevance
Vaginal pH modulator			
All conditions listed in the US Medical Eligibility Criteria for Contraceptive Use	Vaginal pH modulator	— 1	Category 2 if presence of urinary tract infection May be of benefit when spermicide use is a category 3 (ie, concerns for viral shedding and transmission of HIV) or 4 (ie, concerns for genital lesions and increased risk of infection in those at high risk of HIV)
Other conditions			
Sickle cell disease	Depot medroxyprogesterone acetate	1 → 2	Category 2 or 3 based on condition severity and existing thrombosis risk; increased risk of thrombosis
	Combined hormonal contraceptives	2 → 4	Increased risk of thrombosis
Solid organ transplant, with or without graft failure*	Depot medroxyprogesterone acetate	2 → 2	Increased risk of fracture; category 3 if history of or risk factors for nontraumatic fracture
Systemic lupus erythematosus: positive or unknown antiphospholipid antibody	Levonorgestrel-releasing IUD, implant, or progestin-only pill	3 → 2	No increased risk of VTE

Note: Categories of medical eligibility criteria for contraceptive use are: 1 = a condition for which there is no restriction on 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.

DVT= deep venous thrombosis; IUD = intrauterine device; PE = pulmonary embolism; VTE = venous thromboembolism.

*—For patients who have had a solid organ transplant, copper IUD and levonorgestrel-releasing IUD moved from categories 3 (complicated transplant) and 2 (uncomplicated transplant) to 2 (with graft failure) and 1 (no graft failure) for initiation of method; now category 1 for continuation of these methods, with or without graft failure.

Information from references 2, 6, and 8-12.

also be trauma-informed, with an assumption that all people have had trauma exposure, and supportive of all sexual activity that is sex positive and consensual.[2,27,28]

Adolescents. Adolescents should be given the opportunity to privately discuss their sexual and reproductive health care needs and given assurances of confidentiality in the context of relevant law and information about possible confidentiality compromises (eg, billing, medical recordkeeping, medication pickup).[2,29-31] Confidential care encourages adolescent engagement and trust in clinical settings and a forthright exchange of pertinent information.[30,32] It is recommended that clinicians encourage adolescents to share health information with parents or guardians when safe and, if indicated, find common ground on cultural perspectives that can be used to foster social support, communication, allowances for ongoing confidential care, access to sexual and reproductive health care services, and healthy development.[30]

Step 2: Personalize Discussions by Asking About Contraceptive Preferences

Deliberately assessing and prioritizing a patient's preferences, values, and goals are major components of person-centered contraceptive counseling that are rooted in inclusivity and equitable care.[4] Respect for autonomy is important, including the right to use or not use contraception, decline testing, and pursue any pregnancy option in the context of relevant law.[2,23,24] Approximately one-fourth of contraceptive users are likely using a method they prefer less than another

method, and many people fluctuate in their intentions for pregnancy.[33,34]

A person-centered approach may begin with "Do you have an idea [or sense] of what is important to you about your method?"[28] This can be followed up with prompts such as, "Methods differ in how they are used, their effect on menstrual bleeding, and how reliable they are in preventing pregnancies. Can we discuss your feelings about these factors?" or a nuanced discussion about specific methods may be initiated. Specific counseling strategies are discussed in a previous *American Family Physician* article.[23] Use of interactive resources (eg, Bedsider.org) or handouts (eg, Birth Control Methods Chart [eFigure A]) may improve contraceptive counseling by focusing on method characteristics that are commonly valued.[2,24,35]

Mistimed postpregnancy contraceptive counseling may be inadvertently interpreted as judgmental.[36] Furthermore, exerting pressure on patients to choose a particular contraceptive method, which may occur more often when counseling adolescents, people in marginalized and excluded communities, and those who have disabilities or experience poverty, can contribute to perceptions of coercion and decreased satisfaction with their method.[24,36-39] Normalizing a sexual history about practices, partners, sexually transmitted infections (STIs), condom use, pleasure, and reproductive desires, can determine which sexual and reproductive health care services should be offered. Disclosure of sensitive information is not always the goal; patients may understandably omit details for various reasons.[2]

Step 3: Collaboratively Determine Which (If Any) Contraceptive Method Aligns With the Patient's Values and Preferences

Recommendations should be personalized and focus on the patient's reproductive desires and safety. Clinicians can collaboratively and iteratively help a person map their preferences to specific methods but should make it clear that the patient is the final decision-maker.[5,38] It is essential to recognize health conditions that make specific contraceptives or pregnancy unsafe. Menstrual, gynecologic, and obstetric history; medication allergies; infectious or chronic health conditions; and tobacco use may make a method less safe[6] (eTable B). For example, controlled hypertension is a medical eligibility category 3 condition and may necessitate shared decision-making based on availability, practicality, and acceptability of alternative methods; whereas, smoking (age ≥ 35 years) is a category 4 condition and may require a stronger recommendation to preserve safety.[6] Methods that can be used safely based on the US Medical Eligibility Criteria for Contraceptive Use should be offered even if referral is needed.[2,6]

TABLE 2

Summary of Select Changes: 2024 US Selected Practice Recommendations for Contraceptive Use

Recommendation	Clinical relevance
Bleeding irregularities after implant placement	
NSAIDs, hormonal treatment, antifibrinolytics, and SERMs may improve bleeding irregularities after implant placement.	Figure 2 outlines specific dosing regimens.
IUD placement	
Topical gel, cream, spray, or paracervical block may reduce patient pain but may not improve placement success. Other interventions did not show a positive effect on pain.	Examples include self-administered 2% gel vaginally 15 minutes prior or clinician-administered lidocaine-prilocaine cream 7 minutes before procedure.*
Misoprostol may result in a higher likelihood of placement success with second attempt; however, routine use for IUD placement is not recommended.	Consider 400 mcg buccally or vaginally 3-4 hours prior to placement.
Self-administration of injectable contraception	
Self-administration of subcutaneous depot medroxyprogesterone acetate, 104 mg, should be offered as an additional option.	There is no difference in pregnancy rates with self-administration compared with clinician administration.
Transgender and gender-diverse people with a uterus	
Offer contraceptive counseling and services to those using testosterone who are at risk for and do not desire pregnancy.	Testosterone is teratogenic and ovulation can still occur while receiving testosterone therapy.

