U.S. Medical Eligibility Criteria for Contraceptive Use, 2024

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Summary

The 2024 U.S. Medical Eligibility Criteria for Contraceptive Use *(U.S. MEC) comprises recommendations for the use of specific contraceptive methods by persons who have certain characteristics or medical conditions. These recommendations for health care providers were updated by CDC after review of the scientific evidence and a meeting with national experts in Atlanta, Georgia, during January 25–27, 2023. The information in this report replaces the 2016 U.S. MEC* (CDC. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR 2016:65[No. RR-3]:1–103). *Notable updates include 1) the addition of recommendations for persons with chronic kidney disease; 2) revisions to the recommendations for persons with certain characteristics or medical conditions (i.e., breastfeeding, postpartum, postabortion, obesity, surgery, deep venous thrombosis or pulmonary embolism with or without anticoagulant therapy, thrombophilia, superficial venous thrombosis, valvular heart disease, peripartum cardiomyopathy, systemic lupus erythematosus, high risk for HIV infection, cirrhosis, liver tumor, sickle cell disease, solid organ transplantation, and drug interactions with antiretrovirals used for prevention or treatment of HIV infection); and 3) inclusion of new contraceptive methods, including new doses or formulations of combined oral contraceptives, contraceptive patches, vaginal rings, progestin-only pills, levonorgestrel intrauterine devices, and vaginal pH modulator. The recommendations in this report are intended to serve as a source of evidence-based clinical practice guidance for health care providers. The goals of these recommendations are to remove unnecessary medical barriers to accessing and using contraception and to support the provision of person-centered contraceptive counseling and services in a noncoercive manner. Health care providers should always consider the individual clinical circumstances of each person seeking*

contraceptive services. This report is not intended to be a substitute for professional medical advice for individual patients; when needed, patients should seek advice from their health care providers about contraceptive use.

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Related Materials

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Introduction

U.S. Medical Eligibility Criteria for Contraceptive Use, 2024 (U.S. MEC) provides recommendations for health care providers for safe use of contraceptive methods for persons who have certain characteristics or medical conditions within the framework of removing unnecessary medical barriers to accessing and using contraception. U.S. MEC is a companion document to *U.S. Selected Practice Recommendations for Contraceptive Use, 2024* (U.S. SPR) (*1*), which provides recommendations for health care providers that address provision of contraceptive methods and management of side effects and issues related to contraceptive method use (*2*). Both U.S. MEC and U.S. SPR were adapted from global guidance developed by the World Health Organization (WHO) (*3*,*4*). WHO intended for the global guidance to be used by local or national policymakers, family planning program managers, and the scientific community as a reference when they develop family planning guidance at the country or program level (*3*). CDC first published U.S. MEC in 2010, after a formal process during 2008–2010 to adapt the global guidance for use in the United States, which included rigorous identification and critical appraisal of the scientific evidence through systematic reviews and input from national experts on how to translate that evidence into recommendations for U.S. health care providers (*5*); a subsequent update was published in 2016 (*6*).

U.S. MEC and U.S. SPR recommendations are components of quality contraceptive services and can be used in conjunction with other guidance documents such as *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, which provides recommendations for the content and delivery of services related to preventing or for achieving pregnancy (*7*–*9*). Evidence-based guidance can support health care providers when providing person-centered counseling and contraceptive services, including assisting persons in selecting and using contraceptive methods safely and effectively.

Equitable access to the full range of contraceptive methods for all those seeking care is an essential component of high-quality sexual and reproductive health care. Contraceptive services should be offered in a noncoercive manner that supports a person's values, goals, and reproductive autonomy through a shared decision-making process with health care providers (*10*–*14*). Because of the history of and ongoing forced sterilization and reproductive coercion in the United States among persons of racial and ethnic minority groups, persons with disabilities, and other groups that have been marginalized, it is important that persons can select the method that best meets their needs to promote reproductive autonomy (*10*–*12*).

