What's New in the 2024 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), Selected Practice Recommendations for Contraceptive Use (U.S. SPR), and Quality Family Planning (QFP) Guidelines

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CAPTC
California Prevention Training Center

June 24, 2025

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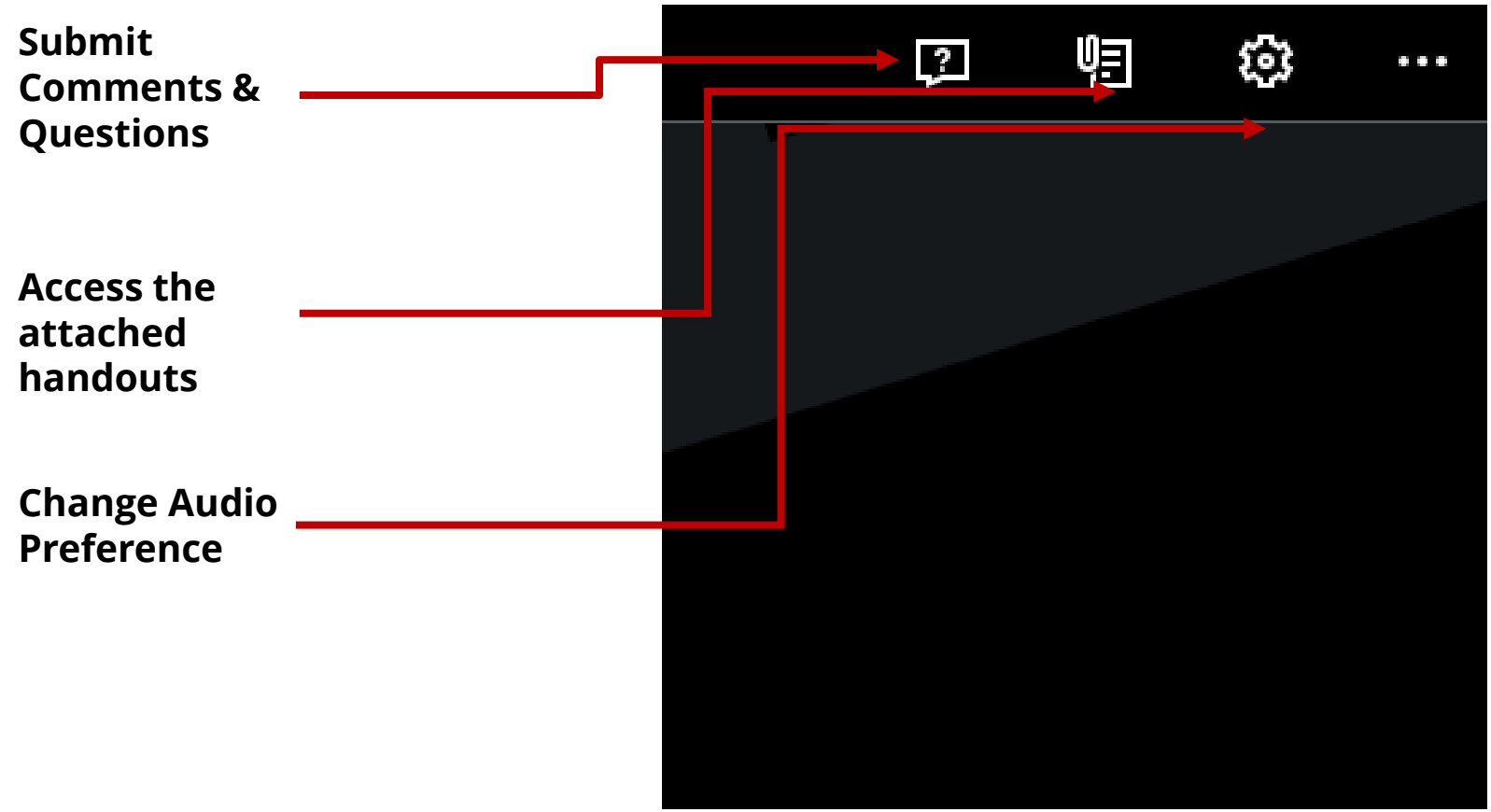

