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Removing unnecessary medical barriers to contraception: celebrating a decade of the US Medical Eligibility Criteria for Contraceptive Use

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Abstract

In 2010, the Centers for Disease Control and Prevention (CDC) released the US Medical Eligibility Criteria for Contraceptive Use, providing recommendations for health care providers on safe use of contraception for people with certain characteristics or medical conditions. Adapted from World Health Organization guidance, the goal of the recommendations is to remove unnecessary medical barriers to contraception. Over the past decade, CDC has updated recommendations based on new evidence, collaborated with national partners to disseminate and implement the guidelines, and conducted provider surveys to assess changes in attitudes and practices around contraception safety and provision. CDC remains committed to supporting evidence-based guidelines for safe use of contraception, as the basis for improving access to contraception and high-quality family planning services, reducing unintended pregnancy, and improving reproductive health in the United States.

Introduction

In June 2010, the Centers for Disease Control and Prevention (CDC) published the first edition of the U.S. Medical Eligibility Criteria for Contraceptive Use (US MEC).[1] Recognized as an "initiative of national importance",[2] the US MEC provides recommendations for health care providers on the safe use of contraception for men and women with certain characteristics or medical conditions. At the time the guidelines were released, about half of pregnancies in the United States were unintended, female sterilization and oral contraceptives were the most commonly used contraceptive methods reported by women, 11% of women at risk of unintended pregnancy were not using any method of contraception, and disparities in access to contraception and unintended pregnancy rates

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existed by age, race and ethnicity, and socioeconomic status.[3, 4] Drawing on CDC's long history of work on contraception safety and effectiveness and the agency's declaration of family planning as one of the ten great public health achievements of the 20th century,[1, 5–8] the 2010 release of the US MEC began CDC's engagement to remove unnecessary medical barriers to contraception access for men and women, including adolescents, in the United States. As we celebrate the 10th anniversary of the initial release of the US MEC, we reflect on its impact and consider future opportunities for improving access to contraception and quality of family planning services through continued implementation of the evidence-based clinical practice guidelines.

Developing the US MEC

The US MEC is based on global guidelines first published by the World Health Organization (WHO)[9] in 1996 and adapted for use in the United States to meet the needs of US health care providers. The guidelines provide recommendations on safe use of specific contraceptive methods for people with certain characteristics (e.g., age, parity, smoking status) and medical conditions (e.g., hypertension, diabetes, HIV). The US MEC includes all Food and Drug Administration (FDA)-approved methods of contraception and over 60 medical conditions and characteristics (Table 1). The goal of the US MEC is to remove unnecessary medical barriers and facilitate access to contraception and high-quality family planning services. While the recommendations include necessary restrictions based on evidence, most contraceptive methods can be safely used by most people, even those with medical conditions. Therefore, providing access to the full range of FDA-approved contraceptive methods through patient-centered counseling and shared decision-making can improve quality of care and allow people to find the contraceptive method that best meets their needs.

The recommendations were developed using standard processes for guideline development[10] and based on critical appraisal of the scientific evidence through systematic reviews with input from external partners.[11] CDC subsequently published the U.S. Selected Practice Recommendations for Contraceptive Use (US SPR) in 2013, which provides recommendations on how to provide contraception (e.g., when to start, the need for back-up contraception, required examinations or tests needed before initiation); these are also adapted from WHO's global guidelines for the U.S. context.[12, 13]

A key challenge with clinical practice guidelines is keeping recommendations up to date as new evidence emerges.[10, 14] CDC continuously monitors peer-reviewed literature and updates recommendations if warranted by newly published evidence.[15] Since the first edition of the US MEC, CDC has released updates to individual recommendations, including hormonal contraception for postpartum women and hormonal contraception for women at high risk of HIV.[16–18] Additionally, the US MEC and US SPR were both revised in 2016, updating existing guidelines and adding recommendations for ulipristal acetate for emergency contraception, additional medical conditions (i.e., cystic fibrosis, multiple sclerosis, use of certain psychotropic drugs or St. John's wort), and new selected practice recommendations (i.e., medications to ease intrauterine device [IUD] insertion).[11, 19]