This report replaces the 2016 version of U.S. MEC (*6*) with new and revised recommendations, on the basis of new evidence and input from experts. This updated document uses gender-inclusive language throughout. However, when summarizing published evidence that describes study populations by specific genders, the wording of the primary studies has been maintained for accuracy. A summary of new and revised recommendations from the 2016 U.S. MEC is provided (Appendix A). Notable updates include

- addition of recommendations for persons with chronic kidney disease, specifically those with nephrotic syndrome, those receiving hemodialysis, and those receiving peritoneal dialysis;
- revisions to recommendations for persons with certain characteristics or medical conditions (i.e., breastfeeding, postpartum, postabortion, obesity, surgery, history of deep venous thrombosis or pulmonary embolism with or without anticoagulant therapy, thrombophilia, superficial venous thrombosis, valvular heart disease, peripartum

cardiomyopathy, systemic lupus erythematosus, cirrhosis, liver tumor, sickle cell disease, and solid organ transplantation);

- revisions to recommendations for persons at high risk for HIV infection (this recommendation was developed and published in 2020) (*15*);
- revisions to recommendations for drug interactions with antiretrovirals to include prevention in addition to treatment for HIV infection (this recommendation was developed and published in 2020) (*15*); and
- inclusion of additional contraceptive methods, including new doses or formulations of combined oral contraceptives (COCs), contraceptive patches, vaginal rings, progestin-only pills (POPs), levonorgestrel intrauterine devices (LNG-IUDs), and vaginal pH modulator.

U.S. MEC recommendations are meant to serve as a source of evidence-based clinical guidance for health care providers and can support the provision of person-centered contraceptive counseling and services in a noncoercive manner. Health care providers should always consider the individual clinical circumstances of each person seeking contraceptive services. This report is not intended to be a substitute for professional medical advice for individual patients; when needed, patients should seek advice from their health care providers about contraceptive use.

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Methods

Since publication of the 2016 U.S. MEC, CDC has monitored the literature for new evidence relevant to the recommendations through the WHO/CDC Continuous Identification of Research Evidence (CIRE) system (*16*). This system identifies new evidence as it is published and allows WHO and CDC to update systematic reviews and facilitate updates to recommendations as new evidence warrants. Automated searches are run in PubMed weekly, and the results are reviewed. Abstracts that meet specific criteria are added to the web-based CIRE system, which facilitates coordination and peer review of systematic reviews for both WHO and CDC. For this update, CDC reviewed all existing recommendations in the 2016 U.S. MEC for new evidence identified by CIRE that had the potential to lead to a changed recommendation. To obtain comments from the public about revisions to CDC's contraception recommendations (U.S. MEC and U.S. SPR), CDC published a notice in the Federal Register (86 FR 46703) on August 19, 2021, requesting public comment on content to consider for revision or addition to the recommendations and how to improve the implementation of the guidance documents (*17*). The comment period closed on October 18, 2021. CDC received 46 submissions from the general public, including private persons, professional organizations, academic institutions, and industry. CDC reviewed each of the submissions and carefully considered them when revising the recommendations.

During January 21, 25, and 26, 2022, CDC held virtual scoping meetings that included 27 participants with expertise in contraception, adolescent health, and thrombosis, as well as representatives from partner organizations, to solicit their individual input on the scope for updating both the 2016 U.S. MEC and 2016 U.S. SPR. The 27 invited participants represented various types of health care providers and health care provider organizations. Lists of participants and potential conflicts of interests are provided at the end of this report. Meeting participants discussed topics to be addressed in the update of U.S. MEC on the basis of the presentation of new evidence published since 2016 (identified through the CIRE system), submissions received through the Federal Register notice, and feedback CDC received from other sources (e.g., health care providers and others through e-mail, public inquiry, and questions received at conferences). CDC identified multiple topics to consider when updating the guidance, including revision of existing recommendations for certain characteristics or medical conditions (postpartum, postabortion, obesity, anticoagulant therapy, known thrombogenic mutations, viral hepatitis, cirrhosis, liver tumors, sickle cell disease, and solid organ transplantation), addition of recommendations for new characteristics or medical conditions (chronic kidney disease and antiphospholipid syndrome), and addition of recommendations for new contraceptive methods (including new formulations of COCs, contraceptive patches, vaginal rings, POPs, LNG-IUDs, and vaginal pH modulator). CDC determined that all other recommendations in the 2016 U.S. MEC were up to date and consistent with the existing body of evidence for that recommendation.