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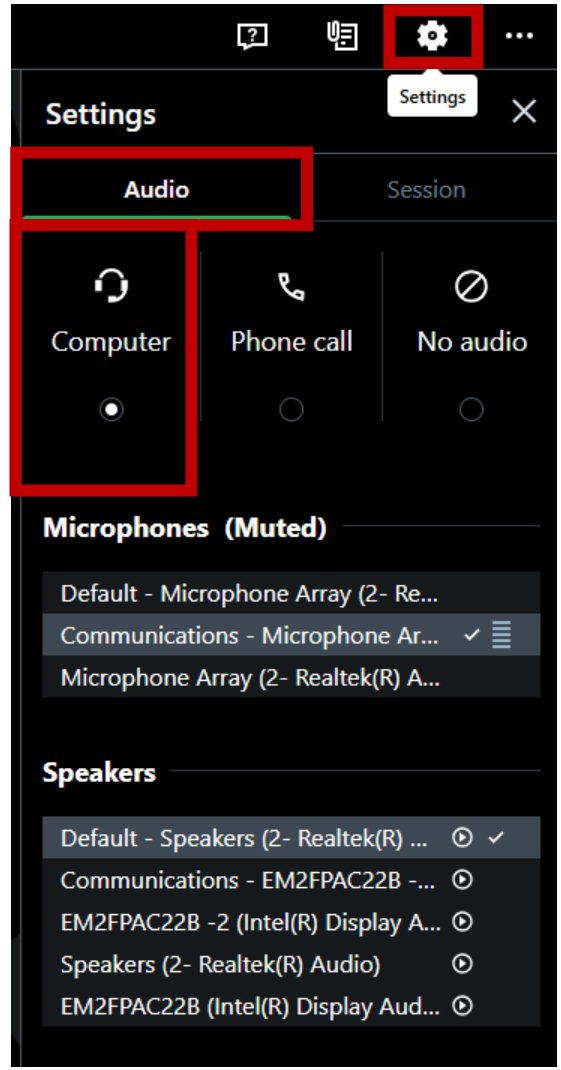

