Proportion of Women Using Contraceptive Method

Proportion of women with unmet need for family planning is as high as 50% by country.

Contraceptive Prevalence & Maternal Deaths

Effect of Unmet Need for Contraception


Unintended, despite method used

49%

Intended

Unintended, no method used

6.4 Million U.S. Pregnancies Annually

Objectives

• Inspire you to prioritize patient-centered contraceptive counseling and provision in your practice

• Make you comfortable using CDC Medical Eligibility Criteria and Selected Practice Recommendations

![Image](image.jpg)

Are you familiar with the US Medical Eligibility Criteria for Contraception?

a. Yes

b. No
Are you familiar with the US Selected Practice Recommendations for Contraception?

a. Yes
b. No

Case #1

A 35 year-old woman comes to you for contraception counseling. She has a h/o a DVT and is not on anticoagulation.

Can my patient use this method?

**US Medical Eligibility Criteria (MEC)**

<table>
<thead>
<tr>
<th>MEC Category</th>
<th>Condition</th>
<th>Contraception Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can use the method</td>
<td>No restrictions</td>
</tr>
<tr>
<td>2</td>
<td>Can use the method</td>
<td>Advantages generally outweigh theoretical or proven risks.</td>
</tr>
<tr>
<td>3</td>
<td>Should not use method unless no other method is appropriate</td>
<td>Theoretical or proven risks generally outweigh advantages</td>
</tr>
<tr>
<td>4</td>
<td>Should not use method</td>
<td>Unacceptable health risk</td>
</tr>
</tbody>
</table>
2016 CDC Updates

- Added Cystic Fibrosis
- Removed “Increased risk of STI”
- Added subconditions
  - Postpartum
  - Gestational Trophoblastic Disease
- Added medications
  - SSRIs
- Simplifications
  - Migraines
  - Antiretroviral therapy

Where do you find the US MEC?
Case #1

After counseling she desires the contraceptive implant. She would like you to place it today.

For each method... how to use?

- When to start – “anytime if reasonably sure that she is not pregnant”
- How long to use backup
- Special considerations – explain recommendations by MEC
- Missed or late doses

“Reasonably Sure Not Pregnant”

D01. How To Be Reasonably Certain that a Woman 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:

- In 157 days after the start of usual menses
- Has not had sexual intercourse since the start of last normal menses
- Has been accurately and consistently using a reliable method of contraception
- Is 47 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 breastfeeding), unpromoted, and of months postpartum

With exception of IUD – can start and do pregnancy test in 2-4 weeks

Case #1

You review the SPR guidelines and decide it is safe to insert today.
Case #2

A 32 yo G3P1T2 presents asking for birth control. She has used the pill before, liked it, and wants it again. She was using the pill the two times she became pregnant and had abortions.

What is the best approach to contraceptive decision making?

1. Encourage women to choose the most highly effective methods
2. Give them information about all methods and let them decide for themselves
3. Give them whichever method they say they want
4. I don’t know – I just wing it every time
# Natural Family Planning

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perfect Use</td>
<td>Typical Use</td>
</tr>
<tr>
<td>No Method</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>4%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Fertility awareness-based methods</td>
<td>5%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Standard Days Method**</td>
<td>3%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Ovulation Method</td>
<td>&lt;1%</td>
<td>13-20%</td>
<td></td>
</tr>
<tr>
<td>Symptothermal</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Including Cycle Beads

---

# Barrier Methods

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perfect Use</td>
<td>Typical Use</td>
</tr>
<tr>
<td>Condoms</td>
<td>2%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Cervical Cap (parous/nullip)</td>
<td>26%/9%</td>
<td>32%/16%</td>
<td></td>
</tr>
<tr>
<td>Sponge (parous/nullip)</td>
<td>20%/9%</td>
<td>24%/12%</td>
<td></td>
</tr>
<tr>
<td>Female Condoms</td>
<td>5%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6%</td>
<td>1.2%</td>
<td></td>
</tr>
</tbody>
</table>