IUD = intrauterine device; NSAID = nonsteroidal anti-inflammatory drug; SERM = selective estrogen receptor modulator.

*—Comprehensive practical guidance on administering medications for reducing pain associated with IUD placement can be found in reference 19.

Information from references 7 and 13-19.

Step 4: Perform a Physical Assessment, If Indicated

A physical assessment is generally not needed and can introduce barriers to care.[7] Self-reported or in-office blood pressure measurements should be obtained before starting estrogen-containing contraceptives because the result could affect medical eligibility criteria.[6] Clinicians should perform a pelvic examination and cervical inspection before IUD insertion; placement should be temporarily deferred if cervicitis or pelvic inflammatory disease is suspected.[7] Clinicians can offer topical lidocaine gel or a paracervical block as a patient-centered intervention to reduce pain during IUD placement.[7,15,16,19,40] Weight status alone does not preclude any contraceptive option, but weight measurement may help determine if changes in weight are associated with use of the method.[6,7] Contraceptives generally do not lead to clinically significant weight gain, with the possible exception of injectable formulations.[41]

Step 5: Provide or Refer for the Contraceptive Method, Help Develop a Plan and Supports for Using the Method, and Confirm Understanding

The US Selected Practice Recommendations for Contraception Use provides guidance on method initiation and management.

FIGURE 1

Step 1: Establish and maintain rapport

- Assure patients that you plan to help them achieve their goals
- Ensure privacy and confidentiality
- Ask permission before discussing sensitive topics
- Demonstrate trustworthiness and accessibility
- Be aware of how personal biases affect clinical practice
- Demonstrate empathy: listen, observe, and withhold judgment

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Step 2: Personalize discussions by asking about contraceptive preferences based on patient needs, desires, and prior experiences

- Consider asking: "Do you have an idea [or sense] of what is important to you about your method?" As needed, use follow-up prompts
- Method type: "There are several different contraceptive methods available, such as taking a pill or placing protection in your uterus. Do you have a preference regarding these options?"
- Method characteristics: "Methods differ in how often you take them, how they affect your bleeding, how effectively they prevent pregnancy, and how private or easily discontinued they are. What factors are most important to you?"
- Consider using interactive counseling resources (eg, Bedsider.org) or handouts (eg, Birth Control Methods Chart [eFigure A])

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Step 3: Collaboratively determine which contraceptives (if any) align with patient preferences

- Iteratively map preferences to available methods, as needed
- Review medical history and medications to determine the safety of preferred methods; refer to the CDC's medical eligibility criteria
- Review expected adverse effects, expectations upon initiation, and noncontraceptive health benefits of chosen method
- Disclose rare but serious adverse effects (eg, venous thromboembolism risk, uterine perforation)
- Patient selects method or defers start
- Consider using interactive counseling resources (eg, Bedsider.org) or handouts (eg, Birth Control Methods Chart [eFigure A])

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Step 4: Physical assessment, when warranted

- Blood pressure measurement (self-report is sufficient) before initiating combined hormonal contraceptives; pelvic examination for IUD placement
- Avoid logistical, emotional, or financial barriers to care (eg, examination, laboratory studies)
- History can accurately determine pregnancy status (Table 3)
- Weight does not affect medical eligibility for any method

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Step 5: Provide or refer for method, instructions, and follow-up plan; confirm understanding

- Method can be initiated immediately if reasonably certain patient is not pregnant; if pregnancy status is uncertain, a quick-start approach is appropriate for methods other than IUD
- Offer a bridge method until preferred method is available or safe (eg, if deferring IUD placement temporarily); refer to the CDC's selected practice recommendations
- Consider prescribing a 1-year supply
- Strategize for success (eg, setting alarms for adherence, instructions for missed doses, individualized follow-up plan)
- Make condoms readily available
- Offer expanded sexual and reproductive health services (eg, advance provision of emergency contraception) if indicated

CDC = Centers for Disease Control and Prevention; IUD = intrauterine device.

Steps for providing contraceptive services.

Information from references 2 and 22.

Methods not available on site should be facilitated through referral networks, preferably through a warm handoff to quality care. If it is reasonably certain that a patient is not pregnant, clinicians can safely offer same-day method initiation[2,7] (Table 3[7]). If pregnancy status is uncertain, initiating a nonintrauterine method as an ongoing or a bridge method (eg, Quick Start algorithm for hormonal contraception; https://www.reproductiveaccess.org/resource/quick-start-algorithm/2025-04-quickstart-algorithm_final) provides interim coverage; follow-up pregnancy testing in 2 to 4 weeks is indicated. Emerging evidence suggests that a person's pregnancy risk is exceptionally low even when a contraceptive is initiated after seven days from the start of their most recent menses regardless of recent unprotected intercourse.[42] Pregnancy test results may be inaccurate due to test characteristics, time since last intercourse, and recent pregnancy; therefore, testing is often unnecessary.[2] Recommendations for backup contraception during method initiation and switching (Table 4[7,22]) and risk mitigation for missed doses (eTable C) are provided in the CDC guidance.[7]

Clinicians should provide comprehensive information, particularly with respect to common adverse effects such as menstrual bleeding expectations. Unbiased expectation setting and shared decision-making may reduce early method discontinuation and increase satisfaction.[5,39,43] Additional considerations for successful contraception care include streamlined access to virtual or in-person follow-up if there are adverse effects (preferably with a continuity clinician), prompt removal of a long-acting method if requested, concurrent use of a barrier method, logistics of pharmacy access, patient-determined reminder systems (eg, smartphone alarms), and education about emergency contraception.[24] When relevant, clinicians should discuss what may need to be documented in the medical record. A teach-back approach can verify understanding.[2]

Postpregnancy Contraception. The CDC provides nuanced safety recommendations on the use of contraceptives in postpregnancy time frames. Estrogen-containing methods should be deferred until at least 3 weeks, if not 6 weeks, postpartum because of venous thromboembolism risk, whereas progestin-only methods can be safely started immediately.[6,7,9,10] Any method can be started safely after a first- or second-trimester pregnancy loss or abortion.[6,7]

Contraception in Patients Approaching Menopause. In Western countries, menopause occurs at a median age of 51 years (range 40-60 years).[7,44] No test can reliably verify cessation of fertility around menopause.[2] Contraception should be considered until a person experiences amenorrhea for one year after previously regular menses, or at least until age 50 to 55 years.[7,44,45] Protocols using serologic testing to guide cessation of contraception around menopause are available but may not be reliable.[7,45,46] Any contraceptive may be used in the perimenopausal time frame, but medical conditions that affect eligibility criteria become increasingly prevalent with age.