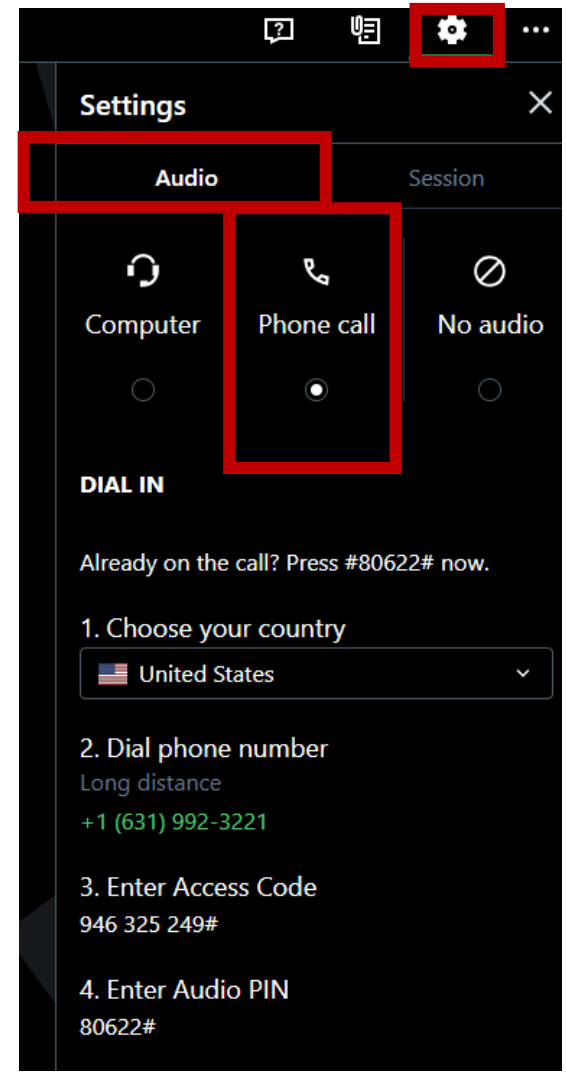

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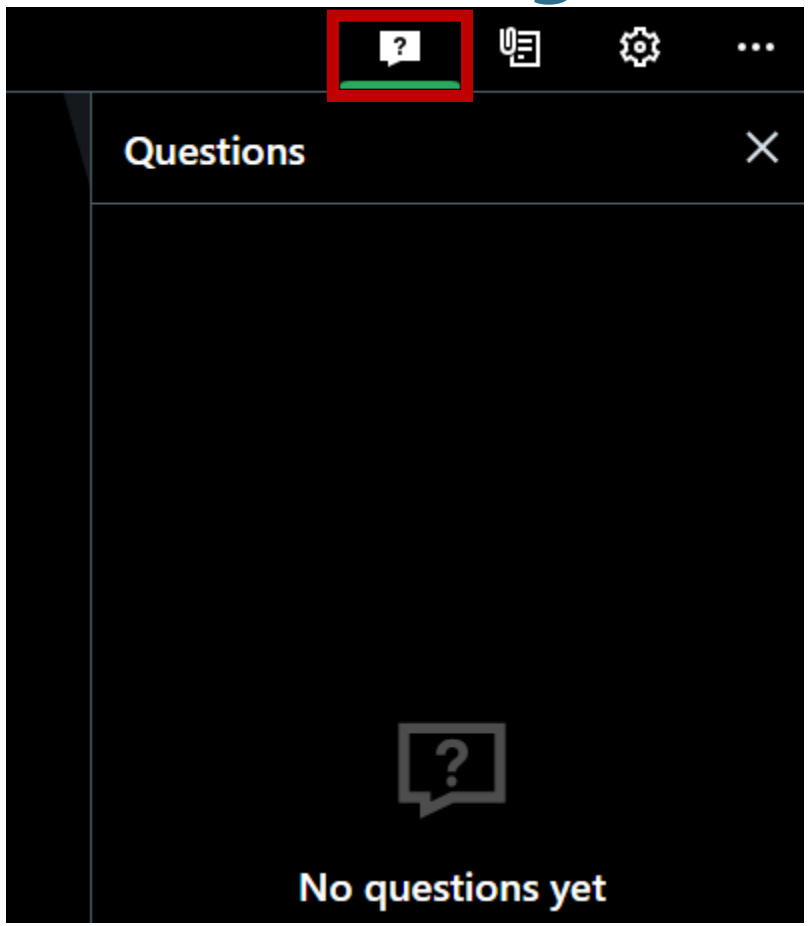

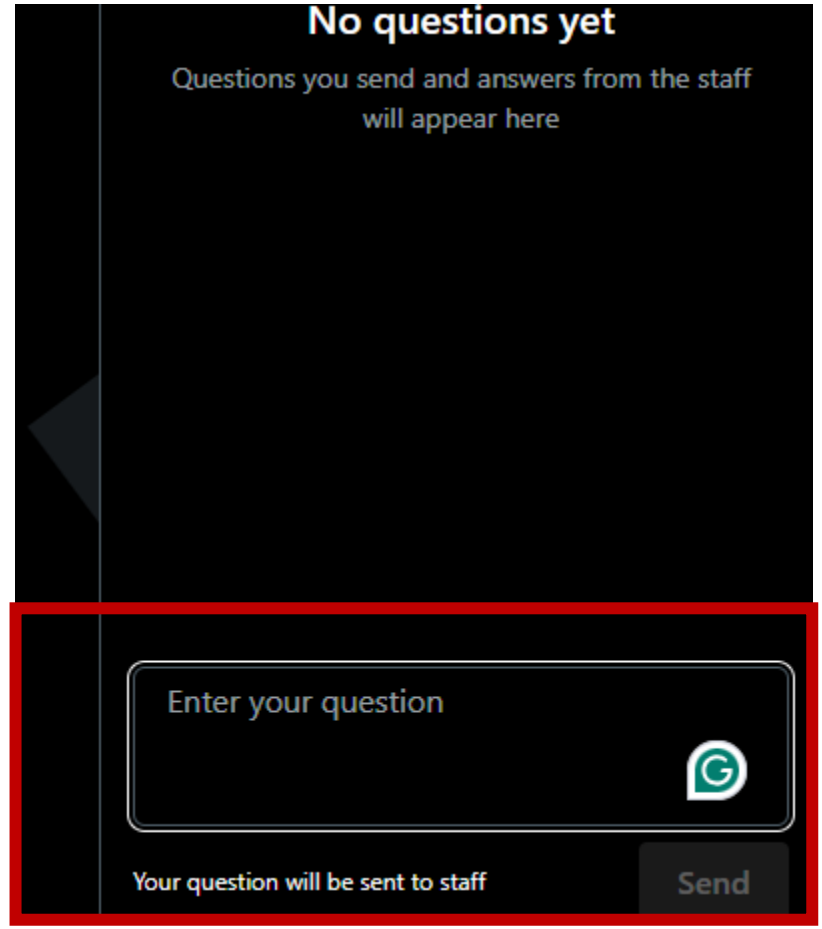

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Family PACT Clinical Webinar