---

# Hormonal Methods

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Failure Rate</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Progestin-only Pills</td>
<td>0.3%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Combined Pill/Patch/Ring</td>
<td>0.3%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>1-month Injection</td>
<td>0.25%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>3-Month Injection</td>
<td>0.2%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>0.05%</td>
<td>0.05%</td>
<td></td>
</tr>
<tr>
<td>LNG IUD</td>
<td>0.2%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Copper IUD</td>
<td>0.8%</td>
<td>0.6%</td>
<td></td>
</tr>
</tbody>
</table>

---

# Differences in Effectiveness

Number of women pregnant in 1 year out of 1,000
What evidence is there that contraceptive counseling matters?
- Counseling influences method selection
- Positive provider relationship higher satisfaction
- Satisfaction with care associated with contraception
- Quality of care correlated with continuation

Forrest, Fam Plann Perspect, 1996.

Shared Decision Making in Family Planning
- SDM improves outcomes (n=348)
- Women want SDM in contraception counseling
- Establishing rapport
  - Increased continuation at six months (AOR 2.3, 95% CI 1.2 - 4.3)
- Eliciting patient perspective during visit:
  - Increased continuation at six months (AOR 1.8, 95% CI 1.0 - 3.2)

Dehlendorf, AJOG, 2016.

Provider Preference Decreases Use
- Provider expressing a preference
  - Lower likelihood of being satisfied with method
    - (56% vs. 67%, p=.02)
- Choosing method that provider recommended associated with:
  - Less satisfaction with method
    - (45% vs. 64%, p=.004)
  - Lower chance of starting method
    - (66% vs. 81%, p=.05)

Dehlendorf, AJOG, 2016.
How do we feel about women not having efficacy be their first priority?

- Conflict between public health and woman-centered perspective
- Requires clarity on feelings about:
  - Pregnancy ambivalence
  - Unintended pregnancy
  - Abortion

Women of Color Counseled Differently

- Women of color are more likely to be report being dissatisfied with their family planning provider
- Women of color and low-income women are more likely to report:
  - Being pressured to use a birth control method
  - Limit their family size
- Disparities in IUD recommendations
  - RCT of standardized patients

RCT: IUD Standardized Patients

Percent of Providers Recommending IUC to Women, Stratified by Patient SES and Race/Ethnicity (n=173)

Among low SES women – Blacks and Latinas more likely.
Contraceptive Counseling

- Preference-sensitive decision
- Patient-centered care
- Respect diverse priorities, concerns, experiences
  - Control over method
  - Safety questions
  - Concern about or desire for side effects
  - Route and frequency of administration
  - Personal and friends'/family members' experiences
  - Convenience
  - Return to fertility
  - Efficacy

Contraceptive Counseling

- Develop awareness of your biases
- Engage in shared decision-making
- Establish rapport
- Questions to pose patients
  - Which method did you come today wanting to use?
  - Are you interested in one of the most effective? Convenient? What does convenient mean to you?
  - When – if ever – do you want a (another) child?
  - What method(s) have you used in the past?
  - What are you doing to protect yourself from STIs?
  - What side effects are you willing to accept or desire?

Don’t assume women know their options

- Provide context for different method characteristics
  - e.g. “There are methods you take once a day, once a week, once a month, or even less frequently. Is that something that makes a big difference to you?”
- Even if express strong interest in one, ask for permission to provide information about others

What about efficacy?

- Frequent misinformation or misconceptions about relative efficacy of methods
- Use natural frequencies:
  - Less than 1 in 100 women get pregnant on IUD
  - 9 in 100 women get pregnant on pill/patch/ring
- Can also emphasize relative numbers
  - Pill/patch/ring have 20 times failure than IUD
Sharing Decision Making

• Provide scaffolding for decision making
  ▫ Given their preferences, what info do they need?
  ▫ Actively facilitate, while avoiding stating opinions not based on patient preferences

Address Patient’s Concerns

• Provide evidence-based information about side effects of methods
  ▫ Proactively address patient concerns in a respectful manner

  “That’s too bad your friend had that experience. I haven’t heard of that before, and I can tell you it definitely doesn’t happen frequently. My guess is that if you were to use this method it would not happen to you.”