Using the US MEC

Over the past 10 years, CDC has also focused on developing and disseminating provider tools to facilitate use of the recommendations. Job aids for providers include a color-coded summary chart of the US MEC recommendations (available in English and Spanish), the US MEC wheel that also summarizes the recommendations, and summary charts of US SPR recommendations. Over 400,000 hardcopy or electronic provider tools and job aids have been distributed across the United States and US territories or downloaded from the CDC website (https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm). The webpages for the US MEC (https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html) and US SPR (https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html) average about 120,000 and 31,000 views per year, respectively. One of CDC's first mobile health applications was the US MEC Contraception app, which was first released in 2013 for iOS. The app has undergone several upgrades, the biggest of which was in 2016 when the US SPR was added and an Android version of the app was developed. Since its release, the app has been downloaded more than 227,000 times across both iOS and Android operating systems (https://apps.apple.com/us/app/contraception/id595752188 for iOS and https://play.google.com/store/apps/details?id=gov.cdc.ondieh.nccdphp.contraception2 for Android). CDC has also developed training on the guidelines for a broad range of audiences who can receive continuing educations credits, including physicians, nurses, health educators, and pharmacists (https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/training.htm).

One of CDC's main strategies for disseminating the recommendations to the wider health care community has been partnering with other federal agencies (e.g., Office of Population Affairs of the U.S. Department of Health and Human Services) and professional organizations whose members provide family planning services. Activities have included engaging professional organizations in planning for the release of the guidelines and guideline updates, presentations at professional organization meetings, and working through liaison activities. Several professional organizations use the US MEC in various formats, including formal endorsement, recommendation, or affirmation of the guidelines for use by their members; incorporating the recommendations into organization policies and protocols; adding links to the US MEC on their organization websites; and highlighting the US MEC in e-blasts, newsletters, and articles in affiliated journals.

Assessing health care provider attitudes and practices related to the US MEC and US SPR

In 2009, CDC launched a series of health care provider surveys to assess changes in attitudes and practices around contraception safety and provision related to US MEC and US SPR recommendations (Table 2). Surveys were fielded with different nationwide samples in 2009-2010 (before the initial release of the US MEC), 2013-2014 (after the initial release of the US MEC and around the time of the initial release of the US SPR), and 2019 (after the release of the US MEC and US SPR) to assess differences in attitudes and

practices over time, as well as changes in awareness and use of the guidelines. The surveys asked providers about their attitudes and practices around the safety of select contraceptive methods for women with certain characteristics or medical conditions, based on US MEC recommendations. In 2013-2014 and 2019, questions were added about US SPR recommendations including required examinations and tests before initiating contraceptive methods and the frequency of same-day start of various contraceptive methods. The surveys also offered a place for providers to list additional medical conditions, patient characteristics, or contraception management topics for which they would like to see recommendations in the US MEC or US SPR.

Key findings from the surveys are summarized in Table 2.[20–24] An evaluation of changes from before and after the initial release of the 2010 US MEC (from the 2009-2010 and 2013-2014 surveys) found several positive changes in provider attitudes, including increases in the proportions of providers correctly reporting that IUDs are safe for adolescents, postpartum women, nulliparous women, women with uterine fibroids, and women with HIV; and that depot medroxyprogesterone acetate (DMPA) is safe for breastfeeding women, women with obesity, women with inflammatory bowel disease, and women with a history of bariatric surgery.[22]

Looking to the Future

Updating and enhancing recommendations

CDC remains committed to updating its contraceptive guidelines for persons with medical conditions or characteristics, based on the best available science through highlighting research gaps, monitoring new evidence, reviewing new and updated WHO recommendations, and considering US health care providers' needs for new guidelines. The scientific community has responded to the need for research to strengthen contraception recommendations, and several studies have been conducted in response to issues previously identified as research gaps.[25, 26] Some US MEC recommendations continue to lack a high quality evidence-base, such as progestin-only contraception for women with thrombogenic conditions, hormonal contraception for women who are breastfeeding, and contraception for women with multiple medical conditions. As additional evidence accumulates, these and other recommendations can be further refined and updated. Topics for future consideration for the US MEC and US SPR include new global recommendations from WHO, new FDA-approved contraceptive methods, and provider-suggested priority medical conditions.

In 2011, the Institute of Medicine Report on "Clinical Practice Guidelines We Can Trust" established standards for developing effective clinical practice guidelines.[10] These standards continue to evolve, including designing new methods for evidence assessment and translation into recommendations,[27, 28] setting new standards to ensure equity and inclusion in the guidelines development process,[29, 30] and developing new approaches to update guidelines more efficiently to create "living guidelines."[14] A "living guidelines" framework uses an evidence-informed process to focus on selecting and updating high priority recommendations, resulting in more rapid and efficient guideline updates. CDC will continue to explore innovative methods for developing evidence-based guidelines to meet the needs of US health care providers.