In preparation for a subsequent expert meeting held during January 25–27, 2023, to review the scientific evidence for potential recommendations, CDC staff members and other invited authors conducted systematic reviews for each of the topics being considered. The purpose of these systematic reviews was to identify direct and indirect evidence about the safety of contraceptive method use by persons with selected characteristics or medical conditions (e.g., risk for disease progression or other adverse health effects in persons with chronic kidney disease who use combined hormonal contraceptives [CHCs]). Person-centered outcomes that might represent contraceptive users' values and preferences (e.g., method continuation and patient satisfaction) were considered where relevant and available for each of the systematic reviews. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed for reporting systematic reviews (*18*). The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was used to assess the certainty of the evidence (*19*,*20*). Certainty of evidence was rated as high, moderate, low, or very low depending on criteria including study design, risk for bias, indirectness, imprecision, and inconsistency. Outcomes evaluated in randomized clinical trials (RCTs) are considered to have high certainty of evidence and those in observational studies to have low certainty; these ratings are adjusted according to the previously mentioned criteria. When direct evidence was limited or not available, indirect evidence (e.g., evidence on proxy outcomes or among healthy persons) and theoretical issues were considered. Reviews are referenced and cited throughout this report; the full reviews will be submitted to peer-reviewed journals and will contain the details of each review, including the systematic review question, literature search protocol (registered in https://www.crd.york.ac.uk/PROSPERO), inclusion and exclusion criteria, evidence tables, and quality assessments. Brief summaries of the evidence and GRADE tables are included (Supplementary Appendix, https://stacks.cdc.gov/view/cdc/156516). CDC staff members continued to monitor new evidence identified through the CIRE system during the preparation for the January 2023 meeting.

In addition to the preparation of the systematic reviews, CDC included patient perspectives in the guideline update process to better consider how the resulting updated recommendations could meet patient preferences and needs. Consideration of patient perspectives can center discussions on the evidence in a person-centered care model, can support inclusion of patient perspectives along with provider perspectives on the evidence, and has the potential to shape recommendations (*14*,*21*,*22*). In November and December 2022, listening sessions were held with a different group of 18 participants, representing themselves or patient advocacy organizations, who provided perspectives from patient populations such as youths; lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) persons; persons with disabilities; and persons with chronic medical conditions. The goal of the listening sessions was to gather insights about participants' experiences, values, preferences, and information needs related to contraceptive choice and decision-making.

During January 25–27, 2023, in Atlanta, Georgia, CDC held a meeting with 40 participants who were invited to provide their individual perspectives on the scientific evidence presented and the implications for practice for U.S. MEC. Thirty-eight participants represented a wide range of expertise in contraception provision, research, and reproductive justice and included obstetricians and gynecologists, pediatricians, family physicians, internal medicine physicians, nurse practitioners, epidemiologists, and others with research and clinical practice expertise in contraceptive safety, effectiveness, and management. Two participants were patient representatives who provided their individual perspectives on the topics discussed throughout the meeting. Six additional participants with expertise relevant to specific topics on the meeting agenda provided information and participated in the discussion on their topic of expertise only (e.g., an expert in kidney disease was asked to provide general information about the condition and to assist in interpreting the evidence and any theoretical concerns on the use of contraceptive methods in persons with the condition). During the meeting, a summary of the information from the patient listening sessions was presented, and the two patient representatives presented information on their individual experiences and perspectives related to receipt of contraceptive services. The evidence from the systematic review for each topic was presented, including direct evidence and any indirect evidence or theoretical concerns. Meeting participants provided their individual perspectives on topics discussed throughout the meeting and on using the evidence to develop recommendations that would meet the needs of U.S. health care providers and the patients they serve. Participants also provided feedback on

the certainty of evidence, the balance of benefits and harms, and values and preferences. Areas of research that need additional investigation also were considered during the meeting. Lists of participants and potential conflicts of interest are provided at the end of this report.

After the January 2023 meeting, CDC determined the recommendations in this report, taking into consideration the individual perspectives provided by the meeting participants. Feedback also was received from a group of four external reviewers, composed of health care providers and researchers who had not participated in the scoping or update meetings. These external reviewers were asked to provide comments on the accuracy, feasibility, and clarity of the recommendations.

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Keeping Guidance Up to Date

As with any evidence-based guidance document, a key challenge is keeping the recommendations up to date as new scientific evidence becomes available. Working with WHO, CDC uses the CIRE system to ensure that WHO and CDC guidance is based on the best available evidence and that a mechanism is in place to update guidance when new evidence becomes available (*16*). CDC will continue to work with WHO to identify and assess all new relevant evidence and determine whether changes in the recommendations are warranted. CDC will completely review U.S. MEC periodically. Updates to the guidance will published in CDC's *Morbidity and Mortality Weekly Report* (*MMWR*) and posted on the CDC website (https://www.cdc.gov/contraception/hcp/contraceptive-guidance).

As part of the process to update these recommendations, CDC identifies gaps in the evidence for the recommendations considered. Evidence is often limited on the safety of contraceptive methods among persons with certain characteristics or medical conditions. Generalizability of the published evidence to all persons seeking contraceptive services presents a challenge because of biases about who might be included in studies on contraceptive safety. New, high-quality research on contraception that addresses priority research gaps inclusive of diverse populations can further strengthen these recommendations and improve clinical practice.

