CDC Contraception Guidance:

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

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

Antoinette T. Nguyen, MD, MPH, FACOG

Senior Medical Officer

Division of Reproductive Health

21 May 2024

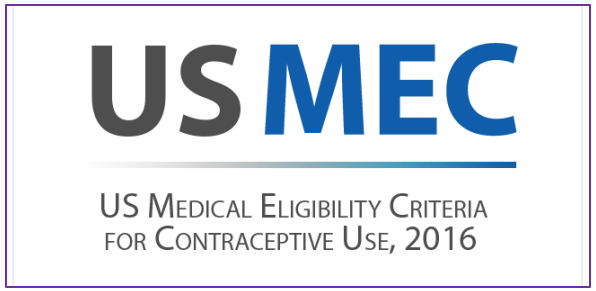
2024 NFPRHA National Conference

Disclosures

The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

I have no conflicts of interest to disclose.

CDC Contraception Guidance



The 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

Resource

2016 US Medical Eligibility Criteria for Contraceptive Use (US MEC)

The 2016 US Medical Eligibility Criteria for Contraceptive Use (US MEC) gives recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions. The recommendations in this report are intended to assist health care providers when they counsel women, men, and couples about contraceptive method choice.

Recommendations about the use of hormonal contraceptive methods (including depot medroxyprogesterone acetate) and intrauterine devices among women at high risk for HIV were updated in April 2020. These were published in the MMWR.

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

Resource

2016 US Selected Practice Recommendations for Contraceptive Use (US SPR)

The 2016 US Selected Practice Recommendations for Contraceptive Use (US SPR) addresses some common issues experienced when starting and using certain contraceptive methods. The recommendations in this report are intended to serve as a source of clinical guidance for health care providers and provide evidence-based guidance to reduce medical barriers to contraception access and use.

CDC added a new recommendation on the self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) in May 2021. This was published in the MMWR.

Quality Family Planning

Providing Quality Family Planning Services (QFP) recommends how to provide family planning services so that people can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.

RELATED PAGES

Providing Quality Family Planning Services

eBook: U.S. Selected Practice Recommendations for Contraceptive Us...

Contraception App

Health Care Providers and Adolescent Sexual and Reproductive Health

Unintended Pregnancy

TOPIC
Reproductive Health

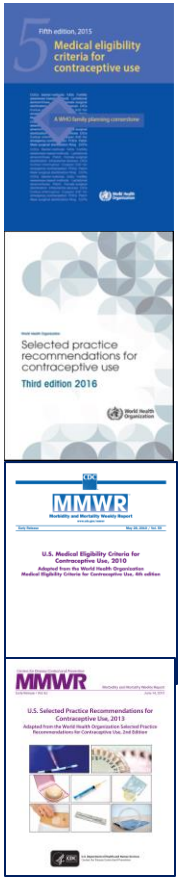
BACK TO TOP

https://www.cdc.gov/reproductive-health/hcp/contraception-guidance/

Improving Contraception Access: Clinical Practice Guidelines

- **Evidence-based clinical guidance for health care providers**
- **Remove unnecessary medical barriers to accessing and using contraception**
- **Support the provision of person-centered contraceptive counseling and services**
  - Reproductive autonomy
  - Shared decision making

History



- **World Health Organization (WHO) global recommendations**
  - First MEC published in 1996, with CDC technical assistance
  - First SPR published in 2001, with CDC technical assistance
  - Currently, MEC 5th edition (2015) and SPR 3rd edition (2016)
- **2010: US MEC first adapted from WHO**
- **2013: US SPR first adapted from WHO**
- **2016: US MEC and US SPR update**
- **Interim updates**
  - 2017/2020: update of US MEC recommendation for women at high risk of HIV
  - 2021: new US SPR recommendation on self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC)

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

- **Clinical guidance for safe use of contraceptive methods by medical conditions and characteristics**
- **> 1800 recommendations for > 60 conditions and characteristics, e.g.**
  - Is it safe for a patient with hypertension to use combined oral contraceptives?
  - Is it safe for an adolescent to use an intrauterine device (IUD)?

US MEC

US Medical Eligibility Criteria for Contraceptive Use, 2016

US MEC 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 – not usually recommended unless more appropriate methods are not available or acceptable.
4	A condition that represents an unacceptable health risk if the contraceptive method is used.

US MEC, 2016

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***		**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.