June 24, 2025

12-1:45 pm

US MEC
US SPR

What's new in the 2024

- CDC Medical Eligibility Criteria for Contraceptive Use (MEC)
- CDC Selected Practice Recommendations for Contraceptive Use (SPR)
- Quality Family Planning (QFP) Guidelines

DHCS
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Family PACT

Disclosures

- Dr. Policar
  - I have no commercial disclosures
  - I participated in the 3 Expert Panels for the CDC MEC/SPR
  - Senior Author/Editor of *Contraceptive Technology*, 22nd ed
- Dr. Karlin
  - I have no commercial disclosures

Learning Objectives

As a result of this lecture, participants will be able to:

1. State which medical condition is addressed for the first time in the US MEC.
2. For people using DMPA, list 3 medical conditions that had changes in their US MEC safety category.
3. Describe two changes in the section of the SPR on bleeding irregularities during implant use.

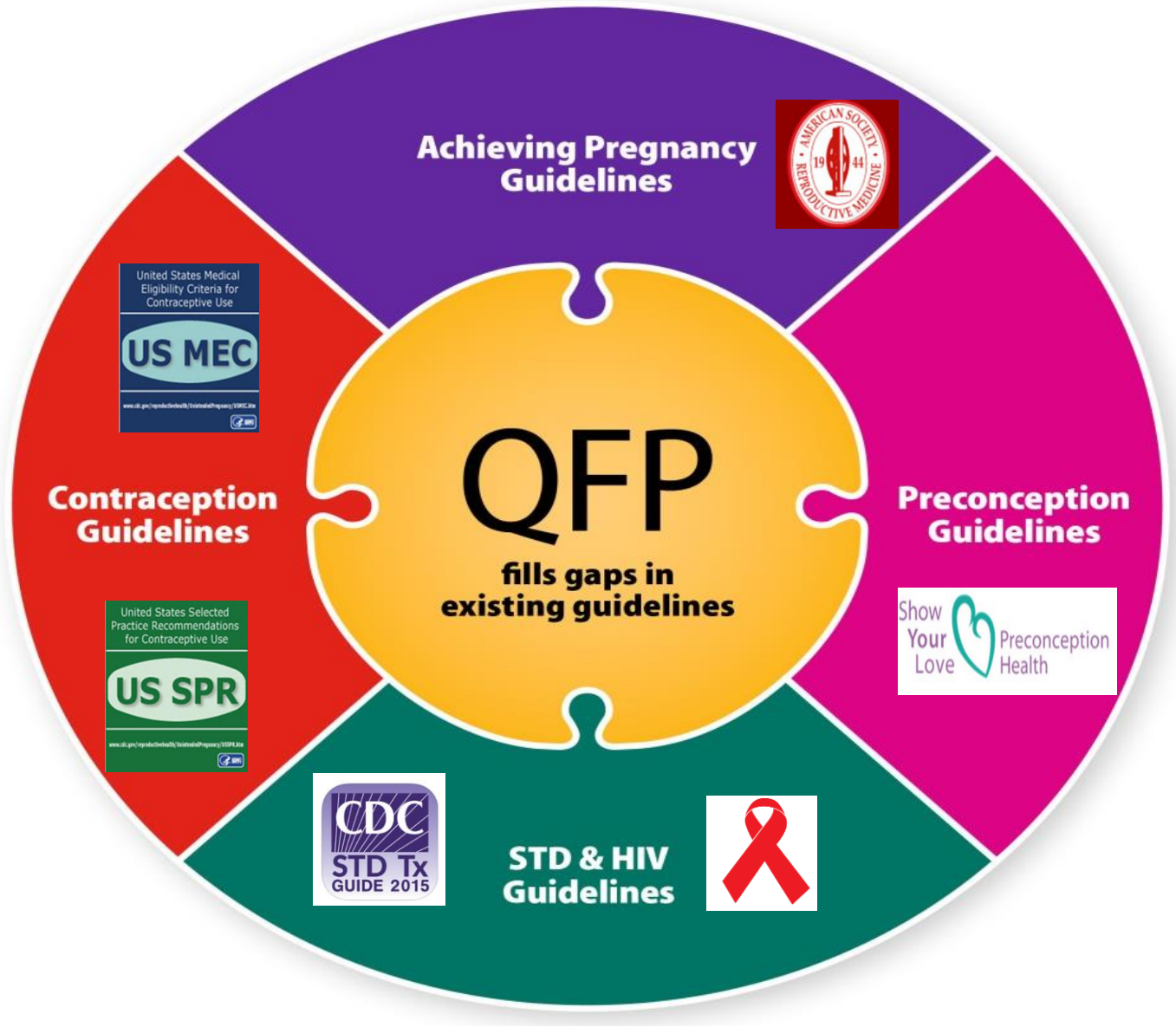
Agenda

- Updated sections the 2024 QFP
- Conventions used in the 2024 MEC and SPR guidelines
- Helpful resources for implementation of the 2024 MEC and SPR
- Updates and modifications in the 2024 MEC and SPR
- Case studies
  - Chronic kidney disease (CKD)
  - Sickle cell disease
- Conclusion
- Audience questions

Basics of US National Family Planning Guidelines

Family PACT

“Suite” of Family Planning Recommendations



Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 63 / No. 4
April 25, 2014

QFP 1.0 (2014) Filling The "Gaps"

Providing Quality Family Planning Services

Recommendations of CDC and the U.S. Office of Population Affairs

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/contad.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- Contraceptive counseling
- Client-centered reproductive goals counseling
- Pregnancy testing and counseling
- Achieving pregnancy
- Basic infertility
- Prepregnancy health
- Preventive health screening of women and men

Quality Family Planning (QFP 2.0) Guidelines

- Extensively updated in 2024 by the U.S. Office of Population Affairs
- New sections
  - Performance Measures to Track and Improve Quality of Care
  - Person-Centered Contraceptive Care Strategies
    - Family PACT webinar on October 19, 2022
    - https://familypact.org/resources/person-centered-contraception-counseling-for-family-pact-clients/

Link to QFP guidelines

https://www.ajpmonline.org/article/S0749-3797(24)00310-6/fulltext

American Journal of
Preventive Medicine

SPECIAL ARTICLE

Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)