Facilitating dissemination and implementation

While evidence-based clinical practice recommendations are the foundation of quality family planning services, guidelines alone are not sufficient to accomplish changes in clinical practice. The US MEC has benefited from strong partnerships with key federal agencies and professional organizations who have disseminated the guidelines to their constituents. However, further dissemination is needed to reach all providers who deliver family planning services, including primary care providers, pediatricians and adolescent medicine specialists, and specialists who see patients with complex medical conditions, inside and outside academic or tertiary care medical centers. One strategy is to expand on previous successful activities, such as joint publications with partners in specialty journals (e.g., contraception recommendations for women with multiple sclerosis).[31] Exploring new partnerships and innovative dissemination activities, such as reaching students in clinical training programs with digital tools, assessing needs of health care providers serving underserved populations, and developing new training opportunities will allow us to expand the reach of the guidelines.[31]

Although widespread dissemination of the guidelines and tools is necessary, the key to effective use of the guidelines is large-scale implementation projects that can assist providers to seamlessly incorporate the recommendations during clinical encounters. Several frameworks to guide implementation have been used for specific recommendations,[32, 33] such as providing immediate postpartum IUD and implant placement.[34–36] Incorporating the guidelines directly into clinical protocols can embed the recommendations into everyday practice. Developing clinical decision support tools, which could be stand-alone or integrated into electronic medical record systems, may also provide clinicians with easy access to CDC guidelines at the point of care.[37] These tools may be particularly important for primary care providers, who address a broad range of patient health issues. CDC's initiative on Adapting Clinical Guidelines for the Digital Age aims to improve the use of clinical guidelines by identifying methods for translating guidelines into digital approaches or products.[37] Along with focused implementation strategies, systemic support needs to be in place to facilitate effective guideline implementation. Specific elements for implementing contraception guidelines and improving access to contraception include availability of trained providers, sufficient stocks of contraceptive methods and supplies, clinic workflows that allow for same-day contraceptive counseling and method provision, and cost and reimbursement systems that ensure that a wide range of contraceptive methods are fully reimbursed, along with associated counseling, and insertion, removal, and replacement procedures, and related services.[38, 39]

Maintaining or enhancing contraception access is critical during public health emergencies, especially when prevention of unintended pregnancy is a primary strategy for reducing epidemic-associated adverse pregnancy and birth outcomes (such as with Ebola and Zika viruses) or in cases of disruption of routine health care services (such as natural disasters and pandemics).[40, 41] Implementation of clinical practice guidelines around contraception can facilitate access and contribute to high quality services. For example, during the 2016-2017 Zika virus outbreak, evidence-based guidelines including the US MEC and US SPR were used to train health care providers in Puerto Rico as part of a contraception

access program that provided client-centered contraceptive counseling and access to the full range of reversible contraceptive methods at no cost for women who chose to prevent pregnancy; the program served more than 29,000 women, of whom 96% received same-day contraception.[42, 43] For public health emergencies that limit access to routine health care services, such as the COVID-19 pandemic, evidence-based guidelines can be used when providing services through alternative modes of delivery, such as telehealth visits or pharmacist provision of contraception.[44, 45]

Conclusions

Considerable progress has been made in improving access to contraception and reducing unintended pregnancy in the United States. Since 2010, the percentage of pregnancies that were unintended dropped to 45%,[3] the mix of contraceptive methods used has expanded with increases in use of long-acting reversible contraception (IUDs and implants) likely reflecting better access to a broad range of methods,[46] and costs of contraception for patients have significantly decreased with the Affordable Care Act.[47] While there have been accomplishments with the use of the US MEC and related materials over the past decade, there is more work to be done. CDC will continue to move the field of evidence-based, clinical practice guidelines for contraception forward, as the basis for efforts to improve access to contraception, reduce unintended pregnancy rates, and improve reproductive, maternal, and infant health in the United States.