TABLE 3

How to Be Reasonably Certain That a Person Is Not Pregnant

A clinician can be reasonably certain that a person is not pregnant if:

1) Patient has no signs or symptoms of pregnancy, and:
2) Patient meets at least one of the following criteria:
   - Is ≤ 7 days after start of normal menses
   - Has not had intercourse since the start of last normal menses
   - Has been correctly and consistently using a reliable method of contraception
   - Is ≤ 7 days after spontaneous or induced abortion
   - Is within 4 weeks postpartum
   - Is fully or nearly fully breastfeeding (ie, exclusively breastfeeding or the majority of feeds [≥ 85%] are breastfeeds), amenorrheic, and < 6 months postpartum

Note: If the patient meets both criteria, there is a negative predictive value of 99% to 100% of pregnancy, and the patient does not need a pregnancy test before initiating contraception.

Adapted with permission from Curtis KM, Nguyen AT, Tepper NK, et al.; Contributors. U.S. selected practice recommendations for contraceptive use, 2024. *MMWR Recomm Rep*. 2024;73(3):8.

REDUCING BARRIERS TO CARE

Clinicians should strive to increase their patient's access to high-quality, evidence-based sexual and reproductive health care[24] (eTable D). Quality improvement initiatives can be guided by validated performance measures (ie, suitable for public reporting) or local quality measures. These initiatives can assess current practice patterns and uncover inequities in care delivery (eg, by sociodemographic groups).[2] Example measures include access to same-day, long-acting contraceptive methods or STI testing. However, requiring services, such as screening for cervical cancer or STIs before contraceptive initiation or promoting specific method initiation rates, is not medically justified and can be coercive.[2,7]

Clinicians should prescribe nonprocedural contraceptives to cover a 1-year supply and can make condoms readily available. Practices can strive to improve accessible care through telehealth, expanded hours, walk-in services, mobile or temporary clinic locations, late policy flexibility, reduced number of visits required, streamlined referral processes, childcare and transportation services, and financial assistance when possible. Furthermore, clinicians can provide education on or facilitate self-care interventions (eg, self-administered subcutaneous depot medroxyprogesterone acetate, over-the-counter progestin-only pills, evidence-based and security-enhanced fertility awareness apps).[2,47,48]

Emergency Contraception

Clinicians can safely offer an advanced supply of levonorgestrel-based emergency contraception (Plan B) or ulipristal (Ella) to patients of any weight. A prescription may mitigate cost.[2] The CDC recommends delaying the start of hormonal contraceptives for 5 days after ulipristal administration to prevent decreased contraceptive effectiveness; shared decision-making is warranted when ulipristal is combined with long-acting or injectable progestin-only contraceptives.[2,6,7,49] Emergency contraceptives have been reviewed in *American Family Physician*.[50]

FOLLOW-UP CONSIDERATIONS

Follow-up visits are not required after starting a contraceptive method. Follow-up or routine visits can include discussions about method satisfaction and changes in health status or medication use that might affect medical eligibility criteria. Blood pressure can be assessed for those using estrogen-containing methods.[7] It is normal and expected that changes in family plans, lifestyle, ability to use a method consistently, or new noncontraceptive needs may prompt method switching.

Bleeding irregularities during contraceptive use are common and typically benign. Medical history should include inconsistent medication use and interactions, and evaluation for infection, pregnancy, and pathologic uterine conditions may be warranted.[7] Irregular bleeding in contraceptive implant users may be temporized with ethinyl estradiol–containing combined oral contraceptives for 14 to 42 days (ie, 20-30 mcg; discarding placebo pills).[7,17] Figure 2 outlines treatment strategies for irregular bleeding.[7,51-56]

A diagnosis of pelvic inflammatory disease does not necessitate IUD removal. If the patient prefers, the device may be left in place for 2 to 3 days for reassessment during a CDC-endorsed antibiotic regimen; continuation of the IUD is based on clinical improvement and patient preference.[7,57] When an IUD is removed, emergency contraception should be offered if sperm could be present.

This article updates a previous article on this topic by Klein, et al.[22]

Data Sources: A PubMed search was completed using the MeSH term contraception, was limited to 5 years and included the following study types: meta-analyses, randomized controlled trials, clinical trials, systematic reviews, and reviews. Essential Evidence Plus, the Cochrane Database of Systematic Reviews, and the US Preventive Services Task Force were also searched. The reference lists of relevant national guidelines and select systematic reviews used to create these guide-

TABLE 4

Backup Contraception When Initiating or Switching Methods

Contraceptive	Backup method: Initiation*	Backup method: Method switching
Copper IUD	None needed	None needed
Levonorgestrel-releasing IUD	7 days; only needed if > 7 days after menstrual bleeding started†	7 days; only needed if > 7 days after menstrual bleeding started‡
Implant	7 days; only needed if > 5 days after starting menses†	7 days; only needed if > 5 days after starting menses§
Injectable	7 days; only needed if > 7 days after starting menses†	7 days; only needed if > 7 days after starting menses§
Combined hormonal contraceptives	7 days; only needed if > 5 days after starting menses†	7 days; only needed if > 5 days after starting menses§
Progestin-only pills		
Norethindrone or norgestrel	2 days; only needed if > 5 days after starting menses†	2 days; only needed if > 5 days after starting menses§
Drospirenone (Slynd)	7 days; only needed if > 1 day after starting menses†	7 days; only needed if > 1 day after starting menses§

Note: Barrier methods, abstinence from intercourse, or if applicable, overlap of the current contraceptive may be used during the recommended backup interval. These recommendations reflect a 7-day continuous treatment interval necessary to suppress ovulation with combined hormonal contraceptives.