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How to Use This Document

The recommendations in this report are intended to help health care providers determine the safe use of contraceptive methods among persons with certain characteristics and medical conditions. Providers can use the information in these recommendations during contraceptive counseling with patients. The tables include recommendations for the use of contraceptive methods by persons with certain characteristics or medical conditions. Each condition is defined as representing either a person's characteristics (e.g., age or postpartum status) or a known medical condition (e.g., diabetes or hypertension). The recommendations refer to contraceptive methods being used for contraceptive purposes; the recommendations do not consider the use of contraceptive methods for treatment of medical conditions because the eligibility criteria in these situations might differ. The conditions affecting eligibility for the use of each contraceptive method are classified into one of four categories (Box 1).

Contraceptive Decision-Making

CDC acknowledges the paramount importance of personal autonomy in contraceptive decision-making. This is critically important because of the context of historical and ongoing contraceptive coercion and reproductive mistreatment in the United States, especially among communities that have been marginalized, including human rights violations such as forced sterilization and enrollment in contraceptive trials without informed consent (*10*–*12*). Coercive practices in the health care system can include provider bias for certain contraceptive methods over a patient's reproductive goals and preferences, lack of person-centered counseling and support, and policies or incentives for uptake of certain contraceptive methods (*11*). For health care providers and the settings in which they work, it is important to acknowledge the structural systems that drive inequities (e.g., discrimination because of race, ethnicity, disability, sex,

gender, and sexual orientation), work to mitigate harmful impacts, and recognize that provider bias (unconscious or explicit) might affect contraceptive counseling and provision of services (*12*). All persons seeking contraceptive care need access to appropriate counseling and services that support the person's values, goals, and reproductive autonomy (*10*–*14*). Health care providers can support the contraceptive needs of all persons by using a person-centered framework and recognizing the many factors that influence individual decision-making about contraception (*10*,*12*,*14*).

The U.S. MEC and U.S. SPR recommendations can be used to support a person's contraceptive decision-making (Box 2). Persons should have equitable access to the full range of contraceptive methods and be given the information they need for contraceptive decision-making in a noncoercive manner. Patient-centeredness has been defined by the Institute of Medicine as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (*23*). Shared decision-making and person-centered approaches to providing health care recognize the expertise of both the medical provider and the patient (*10*,*12*,*23*).

Health care providers should always consider the individual clinical and social factors of each person seeking contraceptive services and discuss reproductive desires, expectations, preferences, and priorities regarding contraception. A person might consider and prioritize many elements when choosing an acceptable contraceptive method, such as safety, effectiveness (*24*), availability (including accessibility and affordability), side effects, user control, reversibility, and ease of removal or discontinuation. In addition, a person's health risks associated with pregnancy and access to comprehensive health care services should be considered in these discussions. A person-centered approach to contraceptive decision-making prioritizes a person's preferences and reproductive autonomy rather than a singular focus on pregnancy prevention and respects the person as the main decision-maker in contraceptive decisions, including the decision not to use contraception or to discontinue contraceptive method use (*12*,*25*). Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling, where applicable, might be an important contributor to the successful use of contraceptive methods. Key resources provide additional information on person-centered contraceptive counseling and care (*7*,*10*,*12*,*26*).

Using U.S. MEC Categories in Practice

Health care providers can use the eligibility categories when assessing the safety of contraceptive method use for persons with certain characteristics or medical conditions. Category 1 comprises conditions for which no restrictions exist for use of the contraceptive method. However, category 1 does not imply that the method is the most appropriate choice for a person, who might be prioritizing other factors when considering contraception. Classification of a method or condition as category 2 indicates the method generally can be used, with additional discussion about risks and benefits, and careful follow-up might be required. For a method or condition classified as category 3, use of that method usually is not recommended unless other more appropriate methods are not available or acceptable. The severity of the condition and the availability, practicality, and acceptability of alternative methods should be considered, and careful follow-up is required. Hence, provision of a contraceptive method to a person with a condition classified as category 3 requires careful clinical judgment and might warrant additional counseling, consultation, or follow-up. Category 4 comprises conditions that represent an unacceptable health risk if the method is used. For example, a person who smokes and is aged <35 years generally can use COCs (category 2). However, for a person aged ≥35 years who smokes <15 cigarettes per day, the use of COCs usually is not recommended unless other methods are not available or acceptable (category 3). A person aged ≥35 years who smokes ≥15 cigarettes per day should not use COCs because of unacceptable health risks, primarily the risk for myocardial infarction and stroke (category 4). The implementation of this clinical guidance might vary within different health systems, clinics, or settings. For example, in certain settings, category 3 might mean that a special consultation is warranted. Health departments and medical societies or organizations can provide information on implementation through additional guidance or clinical protocols.