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Disclaimer:

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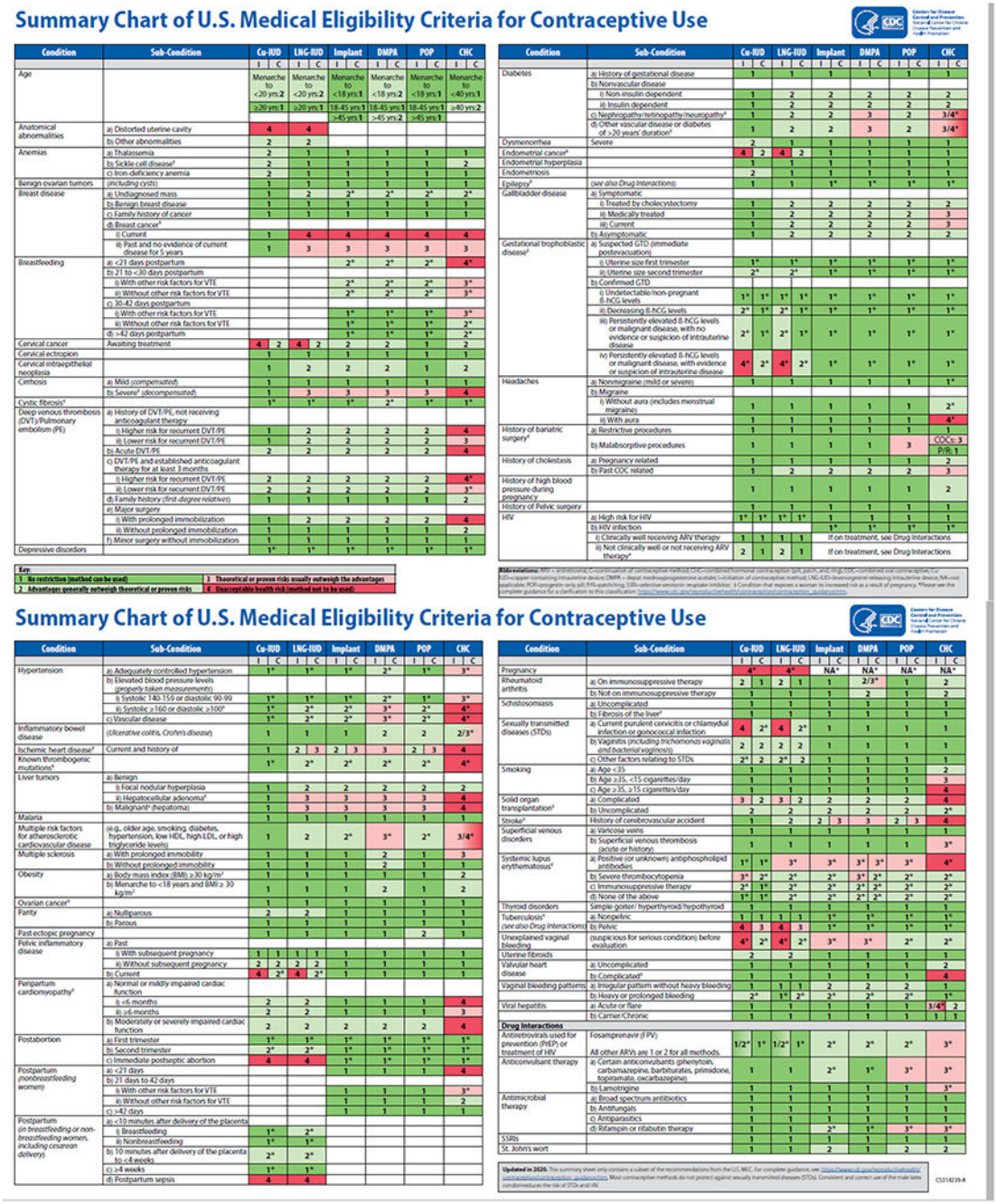
Table 1.

Summary chart of US Medical Eligibility Criteria for Contraceptive Use

(Note to reviewers: we will submit the US MEC color-coded summary chart here: https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf)



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

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[f]	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[g]						
	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[i] (decompensated)	1	3	3	3	3	4
Cystic fibrosis[k]		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[a]	1	2	2	3	2	3/4*
	d) Other vascular disease or diabetes of >20 years' duration[l]	1	2	2	3	2	3/4*
Dysmenorrhea	Severe	2	1	1	1	1	1
Endometrial cancer[d]		4 2	4 2	1	1	1	1
Endometrial hyperplasia		1	1	1	1	1	1
Endometriosis		2	1	1	1	1	1
Epilepsy[f]	(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[j]	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[g]	a) Restrictive procedures	1	1	1	1	1	1
	b) Malabsorptive procedures	1	1	1	1	3	CDC: ≥ 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*	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[a]	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; COC=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; SSRIs=selective serotonin reuptake inhibitors; † 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/mmwr/mec.html

