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Removing medical barriers to contraception — evidence-based recommendations from the Centers for Disease Control and Prevention, 2016☆

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Good news! For the first time in three decades, the unintended pregnancy rate in the United States has dropped — from over 50% during 1981–2008 to 45% between 2008 and 2011 [1]. The US teen pregnancy rate has been falling for some time and is at a historic low [2]. At the same time, overall contraceptive use in the United States has remained fairly steady at about 60% among all females ages 15–44 years, but recently, use of the most effective, long-acting, reversible methods (LARCs) — intrauterine devices (IUDs) and implants — has been increasing [3–5]. Several large projects, including the Contraceptive Choice Project, family planning initiatives in Colorado and Iowa, and a randomized cluster trial of a clinical training intervention, have demonstrated success in increasing the use of contraception overall, including the most effective methods, and most importantly, decreasing unintended pregnancy and abortion rates [6–9]. Finally, the Affordable Care Act requires most health plans to cover certain preventive services for women, including contraceptive methods and counseling [10,11].

It is within this context that the Centers for Disease Control and Prevention (CDC) has updated its evidence-based recommendations for health care providers on contraceptive use — *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016* (US MEC) and *U.S. Selected Practice Recommendations for Contraceptive Use, 2016* (US SPR) [12,13]. Providers are able to offer women, men and couples more safe and effective choices for contraception than ever before. With these expanded options comes the need for evidence-based guidance to help health care providers offer quality family planning care to their patients, including choosing the most appropriate contraceptive method for individual circumstances and using that method correctly, consistently and continuously to maximize effectiveness [12,13]. Evidence-based guidance can also support removal of unnecessary medical barriers to access and successful use of contraceptive methods. Barriers to choosing the optimal contraceptive method can include unnecessary restrictions based on age, parity or presence of a medical condition. Barriers to initiating and continuing contraceptive

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methods impede successful use and include unnecessary screening examinations and tests before starting a method (e.g., a pelvic examination before initiation of combined oral contraceptives), inability to receive contraception on the same day as the visit (e.g., waiting for test results that may not be needed or waiting until the woman's next menstrual cycle to start contraceptive use) and difficulty obtaining continued contraceptive supplies (e.g., requiring unnecessary follow-up visits and restrictions on number of pill packs dispensed at one time) [13].

Based on global guidance from the World Health Organization [14,15], CDC published the first US MEC in 2010 followed by the US SPR in 2013 [16,17]. Since then, these recommendations have been included in the clinical recommendations for the Title X Family Planning Program [18], endorsed by the American College of Obstetricians and Gynecologists [19,20] and disseminated widely to women's health, adolescent and primary care providers. CDC committed to updating the guidance on a regular basis, incorporating new evidence and adding new recommendations to respond to provider needs [16,17].

During 2015–2016, CDC conducted a formal process to revise and update these recommendations, and this issue of *Contraception* contains many of the systematic reviews on which the new guidance is based [21–33]. New recommendations on the safe use of contraceptive methods were added to the US MEC for women with multiple sclerosis and cystic fibrosis and for those using certain psychotropic drugs or St. John's wort. The emergency contraception recommendations were revised, including the addition of ulipristal acetate. CDC also reviewed new evidence and revised recommendations for postpartum women; women who are breastfeeding; women with known dyslipidemias, migraine headaches, superficial venous disease, gestational trophoblastic disease, sexually transmitted diseases and human immunodeficiency virus; and women receiving antiretroviral therapy. In the US SPR, CDC added recommendations on medications to ease IUD insertion and revised recommendations for starting regular contraception after the use of emergency contraception. During this process, CDC identified gaps in the evidence, with the goal of encouraging investigation that can lead to further refinement of the recommendations. A commentary on these research gaps is also included in this issue of *Contraception* [34]. Finally, CDC has developed and updated provider tools that can assist with implementation of the recommendations in practice, including summary charts for both the US MEC and US SPR, a US MEC wheel and an updated electronic app that includes both the US MEC and US SPR recommendations [35].

While recommendations have been updated and will continue to be modified as supported by new evidence, the main messages in the guidance remain the same [12,13]. Most women — including adolescents, those who are postpartum and those with certain medical conditions or other specific characteristics — can safely use most methods of contraception. Most women can start contraceptive methods on the day they request them, and few, if any, tests or examinations are needed before initiating any method. Routine follow-up for most women after starting a contraceptive method includes assessment of her satisfaction with the method, concerns about the method and changes in medical eligibility for continued use. All women, men and couples seeking contraception should have access to the full range of contraceptive methods and counseling and support to use their chosen method successfully.

While exciting progress has been made in reducing unintended pregnancy in the United States, unnecessary barriers to contraception access and use remain. The US MEC and US SPR can help providers continue to remove medical barriers, as they work with patients to choose and use contraception successfully, enabling continued declines in unintended and teen pregnancy.

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