The recommendations address medical eligibility criteria for the initiation and continued use of all contraceptive methods evaluated. The issue of medical eligibility criteria for continuation of a contraceptive method is clinically relevant whenever a medical condition develops or worsens during use of a contraceptive method. When the categories differ for initiation and continuation, these differences are noted. When different initiation and continuation recommendations are not given, the category is the same for initiation and continuation of use.

On the basis of this classification system, the eligibility criteria for initiating and continuing use of a specific contraceptive method are presented in tables (Appendices A, B, C, D, E, and J). In these tables, the first column indicates the condition. Multiple conditions are divided into subconditions to differentiate between varying condition types or severity. The next columns provide classifications of the condition for initiation, continuation, or both into categories 1, 2, 3, or 4 for specific contraceptive methods. For certain conditions, the last column further clarifies the numeric category in cases where the numeric classification does not adequately capture the recommendation. These clarifications are considered a necessary element of the recommendation. The last column also summarizes the evidence for the recommendation if evidence exists. The recommendations for which no evidence is cited might be based on information from sources other than systematic reviews and might take into account individual perspectives from either the WHO or U.S. expert meetings in which these recommendations were developed. For certain recommendations, comments in the third column can provide additional rationale or other information about the recommendation. Information provided along with the numeric recommendation (i.e., clarifications, evidence, and comments) is additional detail that providers can use as part of their counseling and referrals, as needed.

U.S. MEC recommendations comprise one aspect of contraceptive counseling. All persons should be counseled about the full range of contraceptive options for which they are medically eligible. Voluntary informed choice of contraceptive methods is an essential guiding principle of these recommendations, and person-centered contraceptive counseling can help to ensure a person's contraceptive needs are met successfully.

Recommendations for Use of Contraceptive Methods

The classifications for whether persons with certain characteristics or medical conditions can safely use specific contraceptive methods are provided for intrauterine devices (IUDs), including the copper IUD (Cu-IUD) and LNG-IUD (Appendix B); progestin-only contraceptives (POCs), including progestin-only implants, depot medroxyprogesterone acetate injections, and POPs (Appendix C); CHCs, including COCs, combined transdermal patches, and combined vaginal rings (Appendix D); barrier contraceptive methods, including external (male) and internal (female) condoms, spermicides and vaginal pH modulator, and diaphragm with spermicide or cervical cap with spermicide (Appendix E); fertility awareness–based methods (Appendix F); lactational amenorrhea method (Appendix G); coitus interruptus (Appendix H); permanent contraception, including tubal surgery and vasectomy (Appendix I); and emergency contraception, including emergency use of the Cu-IUD and emergency contraceptive pills (Appendix J). A table at the end of this report summarizes the classifications for the hormonal and intrauterine methods (Appendix K).

Prevention of Sexually Transmitted Infections

All patients, regardless of contraceptive choice, should be counseled about the use of condoms and the risk for sexually transmitted infections (STIs), including HIV infection (*27*). Most contraceptive methods, such as hormonal methods, IUDs, and permanent contraception do not protect against STIs, including HIV infection. Consistent and correct use of external (male) latex condoms reduces the risk for STIs, including HIV infection (*27*). Although evidence is limited, use of internal (female) condoms can provide protection from acquisition and transmission of STIs (*27*). Patients also should be counseled that pre-exposure prophylaxis (PrEP), when taken as prescribed, is highly effective for preventing HIV infection (*28*). Additional information about prevention and treatment of STIs is available from CDC's *Sexually Transmitted Infections Treatment Guidelines* (https://www.cdc.gov/std/treatment-guidelines/default.htm) (*27*), and

information on PrEP for prevention of HIV infection is available from the U.S. Public Health Service's *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States — 2021 Update: A Clinical Practice Guideline* (https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf) (*28*).

Pregnancy and Increased Health Risk

Discussion of health risks associated with pregnancy is an important aspect of contraceptive counseling. For persons with certain medical conditions, pregnancy poses increased health risks. Conditions included in U.S. MEC that are associated with increased risk for adverse health events as a result of pregnancy are identified throughout the document (Box 3). This is not a comprehensive list of all conditions that could lead to adverse events during pregnancy. Certain medical conditions included in U.S. MEC recommendations also are treated with teratogenic drugs, which could have adverse effects when used during pregnancy. When applying U.S. MEC classifications during person-centered counseling, health care providers should discuss the risks of a particular contraceptive method as well as the health risks associated with pregnancy. Even though permanent contraception and long-acting, reversible contraceptive methods are highly effective, persons should be provided with the full range of contraceptive options and supported in their autonomous decisions about pregnancy planning and contraceptive choices. Discussions about pregnancy should include reviewing access to comprehensive health care services and subspecialists for a high-risk pregnancy (*29*).