Wrapping Up

• Acknowledge the possibility of dissatisfaction with chosen method, and make a plan if that happens
• Discuss potential issues with adherence
• Allow opportunity for questions

Case #2

During counseling you discover that she wants to take a pill every day because of its convenience and because she can stop it any time. She also likes the effect on acne. How do you prescribe the pill?
Combined Oral Contraceptives

- Estrogen + progestin
- Traditional prescription flawed
  - Daily x 3 weeks / 1 week off
  - Extended cycle may efficacy

Extended Cycle: Shortened hormone-free week

- 23, 24 or 26 days hormones + 2-5 d placebo
  - Decreased ovarian activity at end of placebo
  - Shorter withdrawal bleeds
  - Similar breakthrough bleeding

- 24-day hormone pill - lower pregnancy rate
  - 6.7% vs. 4.7% over 3 years – HR 0.7 (CI 0.6-0.8)

- 3 FDA-approved products in US

Extended Cycle: Fewer Hormone-free Weeks

- 12 weeks hormone/1 week off
  - 84 days LNG 150 µg/EE 30 µg; 7 days placebo
  - Decreased breakthrough bleeding over time

- Continuous for one year
  - Increased spotting in first six months
  - Median 1.5 days spotting in last trimester

- FDA-approved continuous: EE and LNG
  - 90 mcg levonorgestrel + 20 mcg EE

Choosing a COC

- Careful with very low-dose estrogen – ↑ bleeding
- Monophasic fine
- Levonorgestrel may cause fewer VTE
- No clear benefit of drospirenone

**Shortened or erased placebo week if possible 30 or 35 mcg EE + levonorgestrel and monophasic

References:
Prescribing COCs

(Brand) one tab po daily
Dispense #84
3 refills
(4 refills if plans to take
continuously)

Obstacles to obtaining prescription contraception

Among women who had used or wanted to use a prescription contraceptive (N=725)

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>% reporting it as a problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long wait to get appointment</td>
<td>27%</td>
</tr>
<tr>
<td>Doctor office hours not convenient</td>
<td>23%</td>
</tr>
<tr>
<td>Doctor visit costs too much</td>
<td>20%</td>
</tr>
<tr>
<td>No time off from work or school</td>
<td>19%</td>
</tr>
<tr>
<td>Doctor visit takes a long time</td>
<td>17%</td>
</tr>
<tr>
<td>Didn’t want pelvic exam</td>
<td>12%</td>
</tr>
</tbody>
</table>

How comfortable are you with the idea of Over-the-Counter combined birth control pills?

a. Very comfortable
b. Somewhat comfortable
c. Somewhat uncomfortable
d. Very uncomfortable

Global OC prescription requirements

[Map image]
FDA criteria for prescription-to-OTC switch

<table>
<thead>
<tr>
<th>FDA criteria</th>
<th>Oral contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug has no significant toxicity if overdosed</td>
<td>True</td>
</tr>
<tr>
<td>Drug is not addictive</td>
<td>True</td>
</tr>
<tr>
<td>Users can self-diagnose conditions for appropriate use</td>
<td>Women determine if they are at risk of unintended pregnancy</td>
</tr>
<tr>
<td>Users can safely take the medication without a clinician’s screening</td>
<td>Research suggests that women can self-screen for contraindications without involving a clinician</td>
</tr>
<tr>
<td>Users can take the medication as indicated without a clinician’s explanation</td>
<td>Research suggests that continuation is similar/higher among women obtaining pills OTC compared to in a clinic</td>
</tr>
</tbody>
</table>

Where are we now?