IUD = intrauterine device

*—Any method may be initiated at any time if there is reasonable certainty that the person is not pregnant, based on the Centers for Disease Control and Prevention criteria (Table 3).

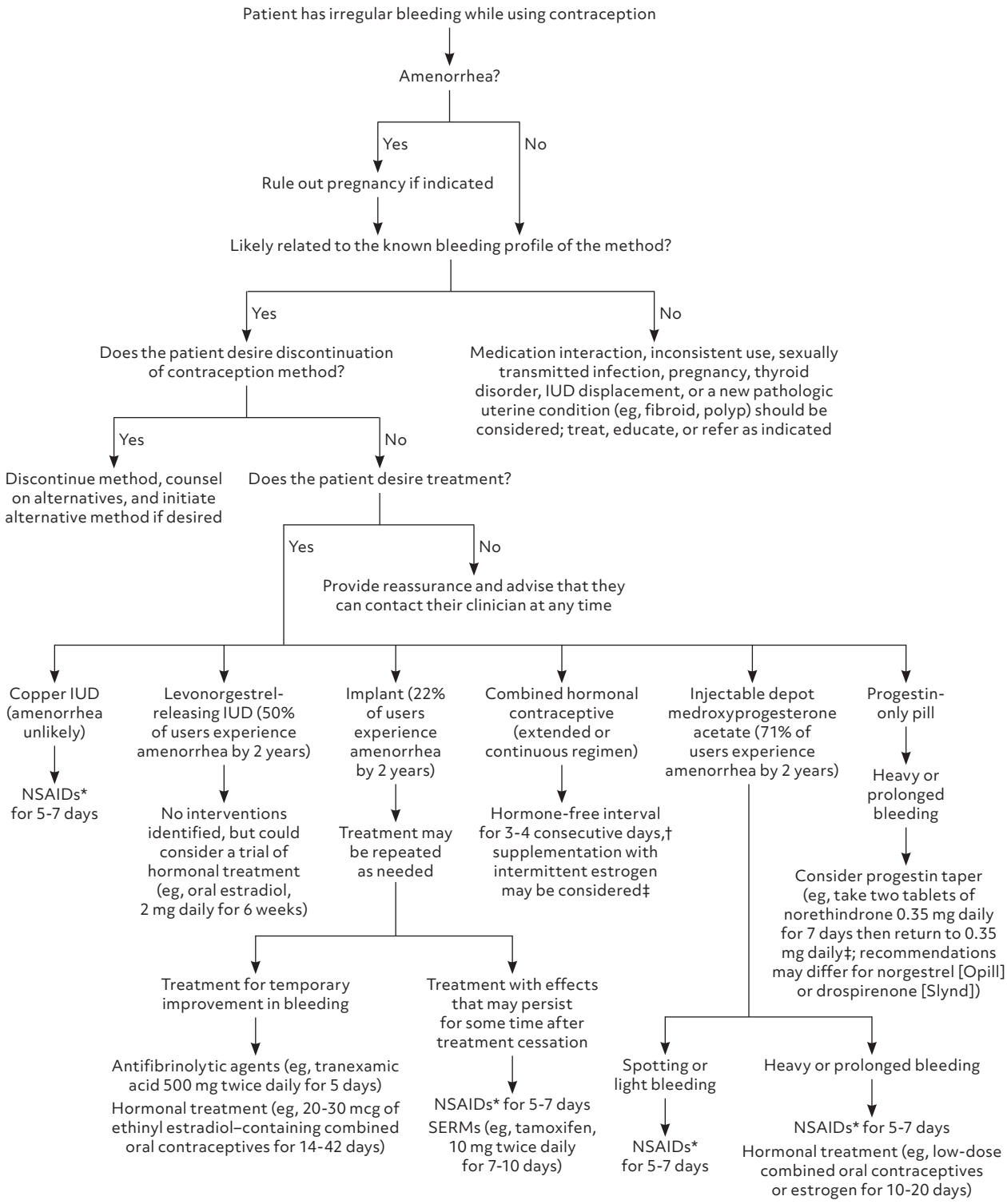
†—If patient is < 21 days postpartum, no backup contraception needed.

‡—When switching from a copper IUD, consider emergency contraceptive pills at the time of placement if residual sperm may be present. There are nuanced recommendations for ulipristal.[7]

§—When switching from an IUD, recommend one of the following options if residual sperm may be present: delay removal for > 7 days after new method is established, abstain from intercourse or use a barrier method for 7 days before removal, or use emergency contraceptive pills at the time of removal. There are nuanced recommendations for ulipristal.[7]

Adapted with permission from Klein DA, Arnold JJ, Reese ES. Provision of contraception: key recommendations from the CDC. *Am Fam Physician*. 2015; 91(9):628, with additional information from reference 7.

FIGURE 2



IUD = intrauterine device; NSAID = nonsteroidal anti-inflammatory drug; SERM = selective estrogen receptor modulator.

*—Examples include celecoxib, 200 mg/day; ibuprofen, 400-800 mg two to three times/day; mefenamic acid, 500 mg two to three times/day.
†—Not recommended during the first 21 days or more than monthly due to the risk of reduced effectiveness.
‡—Recommended by the American College of Obstetricians and Gynecologists.

Management of bleeding irregularities while using contraception.

Information from references 7 and 51-56.

lines were reviewed. Search dates: December 1, 2024, January 18, 2025, and May 27, 2025.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the US Defense Health Agency, US Department of Defense, or the US government.