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Acknowledgments

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Conflicts of interest for invited meeting participants, January 25–27, 2023, Atlanta, Georgia: Elise Berlan, Nexplanon clinical trainer for Merck/Organon; Nicole Chaisson, Nexplanon clinical trainer for Merck/Organon; Mitchell Creinin, received honorarium from Gedeon Richter, Mayne, and Organon, served on advisory board for Gedeon Richter, GlaxoSmithKline, OLIC, and Organon, consulted for Danco, Estetra SRL, FHI360, Mayne, and Medicines360, University

of California-Davis, receives contraceptive research funding from Chemo Research SL, Evofem, Medicines360, Merck, Sebela, and National Institutes of Health National Institute of Child Health and Human Development; Alison Edelman, receives travel reimbursement from American College of Obstetricians and Gynecologists, World Health Organization, CDC, and Gynuity for committee activities, receives royalties from Up to Date, Inc., Oregon Health & Science University receives research funding from Oregon Health & Science University Foundation, Merck, HRA Pharma, Bill & Melinda Gates Foundation, and National Institutes of Health; Emily Godfrey, works with Organon and received honoraria as Nexplanon trainer; Andrew Kaunitz, consultant to Mithra, University of Florida receives research support from Bayer, Merck, Mithra, and Mylan; Aaron Lazorwitz, receives research support from Organon for investigator-initiated research with the etonogestrel contraceptive implant; Yvanna Marlin-Guanga, employed under CommunicateHealth, contractor for U.S. Medical Eligibility Criteria for Contraceptive Use and U.S. Selected Practice Recommendations for Contraceptive Use January 2023 meeting; Rachel Martin, employed under CommunicateHealth, contractor for U.S. Medical Eligibility Criteria for Contraceptive Use and U.S. Selected Practice Recommendations for Contraceptive Use January 2023 meeting; Lydia Pecker, consulted for Novo Nordisk and Global Blood Therapeutics, receives research support from Alexion, National Institutes of Health National Heart, Lung, and Blood Institute, Mellon Foundation, American Society of Hematology, and Doris Duke Foundation; Michael Streiff, consultant for CSL Behring data safety monitoring board member, Janssen consultant on management of cancer-associated thromboembolism, and Pfizer consultant on anticoagulation for venous thromboembolism; Katharine White, receives research support through institution from Bayer, Merck, and Evofem; Tracey Wilkinson, receives project funding from Bayer, Cooper Surgical, and Organon, and nonpaid consultant for HRA Pharma.

CDC Subject Matter Experts and Attendees, January 25–27, 2023, Atlanta, Georgia

Karon Abe, Wanda Barfield, Brook Belay, Emily Cartwright, Elizabeth Clark, Shanna Cox, Suzanne Folger, Sarah Foster, Sophia Garbarino, Karen Hacker, Lisa Hollier, Craig Hooper, Bajha Jordan, Michele Mandel, Meda Pavkov, Stephanie Ramer, Brenda Reed, Jessica Rodenhizer, Lisa Romero, Laura Schieve, Andrea Stewart, Heather Tevendale, Angela Thompson-Paul, Lee Warner, Steffanie Wright, CDC, Atlanta, Georgia.

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Conflicts of Interest

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed. To promote transparency, all meeting participants were asked to disclose potential conflicts of interest to CDC before the expert meeting and to report potential conflicts of interest during the introductory portion of the expert meeting. All potential conflicts of interest disclosed by meeting participants are listed. No participants were excluded from discussion based on potential conflicts

of interest. CDC staff members who ultimately decided and developed these recommendations have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters relevant to these recommendations.