- Considerable evidence base
  - Safety and effectiveness of OTC
  - Women’s demand for OTC
  - BTC status works
- No apparent risk of losing insurance coverage
- Decision to focus on POP
- No company moving forward

Case #2

She initiates the pill and leaves your office satisfied with her decision. You prescribe her 3 months at a time.

Case #3

23 yo G0 is interested in using intrauterine contraception. When she was in college, she had Chlamydia. She has had 3 male partners in the past year.
Every 3-10 Years: Intrauterine Devices

### Copper T 380A IUD – 10 years
- 0.8% failure (1 yr)

### Levonorgestrel IUDs
- **20 mcg/day (5 yr)**
- **18 mcg/day (5 yr)**
- **20 mcg/day (3 yr)**
  - Current approval for 3 yrs
  - Lower cost
  - Smaller: 14 mcg/day (3 yr)
- 0.2% failure (1 yr)

Smaller, 3-year LNG IUD

- Lower dose of progestin (14 mcg v. 20 mcg)
- Smaller size - 28mm x 30mm (v. 32mm x 32mm)
  - 3.8 mm diameter (1 mm less)
- Equivalent efficacy, expulsion risk
- Possibly more bleeding/spotting days
- 6-12% amenorrhea (v. 20-50% higher dose)
- Some women might prefer smaller size

IUD Review

- Current IUDs do NOT cause PID!!
  - Transient increased risk at insertion
  - STI at time of insertion increases risk
  - Risk-based STI screening
  - If screen – do it on same day
- Beyond time of insertion
  - Overall decreased risk with LNG IUS
  - No increased risk with Copper IUD
- Okay to treat for PID with IUD in place

Misoprostol for IUD insertion in nulliparous women

- ~50% providers use miso for nullips
- 4 RCTs (total 303 women)
  - Self-administered
  - Buccal & vaginal
  - 90 min to 8 hours before insertion
- No difference in ease of insertion
  - Misoprostol associated with **increased pain** before and after insertion

---


*Svensson, Obstet Gynecol, 2012.*

*Sivin I, Contraception, 1991.*


*Swenson, Obstet Gynecol, 2012.*

*Espey, AJOG, 2014.*

*Lathrop, Contraception, 2013.*
Selected Practice Recommendations

- Give anytime reasonable not pregnant – for IUD this is most important
- Cu IUD – no backup
- LNG IUD - If within 7 days of period – no backup
- If > 7 days – backup x 7 days
- Address bleeding side effects
- No need for string check
- Evidence-based STI and PID

Case #3

After counseling she selects an IUD and you place it that day. You screen her for CT based on her age.

Case #4

38 yo G2P1T1 woman is seeking contraception. She had pre-eclampsia during her last pregnancy but otherwise she is healthy. Physical exam: Wt= 226 lbs, Ht= 5’5” (BMI=37.6)

Obesity and Contraception

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>C-ARE</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>BMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>BMI &gt; 30 kg/m²</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Age ≥ 45 yrs</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

- Safety: VTE risk?
  - CHC & obesity are independent RF for VTE
  - There may be a synergistic increased risk
  - Risk is lower than pregnancy (29/10,000 Y-yr)
  - If multiple risk factors – CHC may be contraindicated

Horton, Contraception, 2016.
### Obesity & Contraceptive Efficacy

- **OCPs:** no clear difference\(^1,2\)
  - Longer time to steady state\(^3\)
- **Ring:** no difference\(^1,2\)
- **ETG implant:**
  - Lower or lower serum levels, but still inhibitory\(^4,5\)
- **DMPA:** no difference\(^1\)

  - **Patch:** may have lower efficacy\(^1,2,6\)

### Contraception & Weight Gain

- **COC, Patch, Ring:** none or age-expected change\(^1,2,3,6\)
- **LNG-IUS:** age-expected wt gain\(^4\)
- **ETG implant:** minimal if any effect\(^5\)