US MEC, 2016

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

- **Clinical guidance that address provision of contraception, management of side effects, and issues related to contraceptive method use, e.g.**
  - How to be reasonably certain that a person is not pregnant
  - When to start a specific method
  - What exams and tests are needed
  - What follow-up is needed
  - How to manage bleeding irregularities and other problems
  - How many pill packs to provide

US SPR

US Selected Practice Recommendations for Contraceptive Use, 2016

US SPR: How to be reasonably certain a person is not pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

US SPR, 2016

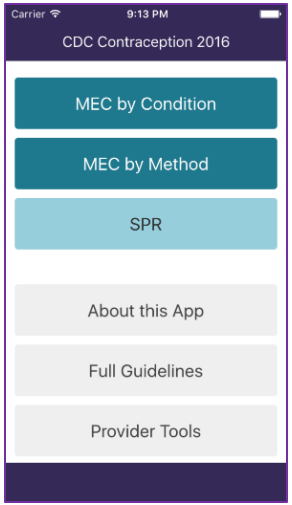
US SPR: When to start using specific contraceptive methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back up) needed	Examinations or tests needed before initiation[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

US SPR, 2016

How the guidance is used

- Title X family planning guidelines
- Endorsed by professional organizations
- Used by service delivery organizations
- Training
- US MEC/SPR app: downloaded over 440,000 times
- Champions



US MEC/SPR Update

US MEC/SPR update process (2022-2024)

- **Determine the scope of the update**
  - Public input through Federal Register Notice
- **Convene scoping meeting with subject matter experts (SMEs) to gather individual input on potential updates**
- **Update existing and conduct new systematic reviews**
  - Plan to publish in peer-reviewed journals
- **Conduct patient engagement listening sessions**
- **Convene meeting with SMEs to gather individual input on the evidence and recommendations**
- **CDC determines the final recommendations**
  - Publication of updated US MEC and US SPR in Morbidity and Mortality Weekly Reports (MMWR)

US MEC/SPR: General revisions

- **Increased emphasis on person-centered contraceptive counseling and provision**
- **Use of gender-inclusive language**
- **Updated terminology for certain conditions, e.g.**
  - Thrombophilia and hematologic conditions
  - Subcategories for cirrhosis and solid organ transplantation

US MEC: New recommendations

- Addition of **chronic kidney disease**
  - Nephrotic syndrome
  - Hemodialysis
  - Peritoneal dialysis

- Inclusion of **additional contraceptive methods**
  - New formulations of combined pills, patches and vaginal rings
  - New formulations of progestin only pills
  - New dose of progestin intrauterine device (IUD)
  - Vaginal pH modulator

US MEC: Updated recommendations

- Postpartum
- Post-abortion: first trimester medication abortion with mifepristone
- DVT/PE: on anticoagulation therapy
- Systemic lupus erythematous (SLE): positive or unknown antibodies
- Cirrhosis
- Liver tumors: hepatocellular adenoma
- Sickle cell disease
- Solid organ transplant
- High risk for HIV
- Additional conditions with increased risk of thrombosis (e.g., major surgery with prolonged immobilization, thrombophilia, superficial venous thrombosis, valvular heart disease, peripartum cardiomyopathy)

US MEC: Take-home messages

- **US MEC can help providers remove unnecessary medical barriers to accessing and using contraception**
- **Most people can safely use most contraceptive methods**
- **Contraceptive counseling and services should be offered in a non-coercive manner that honors a person's values, goals, and reproductive autonomy through a shared decision-making process with providers**
- **When applying US MEC classifications, providers should discuss the risks of a particular contraceptive method as well as the health risks associated with pregnancy**

US SPR: Updates

- **New recommendations**
  - Testosterone use and risk of pregnancy among transgender, gender diverse, and non-binary persons with a uterus
  - Self-administration of subcutaneous injectable contraception

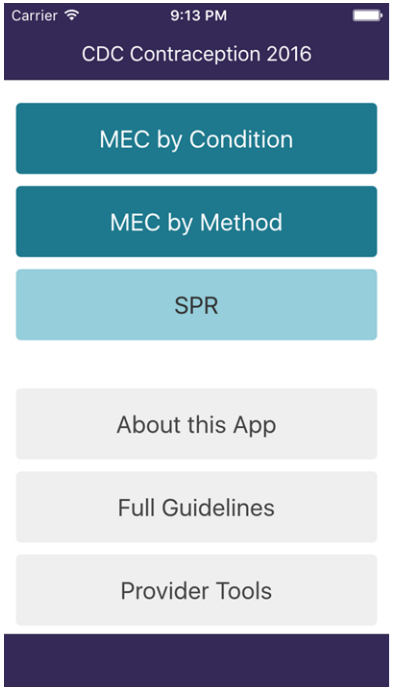
- **Updated recommendations**
  - Provision of medications for IUD placement
  - Bleeding irregularities during implant use