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eTABLE A

Key Resources for Clinicians in the Provision of Contraception

Resource	Content
Contraception counseling and provision	
Providing Quality Family Planning Services in the United States: Recommendations of the US Office of Population Affairs (Revised 2024): https://www.ajpmonline.org/article/S0749-3797(24)00310-6/fulltext	Person-centered contraceptive delivery Determining an individual's needs and desires for services 6 Ps (partners, practices, protection from STIs, past history of STIs, plus, pregnancy preferences) of Sexual History
CDC US Selected Practice Recommendations for Contraceptive Use, 2024: https://www.cdc.gov/contraception/hcp/usspr/index.html	Guidelines for initiating and managing contraceptives How to be reasonably certain an individual is not pregnant Contraceptive options Examinations, testing, and follow-up planning Managing common adverse effects Initiating and switching methods Postpartum and postabortion use
CDC US Medical Eligibility Criteria for Contraceptive Use, 2024: https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html	Safety of specific contraceptive methods categorized by people who have certain characteristics or medical conditions: 1 = A condition for which there is no restriction on 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
CDC's Contraception app summarizing recommendations: https://www.cdc.gov/contraception/hcp/contraceptive-guidance/app.html	Summary of US Medical Eligibility Criteria for Contraceptive Use and US Selected Practice Recommendations for Contraceptive Use
Quick Start algorithm: https://www.reproductiveaccess.org/wp-content/uploads/2024/05/2025-04-Quickstart-Algorithm_Final.pdf	Outlines when contraceptive methods can be safely started
Bedsider.org: https://www.bedsider.org	Birth control options with side-by-side comparisons

continues ➤

CDC = Centers for Disease Control and Prevention; STI = sexually transmitted infection.

eTABLE A (continued)

Key Resources for Clinicians in the Provision of Contraception

Resource	Content
Family Planning	
Training and resources: https://rhntc.org/resources	Includes training and resources for topics such as contraception, infertility, LGBTQ+ communities, and services for men and adolescents
Tips for discussing a pregnancy test result: https://www.ajpmonline.org/article/S0749-3797(24)00310-6/fulltext	Practical tips for discussing a pregnancy test result
CDC guidelines for providing family planning services: https://www.cdc.gov/contraception/index.html	Helping patients achieve pregnancy Contraception Pregnancy testing and counseling Preventive health services and screenings
STI prevention, screening, and treatment	
CDC STI treatment guidelines: https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf and mobile app: https://www.cdc.gov/std/treatment-guidelines/provider-resources.htm	Treatment options for patients who have or are at risk for STIs
Providing Quality Family Planning Services in the United States: Recommendations of the US Office of Population Affairs (Revised 2024): https://www.ajpmonline.org/article/S0749-3797(24)00310-6/fulltext	Framing STI screening and prevention recommendations in clinical practice

CDC = Centers for Disease Control and Prevention; STI = sexually transmitted infection.

Information from:

Paradise SL, Landis CA, Klein DA. Evidence-based contraception: common questions and answers. *Am Fam Physician*. 2022;106(3):251-259.

Romer SE, Blum J, Borrero S, et al. Providing quality family planning services in the United States: recommendations of the U.S. Office of Population Affairs (revised 2024). *Am J Prev Med*. 2024;67(6S):S41-S86.

eTABLE B

Select Conditions and Medication Interactions That Require Additional Consideration When Prescribing Estrogen-Containing Contraceptives

Condition/medication	Associated risk	Comments
Category 4: unacceptable health risk if used		
Breast cancer	Theoretical concern for worse prognosis of disease	Category 3 if in complete remission for 5 years
Chronic kidney disease	Theoretical concern for increased thrombosis risk	Includes current nephrotic syndrome, hemodialysis, and peritoneal dialysis
Deep venous thrombosis or pulmonary embolism	Thromboembolic disease; stroke	Only category 4 if on prophylactic dosing of anticoagulant therapy or not receiving anticoagulant therapy and at higher risk for recurrence; category 3 if on therapeutic dosing of anticoagulant therapy or at lower risk of recurrence
Hypertension (systolic ≥ 160 mm Hg or diastolic ≥ 100 mm Hg)	Acute myocardial infarction and stroke	—
Ischemic heart disease	Acute myocardial infarction	History of or current ischemic heart disease
Known thrombogenic variations	Thromboembolic disease; stroke	Routine screening is not appropriate
Liver disease (decompensated cirrhosis, hepatocellular adenoma, or carcinoma)	May affect estrogen metabolism and place additional burden on decompensated liver	Category 2 if focal nodular hyperplasia
Major surgery with prolonged immobilization	Thromboembolic disease; stroke	—
Migraine with aura	Stroke	—
Postpartum < 21 days	Increased risk of venous thromboembolism	Includes those breastfeeding and not breastfeeding
Sickle cell disease	Venous thrombosis; stroke	—
Smoking and age ≥ 35 years	Cardiovascular disease, including acute myocardial infarction	Category 3 if age ≥ 35 years and < 15 cigarettes per day
Stroke	Recurrence or worsening of disease	History of cerebrovascular accident
Systemic lupus erythematosus (with antiphospholipid antibodies)	Arterial and venous thrombosis	Only category 4 if positive (or unknown) antiphospholipid antibodies

continues ➤

Note: Further characterization of conditions and clarification are available at http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm. Estrogen-containing contraceptives (ie, combined hormonal contraceptives) include combined oral contraceptives, combined hormonal patch, and combined vaginal ring.

eTABLE B (continued)

Select Conditions and Medication Interactions That Require Additional Consideration When Prescribing Estrogen-Containing Contraceptives

Condition/medication	Associated risk	Comments
Category 4: unacceptable health risk if used		
Valvular heart disease	Arterial thrombosis	Only category 4 if complicated
Vascular disease	Acute myocardial infarction and stroke	Category 4 unless it is superficial disease
Category 3: theoretical or proven risks usually outweigh advantages		
Acute viral hepatitis	May affect estrogen metabolism and place additional burden on decompensated liver	Initiation only; category 4 if severe
Bariatric surgery	May decrease effectiveness of oral contraceptives (not patch or ring)	Only category 3 for malabsorptive procedures (eg, Roux-en-Y gastric bypass, biliopancreatic bypass), not restrictive procedures (eg, gastric banding)
Diabetes with complications (or > 20 years duration)	May worsen control of diabetes, which may worsen diabetic complications	Category 4 if severe
Gallbladder disease, symptomatic or medically treated	Increases risk for gallbladder disease and may worsen existing gallbladder disease	Excludes those who are postcholecystectomy
Hypertension (adequately controlled or systolic blood pressure of 140 to 159 mm Hg or diastolic blood pressure of 90 to 99 mm Hg)	Acute myocardial infarction and stroke	—
Inflammatory bowel disease	Thromboembolic disease; stroke	Category 3 for active or complicated disease only (treatment or sequelae may predispose patient to thromboembolism)
Lamotrigine monotherapy	Seizure activity may increase	Lamotrigine levels may decrease
Rifampin or rifabutin therapy	Reduces contraceptive effectiveness	This interaction does not apply to most broad-spectrum antibiotics, antifungals, and antiparasitics
Specific anticonvulsants (eg, topiramate, phenytoin)	Reduces contraceptive effectiveness	Consider other contraceptive options and ethinyl estradiol dose of at least 30 mcg
Specific antiretrovirals (eg, fosamprenavir)	Reduces antiretroviral effectiveness	Recommend condom use and ethinyl estradiol dose of at least 30 mcg