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This update, titled Providing Quality Family Planning Services[a] in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024), provides recommendations developed by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). These recommendations represent an update to Providing Quality Family Planning (QFP) Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA), originally published in 2014. The updated recommendations outline how to provide quality sexual and reproductive health (SRH) services for people of reproductive age but can also be used to guide the care of people of any age when the content is relevant to their needs, including family-building services, contraception, pregnancy testing and counseling, early pregnancy management, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) prevention and testing services, and other preventive health services. The recommendations aim to enable health care providers with the knowledge, skills, and attitudes to ensure that all people, regardless of individual characteristics such as sex, sexual orientation and gender identity, age, disability, or race, can have their SRH needs met. The primary audience for these recommendations is providers and potential providers of SRH services to people of reproductive age, such as providers working in clinical settings dedicated to SRH service delivery, including those funded by the Title X family planning program[b] as well as primary care providers and other subspecialty providers who may identify SRH needs and make referrals.

During the past decade, several changes have taken place in the United States that have affected SRH care delivery, including technological advances, recognition of long-standing inequities, and other legal and regulatory changes. This broader context has been considered in designing the updated recommendations.

This update of the QFP aims to provide guidance on the provision of person-centered SRH care focused on individuals' needs, values, and preferences. The update offers specific recommendations for how to provide high-quality SRH care and connects users to relevant guidelines, primary research, and other resources to inform best practices. In addition to incorporating new evidence,

QFP Guide

Explore the QFP | Download the QFP | About the QFP

Providing Quality Family Planning (QFP) Services in the United States

Recommendations of the U.S. Office of Population Affairs (Revised 2024)

Get Started ›

Search the QFP for key topics...

https://www.qfpguide.org/

The **QFP** is for any and **all health care providers** who care for patients of reproductive age. QFP provides information on the following topics:

- Fundamentals of Sexual and Reproductive Health Care Delivery
- Determining an Individual's Need and Desire for Services
- Person-Centered Contraceptive Care Delivery
- STI and HIV Services
- Family Building
- Pregnancy Testing and Counseling
- Early Pregnancy Management
- Screening and Other Preventive Health Care
- Using Performance Measures to Track and
- Summary

US MEC: Focus on *Safety* for Contraceptive Users

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

U.S. Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 73 / No. 4
August 8, 2024