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References

1. Curtis KM, Nguyen AT, Tepper NK, et al. U.S. selected practice recommendations for contraceptive use, 2024. MMWR Recomm Rep 2024;73(No. RR-3):1–77.
2. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. selected practice recommendations for contraceptive use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. https://doi.org/10.15585/mmwr.rr6504a1 PMID:27467319
3. World Health Organization. Medical eligibility criteria for contraceptive use. Geneva, Switzerland: World Health Organization; 2015. https://www.who.int/publications/i/item/9789241549158
4. World Health Organization. Selected practice recommendations for contraceptive use. Geneva, Switzerland: World Health Organization; 2016. https://www.who.int/publications/i/item/9789241565400
5. CDC. U.S. medical eligibility criteria for contraceptive use, 2010. MMWR Recomm Rep 2010;59(No. RR-4):1–86. PMID:20559203
6. Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. medical eligibility criteria for contraceptive use, 2016. MMWR Recomm Rep 2016;65(No. RR-3):1–103. https://doi.org/10.15585/mmwr.rr6503a1 PMID:27467196
7. Gavin L, Moskosky S, Carter M, et al.; CDC. Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep 2014;63(No. RR-4):1–54. PMID:24759690
8. Gavin L, Pazol K. Update: providing quality family planning services—recommendations from CDC and the U.S. Office of Population Affairs, 2015. MMWR Morb Mortal Wkly Rep 2016;65:231–4. https://doi.org/10.15585/mmwr.mm6509a3 PMID:26963363
9. Gavin L, Pazol K, Ahrens K. Update: providing quality family planning services—recommendations from CDC and the U.S. Office of Population Affairs. MMWR Morb Mortal Wkly Rep 2017;66:1383–5. https://doi.org/10.15585/mmwr.mm6650a4 PMID:29267259
10. American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women, Contraceptive Equity Expert Work Group, and Committee on Ethics. Patient-centered contraceptive counseling: ACOG committee statement number 1. Obstet Gynecol 2022;139:350–3. https://doi.org/10.1097/AOG.0000000000004659 PMID:35061341
11. American Public Health Association. Opposing coercion in contraceptive access and care to promote reproductive health equity. Washington, DC: American Public Health Association; 2021. https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Contraceptive-Access
12. Holt K, Reed R, Crear-Perry J, Scott C, Wulf S, Dehlendorf C. Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. Am J Obstet Gynecol 2020;222(4S):S878.e1–e6. https://doi.org/10.1016/j.ajog.2019.11.1279 PMID:31809706
13. United Nations Population Fund. Programme of Action of the International Conference on Population and Development. Cairo, Egypt: United Nations; 1995. https://unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf
14. World Health Organization. Framework for ensuring human rights in the provision of contraceptive information and services. Geneva, Switzerland: World Health Organization; 2014. https://www.who.int/publications/i/item/9789241507745
15. Tepper NK, Curtis KM, Cox S, Whiteman MK. Update to U.S. medical eligibility criteria for contraceptive use, 2016: updated recommendations for the use of contraception among women at high risk for HIV infection. MMWR Morb

Mortal Wkly Rep 2020;69:405–10. https://doi.org/10.15585/mmwr.mm6914a3 PMID:32271729

16. Mohllajee AP, Curtis KM, Flanagan RG, Rinehart W, Gaffield ML, Peterson HB. Keeping up with evidence a new system for WHO's evidence-based family planning guidance. Am J Prev Med 2005;28:483–90. https://doi.org/10.1016/j.amepre.2005.02.008 PMID:15894153
17. CDC. Updating CDC's contraception guidance documents: U.S. medical eligibility criteria for contraceptive use and U.S. selected practice recommendations for contraceptive use. Atlanta, GA: US Department of Health and Human Services, CDC; 2021. https://www.govinfo.gov/content/pkg/FR-2021-08-31/pdf/2021-18769.pdf
18. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. https://doi.org/10.1136/bmj.n71 PMID:33782057
19. Guyatt G, Oxman AD, Akl EA, et al. GRADE guidelines: 1. Introduction-GRADE evidence profiles and summary of findings tables. J Clin Epidemiol 2011;64:383–94. https://doi.org/10.1016/j.jclinepi.2010.04.026 PMID:21195583
20. Guyatt GH, Oxman AD, Vist GE, et al.; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ 2008;336:924–6. https://doi.org/10.1136/bmj.39489.470347.AD PMID:18436948
21. Armstrong MJ, Rueda JD, Gronseth GS, Mullins CD. Framework for enhancing clinical practice guidelines through continuous patient engagement. Health Expect 2017;20:3–10. https://doi.org/10.1111/hex.12467 PMID:27115476
22. Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. Clinical practice guidelines we can trust. In: Graham R, Mancher M, Miller Wolman D, Greenfield S, Steinberg E, eds. Clinical practice guidelines we can trust. Washington, DC: National Academies Press; 2011.
23. Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press; 2001.
24. Bradley SEK, Polis CB, Micks EA, Steiner MJ. Effectiveness, safety, and comparative side effects. In: Cason P, Cwiak C, Edelman A, Kowal D, Marrazzo JM, Nelson AL, et al., editors. Contracept Technol. 22nd ed. Burlington, MA: Jones-Bartlett Learning; 2023.
25. Potter JE, Stevenson AJ, Coleman-Minahan K, et al. Challenging unintended pregnancy as an indicator of reproductive autonomy. Contraception 2019;100:1–4. https://doi.org/10.1016/j.contraception.2019.02.005 PMID:30851238
26. Reproductive Health National Training Center. Contraceptive counseling and education eLearning. Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Population Affairs, Office on Women's Health; 2022. https://rhntc.org/resources/contraceptive-counseling-and-education-elearning
27. Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. MMWR Recomm Rep 2021;70:1–187. https://doi.org/10.15585/mmwr.rr7004a1 PMID:34292926
28. CDC. US Public Health Service preexposure prophylaxis for the prevention of HIV infection in the United States—2021 update: a clinical practice guideline. Atlanta, GA: US Department of Health and Human Services, CDC; 2021. https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf
29. Blackwell S, Louis JM, Norton ME, et al. Reproductive services for women at high risk for maternal mortality: a report of the workshop of the Society for Maternal-Fetal Medicine, the American College of Obstetricians and Gynecologists, the Fellowship in Family Planning, and the Society of Family Planning. Am J Obstet Gynecol 2020;222:B2–18. https://doi.org/10.1016/j.ajog.2019.12.008 PMID:32252942