Note: Further characterization of conditions and clarification are available at http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm. Estrogen-containing contraceptives (ie, combined hormonal contraceptives) include combined oral contraceptives, combined hormonal patch, and combined vaginal ring.

Adapted from Klein DA, Arnold JJ, Reese ES. Provision of contraception: key recommendations from the CDC. *Am Fam Physician*. 2015;91(9):625-633, with additional information from Nguyen AT, Curtis KM, Tepper NK, et al.; Contributors. U.S. medical eligibility criteria for contraceptive use, 2024. *MMWR Recomm Rep*. 2024;73(4):1-126, and Centers for Disease Control and Prevention (CDC). U.S. Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR Recomm Rep*. 2010;59(RR-4):1-86.

eTABLE C

Recommendations for Contraception Use in People Who Miss Doses or Experience Vomiting or Severe Diarrhea

Contraceptive	Duration since last dose	Recommendation	Transition to next cycle	Backup method	Emergency method
Combined oral contraceptives	< 48 hours and one missed pill	Take the late or missed pill as soon as possible; this is not needed in cases of vomiting or diarrhea	Take the remaining pills at the usual time each day (this may require taking 2 pills on the first day)	None	Not usually needed*
	≥ 48 hours and two or more missed pills	Take the most recent missed pill as soon as possible; other missed pills should be discarded For cases of vomiting or severe diarrhea, take the next pill as soon as tolerated	Take the remaining pills at the usual time each day (this may require taking 2 pills on the first day)†	7 consecutive days (without vomiting or severe diarrhea)	If appropriate‡
Combined hormonal patch (delayed application or detachment)	< 48 hours	Apply a new patch as soon as possible	Keep the same patch-changing day	None	Not usually needed*
	≥ 48 hours	Apply a new patch as soon as possible	Keep the same patch-changing day†	7 consecutive days	If appropriate‡
Combined vaginal ring (delayed insertion of a new ring or reinsertion of a current ring)	< 48 hours	Insert ring as soon as possible	Keep the ring in until scheduled removal day	None	Not usually needed*
	≥ 48 hours	Insert ring as soon as possible	Keep the ring in until scheduled removal day†	7 consecutive days	If appropriate‡
Injectables (ie, Depot medoxyprogresterone acetate)	< 2 weeks (< 15 weeks after previous injection)	Proceed with injection	Subsequent injection in 13 weeks (retime schedule from new injection)	None	None
	≥ 2 weeks	Treat as new start	—	7 consecutive days	Consider

continues ➤

*—Consider using an emergency method if combined hormonal contraceptives were missed earlier in the cycle or in the last week of the previous cycle.
†—If a dose is missed in the last week of the cycle (days 15-21 of a 28-day pill pack, or week 3 of the patch or ring), omit the hormone-free interval and start the next cycle. If method is unavailable, use backup method until the regular method has been restarted for 7 days.
‡—An emergency method is more likely to be needed if a dose is missed during the first week and unprotected intercourse had occurred in the previous 5 days. There are nuanced recommendations for ulipristal acetate.[7]

eTABLE C (continued)

Recommendations for Contraception Use in People Who Miss Doses or Experience Vomiting or Severe Diarrhea

Contraceptive	Duration since last dose	Recommendation	Transition to next cycle	Backup method	Emergency method
Progestin-only pill					
Norethindrone or norgestrel	> 3 hours past recommended dose (ie, > 27 hours since last dose) or vomiting or severe diarrhea within 3 hours of dose	Take one pill as soon as possible	Take the remaining pills at the usual time each day (this may require taking two pills on the first day)	2 consecutive days (without vomiting or severe diarrhea)	Consider if recent unprotected intercourse
Drospirenone (Slynd)	< 48 hours	Take the late or missed pill as soon as possible	Take the remaining pills at the usual time each day	None	Not usually needed
	≥ 48 hours (or ≥ 24 hours with vomiting or severe diarrhea)	Take the last missed pill as soon as possible	Take the remaining pills at the usual time each day	7 days	If appropriate‡

*—Consider using an emergency method if combined hormonal contraceptives were missed earlier in the cycle or in the last week of the previous cycle.
†—If a dose is missed in the last week of the cycle (days 15-21 of a 28-day pill pack, or week 3 of the patch or ring), omit the hormone-free interval and start the next cycle. If method is unavailable, use backup method until the regular method has been restarted for 7 days.
‡—An emergency method is more likely to be needed if a dose is missed during the first week and unprotected intercourse had occurred in the previous 5 days. There are nuanced recommendations for ulipristal acetate.[7]

Adapted with permission from Klein DA, Arnold JJ, Reese ES. Provision of contraception: key recommendations from the CDC. *Am Fam Physician*. 2015;91(9):629, with additional information from Curtis KM, Nguyen AT, Tepper NK, et al. Contributors. U.S. selected practice recommendations for contraceptive use, 2024. *MMWR Recomm Rep*. 2024; 73(3):1-77.

eTABLE D

Select Performance Measures and Quality Improvement Targets for Sexual and Reproductive Health Care