#### BMI

- **BMI < 25**
- **BMI 25 – 30**
- **BMI > 30**

### Emergency Contraception

**Mechanism:**
- Delay follicular rupture, no harm to existing pregnancy

- **Levonorgestrel** 1.5 mg x 1, up to 5 days
- **Ulipristal Acetate**
  - Selective progesterone receptor modulator
  - 30 mg, up to 5 days
Emergency Contraception: Efficacy

**Effectiveness:**\(^1,2\)

UPA more effective than LNG EC
- Taken at 120 hrs: OR = .55 (0.32–0.93)
- Taken at 24 hrs: OR = .35 (0.11–0.93)

Obese women have lower EC efficacy
- LNG: No efficacy > 70-75 kg (>154-165lb)
  - Large drop in efficacy at BMI > 26
  - PK data: Doubling the LNG dose may increase efficacy\(^6\)
- UPA: Less efficacy in obese women but still effective
  - May lose efficacy at weight of 90 kg (198 lb) or BMI > 35

Alternatives to LNG EC & Ulipristal Acetate?
- Copper IUD - <0.1% failure
  - VERY effective as EC up to 5+ days
  - SPR can place beyond 5 days if not > than 5 days after ovulation
  - More effective than LNG EC
- Mifepristone (10, 25 or 50 mg)
  - More effective than LNG
  - Yuzpe regimen
  - More side effects and less effective

References
- Many easily accessible resources exist to help solve contraception quandaries...

Case #4

38 yo G2P1T1 obese woman desires birth control.
- Assess for other risk factors
- If none all methods safer than pregnancy
- If smoker or other RF – may avoid CHC
- For EC – recommend UPA

References
- Many easily accessible resources exist to help solve contraception quandaries...
Conclusion

- Support women through shared decision making
- Use the many available references
- Remember that contraception is safer than pregnancy

Thanks to Phil Darney, Mike Policar, Carolyn Sufrin, Nika Seidman, Valerie French, Merrie Warden, Christine Deblendorf, Dan Grossman.
### Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>Cu-UDG</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Menarche &lt;20 yrs</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<tr>
<td>Anatomical abnormalities</td>
<td>a) Distorted uterine cavity</td>
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<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<tr>
<td>Breast disease</td>
<td>a) Undiagnosed mass</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<tr>
<td>Cervical ectropion</td>
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<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td></td>
</tr>
<tr>
<td>Cystic fibrosis‡</td>
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<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<td></td>
</tr>
<tr>
<td>Deep venous thrombosis (DVT)/Pulmonary embolism (PE)</td>
<td>a) History of DVT/PE, not receiving anticoagulant therapy</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<td>Depressive disorders</td>
<td>a) Major depression</td>
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<td>1 1 1 1 1</td>
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<tr>
<td>Diabetes</td>
<td>a) History of gestational diabetes</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
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<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
<td>1 1 1 1 1</td>
</tr>
<tr>
<td>Endometrial cancer‡</td>
<td>4 2 4 2 2 2 2 2 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy‡</td>
<td>(see also Drug Interactions)</td>
<td>1 1 1 1 1 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td>a) Symptomatic</td>
<td>1 1 1 1 1 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational trophoblastic disease‡</td>
<td>a) Suspected GTD (immediate postevacuation)</td>
<td>1 1 1 1 1 1 1 1 1</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Headaches</td>
<td>a) Migraine</td>
<td>1 1 1 1 1 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of bariatric surgery‡</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of cholestasis</td>
<td>a) Pregnancy related</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of high blood pressure during pregnancy</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>HIV</td>
<td>a) High risk for HIV</td>
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<td>Intolerance with contraceptive method</td>
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<tr>
<td>Key:</td>
<td>1 No restriction (method can be used)</td>
<td>2 Advantages generally outweigh theoretical or proven risks</td>
<td>3 Theoretical or proven risks usually outweigh the advantages</td>
<td>4 Unacceptable health risk (method not to be used)</td>
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</table>