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

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
		I C	I C	I C	I C	I C	I C
Hypertension	a) Adequately controlled hypertension	1*	1*	1*	2*	1*	3*
	b) Elevated blood pressure levels properly taken measurements):						
	i) Systolic 140-159 or diastolic 90-99	1*	1*	1*	2*	1*	3*
	ii) Systolic ≥160 or diastolic ≥100[b]	1*	2*	2*	3*	2*	4*
	c) Vascular disease	1*	2*	2*	3*	2*	4*
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	1	1	1	2	2	2/3*
Ischemic heart disease[c]	Current and history of	1 2 3	2 3	3	3	2 3	4
Known thrombogenic mutations[e]		1*	2*	2*	2*	2*	4*
Liver tumors	a) Benign						
	i) Focal nodular hyperplasia	1	2	2	2	2	2
	ii) Hepatocellular adenoma[d]	1	3	3	3	3	4
	b) Malignant[d] (hepatoma)	1	3	3	3	3	4
Malaria		1	1	1	1	1	1
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1	2	2*	3*	2*	3/4*
Multiple sclerosis	a) With prolonged immobility	1	1	1	2	1	3
	b) Without prolonged immobility	1	1	1	2	1	1
Obesity	a) Body mass index (BMI) ≥30 kg/m^2	1	1	1	1	1	2
	b) Menarche to <18 years and BMI ≥ 30 kg/m^2	1	1	1	2	1	2
Ovarian cancer[d]		1	1	1	1	1	1
Parity	a) Nulliparous	2	2	1	1	1	1
	b) Parous	1	1	1	1	1	1
Past ectopic pregnancy		1	1	1	1	2	1
Pelvic inflammatory disease	a) Past						
	i) With subsequent pregnancy	1 1	1 1	1	1	1	1
	ii) Without subsequent pregnancy	2 2	2 2	1	1	1	1
	b) Current	4 2*	4 2*	1	1	1	1
Peripartum cardiomyopathy[f]	a) Normal or mildly impaired cardiac function						
	i) <6 months	2	2	1	1	1	4
	ii) ≥6 months	2	2	1	1	1	3
	b) Moderately or severely impaired cardiac function	2	2	2	2	2	4
Postabortion	a) First trimester	1*	1*	1*	1*	1*	1*
	b) Second trimester	2*	2*	1*	1*	1*	1*
	c) Immediate postseptic abortion	4	4	1*	1*	1*	1*
Postpartum (nonbreastfeeding women)	a) <21 days			1	1	1	4
	b) 21 days to 42 days						
	i) With other risk factors for VTE			1	1	1	3*
	ii) Without other risk factors for VTE			1	1	1	2
	c) >42 days			1	1	1	1
Postpartum (in breastfeeding or non-breastfeeding women, including cesarean delivery)	a) <10 minutes after delivery of the placenta						
	i) Breastfeeding	1*	2*				
	ii) Nonbreastfeeding	1*	1*				
	b) 10 minutes after delivery of the placenta to <4 weeks	2*	2*				
	c) ≥4 weeks	1*	1*				
	d) Postpartum sepsis	4	4				