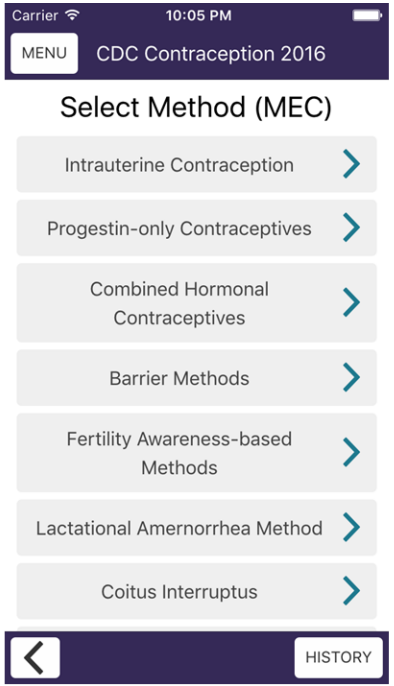
- **Changes to align with updates to US MEC 2024**

US SPR: Take-home messages

- US SPR can help providers decrease medical barriers to initiating and using contraception
- Most people can start most contraceptive methods at any time
- Few, if any, exams or tests are needed
- Routine follow-up generally not required
- Recommendations for person-centered counseling and management of potential issues with contraceptive initiation and continuation

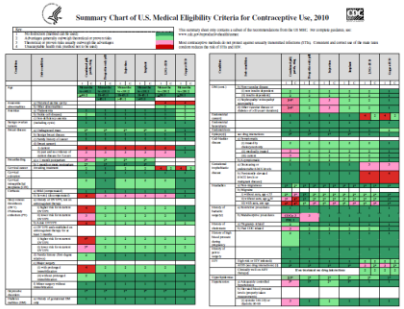
US MEC/SPR App

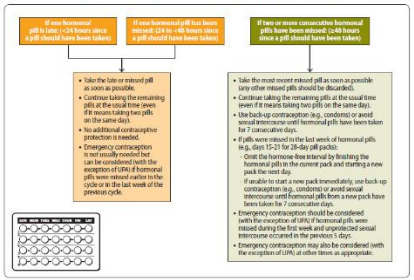


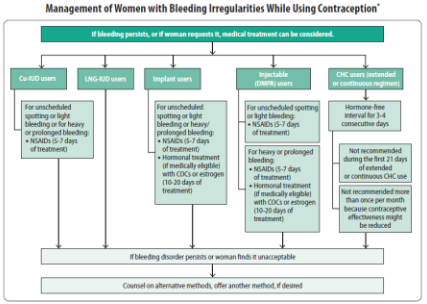


Additional US MEC/SPR provider tools

- **US MEC summary table (English, Spanish)**
- **US SPR quick reference charts**
  - When to start contraceptive methods and routine follow up
  - What to do if late, missed or delayed CHC or POP
  - Management of IUD when PID is found
  - Management of bleeding irregularities while using contraception







Online access

- https://www.cdc.gov/reproductive-health/hcp/contraception-guidance/

The 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

Resource

2016 US Medical Eligibility Criteria for Contraceptive Use (US MEC)

The 2016 US Medical Eligibility Criteria for Contraceptive Use (US MEC) gives recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions. The recommendations in this report are intended to assist health care providers when they counsel women, men, and couples about contraceptive method choice.

Recommendations about the use of hormonal contraceptive methods (including depot medroxyprogesterone acetate) and intrauterine devices among women at high risk for HIV were updated in April 2020. These were published in the MMWR.

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

Resource

2016 US Selected Practice Recommendations for Contraceptive Use (US SPR)

The 2016 US Selected Practice Recommendations for Contraceptive Use (US SPR) addresses some common issues experienced when starting and using certain contraceptive methods. The recommendations in this report are intended to serve as a source of clinical guidance for health care providers and provide evidence-based guidance to reduce medical barriers to contraception access and use.

CDC added a new recommendation on the self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) in May 2021. This was published in the MMWR.

Quality Family Planning

Providing Quality Family Planning Services (QFP) recommends how to provide family planning services so that people can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.

Dissemination and implementation

2024 US MEC and US SPR will be published in late summer

- Broad and diverse set of partners
- Update and disseminate provider tools and app
- Meeting and conference presentations
- Publications and other outreach

US MEC
US SPR

Antoinette Nguyen, MD, MPH
oms6@cdc.gov

CDC, Division of Reproductive Health
CDC Contraceptive Guidance for Health Care Providers | Reproductive Health | CDC

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 cdc.gov