**Condition Sub-Condition**

- Cu-IUD
- Cu-UDG
- Implant
- DMPA
- POP
- CHC

**Medications:**
- COC: Combined oral contraceptive; NPL: nulliparous
- COP: Combined oral contraceptive; P/R: patch/ring
- I=initiation of contraceptive method
- LNG-IUD: Levonorgestrel-releasing intrauterine device
- NA: Not applicable
- POP: Progestin-only pill
- P/R: Patch/ring
- CHC: Combined hormonal contraception (pill, patch, and ring)
- COC: Combined oral contraceptive
- Cu-IUD: Copper-containing intrauterine device
- DMPA: Depot medroxyprogesterone acetate
- GTD: Gestational trophoblastic disease
- VTE: Venous thromboembolism
- HIV: Human immunodeficiency virus

**Note:** Please see the complete guidance for a clarification to this classification.
## Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

### Conditions and Sub-Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
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<tbody>
<tr>
<td>Hypertension</td>
<td>a) Adequately controlled hypertension</td>
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<td>b) Elevated blood pressure level</td>
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<td>i) Systolic 140-159 or diastolic 90-99</td>
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<td>ii) Systolic &gt;160 or diastolic &gt;100</td>
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<td></td>
<td>c) Vascular disease</td>
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<td>Inflammatory bowel disease</td>
<td>(Ulcerative colitis, Crohn's disease)</td>
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<td>i) Focal nodular hyperplasia</td>
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<td>ii) Hepatocellular adenoma</td>
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<td>ii) With subsequent pregnancy</td>
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<td>ii) Without subsequent pregnancy</td>
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<td>ii) &gt;6 months</td>
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<td>b) Moderately or severely impaired cardiac function</td>
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<td>b) Second trimester</td>
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<td>c) Immediate postpartum abortion</td>
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<td>Postpartum (nonbreastfeeding women)</td>
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<td>ii) With other risk factors for VTE</td>
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<td>iii) Without other risk factors for VTE</td>
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<td>c) &gt;42 days</td>
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<td>Postpartum (in breastfeeding or non- breastfeeding women, including cesarean delivery)</td>
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<td>b) Breasfeeding</td>
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<td>b) Nonbreastfeeding</td>
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<td>b) 10 minutes after delivery of the placenta to &lt;4 weeks</td>
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<td></td>
<td>c) &gt;4 weeks</td>
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### Condition Sub-Condition

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<tr>
<th>Condition</th>
<th>Sub-Condition</th>
<th>Cu-IUD</th>
<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
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</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>a) On immunosuppressive therapy</td>
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<td>b) Not on immunosuppressive therapy</td>
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<td>Schistosomiasis</td>
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<td>Sexually transmitted diseases (STDs)</td>
<td>a) Current purulent cervicitis or chlamydial infection or gonococcal infection</td>
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<td>b) Vaginitis (including trichomons vaginalis and bacterial vaginosis)</td>
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<td>c) Other factors relating to STDs</td>
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<td>Smoking</td>
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<td>b) Age ≥35, ≤15 cigarettes/day</td>
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<td>c) Age ≥35, &gt;15 cigarettes/day</td>
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<td>Solid organ transplantation</td>
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<td>b) Uncomplicated</td>
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<td>Unexplained vaginal bleeding (suspicious for serious condition) before evaluation</td>
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<td>b) Heavy or prolonged bleeding</td>
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<td>b) Carrier/Chronic</td>
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### Drug Interactions

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<th>Sub-Condition</th>
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<th>LNG-IUD</th>
<th>Implant</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
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<tbody>
<tr>
<td>Antiretroviral therapy</td>
<td>a) Certain antiretrovirals (phenytoin, efavirenz, nevirapine, atazanavir, lopinavir)</td>
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<td>b) Lamotrigine</td>
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<td>b) Interactions with other medications</td>
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<td>b) Antifungals</td>
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<td>c) Anticonvulsants</td>
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<td>d) Rifampin or rifabutin therapy</td>
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Updated July 2016. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/updatedmeccnic.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.