Condition	Sub-Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
		I C	I C	I C	I C	I C	I C
Pregnancy		4*	4*	NA*	NA*	NA*	NA*
Rheumatoid arthritis	a) On immunosuppressive therapy	2 1	2 1	1	2/3*	1	2
	b) Not on immunosuppressive therapy	1	1	1	2	1	2
Schistosomiasis	a) Uncomplicated	1	1	1	1	1	1
	b) Fibrosis of the liver[e]	1	1	1	1	1	1
Sexually transmitted diseases (STDs)	a) Current purulent cervicitis or chlamydial infection or gonococcal infection	4 2*	4 2*	1	1	1	1
	b) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	2 2	2 2	1	1	1	1
	c) Other factors relating to STDs	2* 2	2* 2	1	1	1	1
Smoking	a) Age <35	1	1	1	1	1	2
	b) Age ≥35, <15 cigarettes/day	1	1	1	1	1	3
	c) Age ≥35, ≥15 cigarettes/day	1	1	1	1	1	4
Solid organ transplantation[f]	a) Complicated	3 2	3 2	2	2	2	4
	b) Uncomplicated	2	2	2	2	2	2*
Stroke[a]	History of cerebrovascular accident	1	2	2 3	3	2 3	4
Superficial venous disorders	a) Varicose veins	1	1	1	1	1	1
	b) Superficial venous thrombosis (acute or history)	1	1	1	1	1	3*
Systemic lupus erythematosus[f]	a) Positive (or unknown) antiphospholipid antibodies	1* 1*	3*	3*	3* 3*	3*	4*
	b) Severe thrombocytopenia	3* 2*	2*	2*	3* 2*	2*	2*
	c) Immunosuppressive therapy	2* 1*	2*	2*	2* 2*	2*	2*
	d) None of the above	1* 1*	2*	2*	2* 2*	2*	2*
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1	1	1	1	1	1
Tuberculosis[k] (see also Drug Interactions)	a) Nonpelvic	1 1	1 1	1*	1*	1*	1*
	b) Pelvic	4 3	4 3	1*	1*	1*	1*
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4* 2*	4* 2*	3*	3*	2*	2*
Uterine fibroids		2	2	1	1	1	1
Valvular heart disease	a) Uncomplicated	1	1	1	1	1	2
	b) Complicated[h]	1	1	1	1	1	4
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1	1 1	2	2	2	1
	b) Heavy or prolonged bleeding	2*	1* 2*	2*	2*	2*	1*
Viral hepatitis	a) Acute or flare	1	1	1	1	1	3/4* 2
	b) Carrier/Chronic	1	1	1	1	1	1 1
Drug Interactions							
Antiretrovirals used for prevention (PrEP) or treatment of HIV	Fosamprenavir (FPV) /r All other ARVs are 1 or 2 for all methods.	1/2* 1*	1/2* 1*	2*	2*	2*	3*
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1	1	2*	1*	3*	3*
	b) Lamotrigine	1	1	1	1	1	3*
Antimicrobial therapy	a) Broad spectrum antibiotics	1	1	1	1	1	1
	b) Antifungals	1	1	1	1	1	1
	c) Antiparasitics	1	1	1	1	1	1
	d) Rifampin or rifabutin therapy	1	1	2*	1*	3*	3*
SSRIs		1	1	1	1	1	1
St. John's wort		1	1	2	1	2	2

Updated in 2020. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm?s_cid=rr6504a1_w#contraception_guidance.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.

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Table 2.

Health care provider attitudes and practices related to the US Medical Eligibility Criteria for Contraceptive Use and the US Selected Practice Recommendations for Contraceptive Use

Timing of survey	Survey sample	Key findings
2009-2010 Before the initial release of the US MEC	2,000 federally-funded Title X clinics 2,000 office-based physicians[a]	A significantly higher proportion of Title X clinic providers than office-based physicians reported on-site availability of all contraceptive methods except the levonorgestrel-releasing IUD.[20] About 30% of providers considered IUDs to be unsafe, very unsafe, and were unsure about safety for nulliparous women, and the majority (65-80%) rarely or never provided IUDs to nulliparous women.[21]
2013-2014 After the initial release of the US MEC and around the time of the initial release of the US SPR	2,000 federally-funded Title X clinics 2,000 non-Title X clinics[b] 2,000 office-based physicians[a]	Changes between the 2009-2010 and 2013-2014 surveys (before and after the initial release of the 2010 US MEC) found increases in the proportions of providers correctly reporting that IUDs are safe for adolescents, postpartum women, nulliparous women, women with uterine fibroids, and women with HIV; and that DMPA is safe for breastfeeding women, women with obesity, women with inflammatory bowel disease, and women with a history of bariatric surgery.[22] Approximately two-thirds of providers considered same-day initiation of IUDs and implants for adolescents to be safe; this proportion was higher among those trained versus not trained in IUD and implant insertion, among those who received Title X funding for public-sector providers, and among adolescent medicine specialists for office-based physicians.[23] While most providers reported that same-day initiation of combined hormonal contraception and DMPA was safe for adolescents, fewer providers reported same-day start for adolescents in practice.[24]
2019 After the release of both the US MEC and US SPR	2,000 federally-funded Title X clinics 2,000 non-Title X clinics[b] 2,000 office-based physicians[a]	Results from the 2019 survey are forthcoming and will focus on prevalence of clinical practices to improve access to contraception.

[a]Office-based physicians, specializing in obstetrics and gynecology, family medicine, and adolescent medicine

[b]Providing publicly-funded family planning services

US MEC, US Medical Eligibility Criteria for Contraceptive Use; US SPR, US Selected Practice Recommendations for Contraceptive Use; IUD, intrauterine devices; HIV, human immunodeficiency virus; DMPA, dept medroxyprogesterone