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BOX 1. Categories of medical eligibility criteria for contraceptive use

U.S. MEC 1 = A condition for which there is no restriction for the use of the contraceptive method

U.S. MEC 2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks

U.S. MEC 3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method

U.S. MEC 4 = A condition that represents an unacceptable health risk if the contraceptive method is used

Abbreviation: U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use*.

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BOX 2. Using the *U.S. Medical Eligibility Criteria for Contraceptive Use* and *U.S. Selected Practice Recommendations for Contraceptive Use* recommendations to support contraceptive decision-making

- CDC acknowledges the paramount importance of personal autonomy in contraceptive decision-making.
- Persons should have equitable access to the full range of contraceptive methods.
- Contraceptive services should be offered in a noncoercive manner that honors a person's values, goals, and reproductive autonomy.
- Shared decision-making and person-centered approaches recognize the expertise of both the health care provider and the person.
- A person-centered approach to contraceptive decision-making
    - ° prioritizes a person's preferences and reproductive autonomy rather than a singular focus on pregnancy prevention,
    - ° respects the person as the main decision-maker in contraceptive decisions, and
    - ° includes respecting the decision not to use contraception or to discontinue contraceptive method use.
- U.S. MEC and U.S. SPR recommendations can be used by health care providers to support persons in contraceptive decision-making.
- U.S. MEC and U.S. SPR recommendations can be used by health care providers to remove unnecessary medical barriers to accessing and using contraception.

Abbreviations: U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use*; U.S. SPR = *U.S. Selected Practice Recommendations for Contraceptive Use*.

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BOX 3. Conditions included in *U.S. Medical Eligibility Criteria for Contraceptive Use* associated with increased risk for adverse health events as a result of pregnancy*

- Breast cancer
- Chronic kidney disease: with current nephrotic syndrome, receiving hemodialysis, or receiving peritoneal dialysis
- Complicated valvular heart disease
- Cystic fibrosis
- Decompensated cirrhosis
- Deep venous thrombosis/pulmonary embolism
- Diabetes: insulin dependent; with nephropathy, retinopathy, or neuropathy or other vascular disease; or of >20 years' duration
- Endometrial cancer
- Epilepsy
- Gestational trophoblastic disease
- Hepatocellular adenoma and malignant liver tumors (hepatocellular carcinoma)
- History of bariatric surgery within the past 2 years
- HIV infection: not clinically well or not receiving antiretroviral therapy
- Hypertension (systolic ≥160 mm Hg or diastolic ≥100 mm Hg)
- Ischemic heart disease
- Ovarian cancer
- Peripartum cardiomyopathy
- Schistosomiasis with fibrosis of the liver
- Sickle cell disease
- Solid organ transplantation within the past 2 years
- Stroke
- Systemic lupus erythematosus
- Thrombophilia (e.g., factor V Leiden mutation; prothrombin gene mutation; protein S, protein C, and antithrombin deficiencies; or antiphospholipid syndrome)
- Tuberculosis

* Even though permanent contraception and long-acting, reversible contraceptive methods are highly effective, persons should be provided with the full range of contraceptive options and supported in their autonomous decisions about pregnancy planning and contraceptive choices. Discussions about pregnancy should include reviewing access to comprehensive health care services and subspecialists for a high-risk pregnancy.

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