Quality measure	Comments and examples
Contraceptive services	
☐ Offer a full range of contraceptive methods*†	Improve access to long-acting contraceptives (eg, same-day services, in postpartum time frames) or bridge method with warm handoff; availability of on-site pregnancy testing
☐ Provide a 1-year supply of short-acting or injectable contraceptives	Minimize frequency of refills (insurance coverage may guide)
☐ Offer advance provision of emergency contraception	Levonorgestrel-based emergency contraception (Plan B) or ulipristal (Ella) methods
☐ Have emergency contraceptives onsite	Levonorgestrel-based emergency contraception (Plan B) or ulipristal (Ella) methods
☐ Provide education on over-the-counter access to oral contraceptives	May be particularly helpful for people who have limited access to care or confidentiality concerns
☐ Offer free condoms	Educate on practical condom use and partner negotiation skills
STIs	
☐ STI screening and treatment†‡	Include self-swab options; test extragenital sites when indicated; have treatment options onsite
☐ Expedited partner therapy	Chlamydia; gonorrhea with caveats (legal in many states)
☐ Offer preexposure prophylaxis for HIV and STIs	Based on Centers for Disease Control and Prevention guidance, which now includes recommendations for doxycycline postexposure prophylaxis for STIs
☐ Offer nonoccupational postexposure prophylaxis for HIV	Based on Centers for Disease Control and Prevention guidance, which now includes recommendations for doxycycline postexposure prophylaxis for STIs
☐ Offer immunization services†‡	Hepatitis A and B virus, human papillomavirus, and Mpox virus

continues ➤

Note: Services may depend on local needs, facility capacity, and the legal and regulatory environment. Federal conscience laws protect clinicians who refuse to participate on religious or moral grounds. Validated performance measures are suitable for public reporting; unvalidated measures can enable local quality improvement activities.

FDA = US Food and Drug Administration; PFLAG = Parents, Families, Friends, and Allies United with LGBTQ People; STI = sexually transmitted infection.

*—More information is available from the University of California San Francisco at https://pcrhp.ucsf.edu/performance-measures.
†— More information is available from Partnership for Quality Measurement at https://p4qm.org/measures.
‡— More information is available from the National Committee for Quality Assurance at https://www.ncqa.org/hedis/measures.
§—More information from the Centers for Medicare and Medicaid Services is available at https://p4qm.org/measures.

eTABLE D (continued)

Select Performance Measures and Quality Improvement Targets for Sexual and Reproductive Health Care

Quality measure	Comments and examples
Related services or referrals	
☐ Sexual violence or coercion screening and management	Sexual- and gender-based violence, intimate partner violence, and human trafficking
☐ Pregnancy-related care	Ensure quality ante-, intra-, and postpartum care
☐ Preconception care	Include nutrition counseling, folic acid supplementation, management of chronic medical and mental health conditions, avoidance of problematic drugs/medications
☐ Family building care	Include infertility evaluations, ovulation predictor kits, medically-assisted reproduction, adoption, fostering, and surrogacy options
☐ Pregnancy options counseling	Offer options based on patient desires (ie, parenting, abortion, or adoption)
☐ Cancer screening†	Breast, cervix, anus, and oropharynx
☐ Care for sexual or gender-diverse people	Offer gender-affirming care and support resources, such as the LGBT National Help Center, PFLAG, Trans Lifeline, or the Trevor Project
☐ Perimenopause care	Lifestyle and hormone therapy or nonhormonal options
☐ Care to improve sexual function	—
☐ Discuss safe internet and social media use	—
☐ Discuss principles of sexual consent	Healthy relationships, and safe and pleasurable sexual practices
☐ Mental health and substance use care†§	—

continues ➤

Note: Services may depend on local needs, facility capacity, and the legal and regulatory environment. Federal conscience laws protect clinicians who refuse to participate on religious or moral grounds. Validated performance measures are suitable for public reporting; unvalidated measures can enable local quality improvement activities.

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eTABLE D (continued)

Select Performance Measures and Quality Improvement Targets for Sexual and Reproductive Health Care

Quality measure	Comments and examples
Access to services	
☐ Identify contraceptive or pregnancy prevention needs*	In postpartum and nonpostpartum settings
☐ Offer telehealth services	Self-administered subcutaneous depot medroxyprogesterone acetate, 104 mg; fertility awareness apps approved by the FDA
☐ Offer walk-in sexual and reproductive health appointments and expanded appointment times	—
☐ Establish relationships with referral networks	Know what services can be provided for different needs and timelines for those services
Person-centered services	
☐ Provide person-centered contraceptive counseling*†	Focus on the person's unique values, preferences, and circumstances without judgement
☐ Assure confidentiality	In the context of state minor consent and confidentiality laws
☐ Implement trauma-informed principles	Assume trauma exposure; emphasize autonomy and safety; offer a support person during examinations; build rapport by asking how the person would like to be supported, discussing person-centered goals, giving reassurance that the patient is in control, explaining examination steps, gaining permission, stopping immediately if asked, and confirming documentation preferences
☐ Assess personal biases (clinician and staff)	Educate and train, encourage courteous interactions
☐ Offer language/translation services	Ensure access to qualified language service providers

Note: Services may depend on local needs, facility capacity, and the legal and regulatory environment. Federal conscience laws protect clinicians who refuse to participate on religious or moral grounds. Validated performance measures are suitable for public reporting; unvalidated measures can enable local quality improvement activities.

FDA = US Food and Drug Administration; PFLAG = Parents, Families, Friends, and Allies United with LGBTQ People; STI = sexually transmitted infection.

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§—More information from the Centers for Medicare and Medicaid Services is available at https://p4qm.org/measures.

Information from:

Manzer JL, Carrillo-Perez A, Tingey L, et al. Client perspectives on contraceptive care: a systematic review. *Am J Prev Med*. 2024;67(6S):S22-S31.

Romer SE, Blum J, Borrero S, et al. Providing quality family planning services in the United States: recommendations of the U.S. Office of Population Affairs (revised 2024). *Am J Prev Med*. 2024;67(6S):S41-S86.

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eFIGURE A

Birth Control Methods Chart

RHNTC REPRODUCTIVE HEALTH NATIONAL TRAINING CENTER

Designed for providers to help clients consider their birth control options, this chart takes client autonomy into account and presents methods that clients can start and stop on their own and those that require provider involvement (prescription or procedure). The chart highlights method characteristics, including use & frequency, so clients can make informed decisions, based on their own preferences. Note: Within each table, the methods are listed in order of number of pregnancies expected, and side effects are alphabetized within each method. Not all risks and benefits for each method are included on this chart.

CLIENTS CAN START AND STOP ON THEIR OWN

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Fertility Awareness-based (FAB)	2–23 out of 100 (depends on specific FAB method)	Client tracks signs of fertility daily and abstains from sex on fertile days.	None	None	Must have regular cycles and be comfortable tracking basal body temperature and cervical mucus.
Pill (progestin-only), Opill	7 out of 100	Client takes by mouth same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Available OTC. Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.
Condom (external)	13 out of 100	Client rolls onto erect penis (external) every time has sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Spermicide or vaginal sponge	21–28 (spermicide alone) or 17 (sponge w/ spermicide) out of 100	Client inserts into vagina before penile-vaginal sex every time.	None	Vaginal irritation	Pair with another method for back-up.
Condom (internal)	21 out of 100	Client inserts into vagina (internal) every time has sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Withdrawal	25 out of 100	Partner with penis ejaculates outside of and away from vagina.	None	None	Requires a cooperative partner.

REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—*CONTINUED ON OTHER SIDE*

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Shot (IM/SC) progestin-only	4 out of 100	Provider administers shot (IM), or the client self-administers shot (SC) every 12–15 weeks.	Spotting, lighter period, or no period	Bone density loss, headache, weight gain	Delay in fertility return. Not visible to others.
Patch (transdermal system estrogen + progestin)	7 out of 100	Client places patch on back, butt, or belly. Every month, changes patch weekly for 3 weeks and no patch for 1 week.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, skin irritation, stomach pain	May be less effective in people with a BMI of 30 or over. Extended/continuous use option.*
Pill (combined estrogen + progestin)	7 out of 100	Client takes by mouth daily.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, risk for blood clots	May reduce acne, cramping, and PMS. Routine blood pressure checks recommended. Extended/continuous use option.
Ring (estrogen + progestin)	7 out of 100	Client places ring into vagina. Every month, keeps ring in vagina for 3 weeks and then removes for 1 week.	Lighter period or temporary spotting	Breast tenderness, nausea	Two types: monthly and yearly. May reduce acne, cramping, and PMS. Not visible but can be felt by partners.
Pill (progestin-only, "the mini pill")	7 out of 100	Client takes by mouth at the same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.

continues ➤

Birth control methods chart.

Note: Methods are listed in order by lowest pregnancy risk, and side effects are alphabetized within each method.

eFIGURE A (continued)

REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—*CONTINUED*

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Diaphragm or cervical cap (both w/spermicide) 	17 (diaphragm) and 22–23 (cap) out of 100	Client inserts into vagina with spermicide before every instance of penile-vaginal sex.	None	Allergic reactions, UTI, vaginal irritation	Same device may be used for two years.
Vaginal contraceptive gel (Phexxi) 	28 out of 100	Client inserts into vagina before each act of penile-vaginal sex.	None	Allergic reactions, UTI, vaginal irritation	May act as lubricant for dryness.

REQUIRES PROVIDER FOR CLIENTS TO START AND STOP (REVERSIBLE METHODS)

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Implant (progestin-only)	<1 out of 100	Provider inserts rod under skin in upper arm. Lasts up to 5 years* and can be removed earlier.	Unpredictable spotting, lighter period, or no period	Acne, depressed mood, headache, mood swings, weight gain	Mild pain with placement. Not visible but can be felt by partners.
Levonorgestrel IUD (progestin-only) 	<1 out of 100	Provider inserts device into uterus. Varies by type, up to 8 years, and can be removed earlier.	Spotting, lighter period, or no period	Cramping pain with placement	Not visible but can be felt by partners.
Non-hormonal copper IUD 	<1 out of 100	Provider inserts device into uterus. Lasts up to 12 years* and can be removed earlier.	Spotting or heavier period	Cramping pain with placement	Effective as EC within 5 days* of unprotected sex. Not visible but can be felt by partners.

REQUIRES PROVIDER TO PERFORM PROCEDURE (PERMANENT METHODS)

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Tubal ligation 	<1 out of 100	Single surgical procedure done at a hospital.	None	Bleeding, surgical pain	Requires anesthesia and up to 2 weeks of recovery.
Vasectomy 	<1 out of 100	Single outpatient surgical procedure.	NA	Bleeding, surgical pain	Up to 2 days for recovery.

EMERGENCY CONTRACEPTION (EC)

Method	Number of Pregnancies Expected[1]	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Non-hormonal copper IUD* 	<1 out of 100	Provider inserts device into uterus within 5 days of unprotected sex.	Spotting or heavier period	Cramping pain with placement	Lasts up to 12 years* and can be removed earlier.
Ulipristal acetate (ella) 	7 out of 10 who would have become pregnant will not	Client takes by mouth as soon as possible within 5 days of unprotected sex.	Spotting or period at new time	Abdominal pain, dizziness, headache, nausea	Requires prescription. May be less effective in people over 194 pounds.
Levonorgestrel 1.5mg pill (Plan B) 	7 out of 8 who would have become pregnant will not	Client takes by mouth within 120 hours (~5 days)* of unprotected sex.	May induce spotting or period	Breast tenderness, dizziness, headache, nausea, stomach pain, tiredness, vomiting	Available OTC. May be less effective in people over 165 pounds.

*Use of this product for an extended duration has not been approved by FDA. Use of the non-hormonal copper IUD for EC has not been approved by FDA. Cason P, Cwiak C, Edelment A, et al.[Eds.] Contraceptive Technology. 22nd edition. Burlington, MA:Jones-Bartlett Learning, 2023.

[1]Data is drawn from Bradley SEK, et al., Effectiveness, safety, and comparative side effects. In: Cason P, Cwiak C, Edelment A, et al. [Eds.] Contraceptive Technology. 22nd edition. Burlington, MA: Jones-Bartlett Learning, 2023. For more information, check the product insert.

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Birth control methods chart.

Note: Methods are listed in order by lowest pregnancy risk, and side effects are alphabetized within each method.