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

https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7304a1-H.pdf

US SPR 2024: Focus on *Efficacy and Acceptability*

US SPR
US Selected Practice Recommendations for Contraceptive Use, 2024

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 73 / No. 3
August 8, 2024

U.S. Selected Practice Recommendations for Contraceptive Use, 2024

https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7303a1-H.pdf

US Medical Eligibility Criteria, 2024

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

Cat	Definition	Recommendation
1	No restriction in use	Use the method
2	Advantages generally outweigh theoretical or proven risks	More than usual follow-up needed
3*	*Proven* risks (with data) or *theoretical* risks (no data) outweigh advantages • May use if all Cat 1-2 methods are not acceptable or available • In general, safer than pregnancy	• Use clinical judgment that the person can use safely • The severity of the condition and the availability, practicality, and acceptability of alternative methods should be considered
4	Unacceptable health risk	Do not use the method

*In certain settings, category 3 might mean that a special consultation is warranted

US MEC: The "Last Column" Clarification/Evidence/Comments

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

- *Clarifications* are a *necessary element* of the recommendation
  - Clarifies the numeric category when the number *does not* adequately capture the recommendation
  - Summarizes the evidence for the recommendation if it exists
  - When no evidence is available, it accounts for perspectives from the WHO or U.S. expert meetings
- *Comments* provide additional rationale about the recommendation
  - Additional detail that can be used for counseling and referrals

2024 US MEC: Headaches

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

	Cu-IUD	LNG-IUD	Implant	DMPA	POP	OC/P/R
Non-migrainous	1	1	1	1	1	1*
Migraine						
Without aura	1	1	1	1	1	2*
With aura	1	1	1	1	1	4*

Clarification/Evidence/Comment

- Classification depends on accurate diagnosis of those severe headaches that are migraines or not, as well as diagnosis of ever experiencing aura
- For more information, see the International Headache Society's International Classification of Headache Disorders, 3rd ed.
- Any new headaches or marked changes in headaches should be evaluated
- Classification is for persons without any other risk factors for stroke

US MEC/SPR: 2024 Updates

US MEC
US SPR

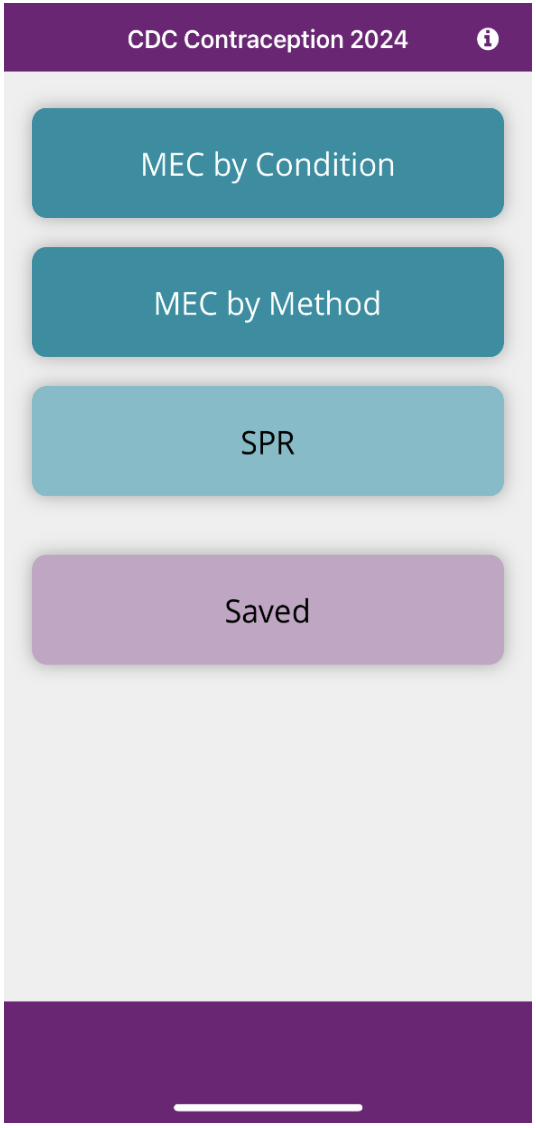
- Emphasis on person-centered counseling and method provision
  - Reproductive autonomy
  - Shared decision making
  - Person-centered approach to contraceptive decision-making
- Use of gender-inclusive language
- Updated terminology for certain conditions, e.g.
  - Thrombophilia and hematologic conditions
  - Subcategories for cirrhosis and solid organ transplantation

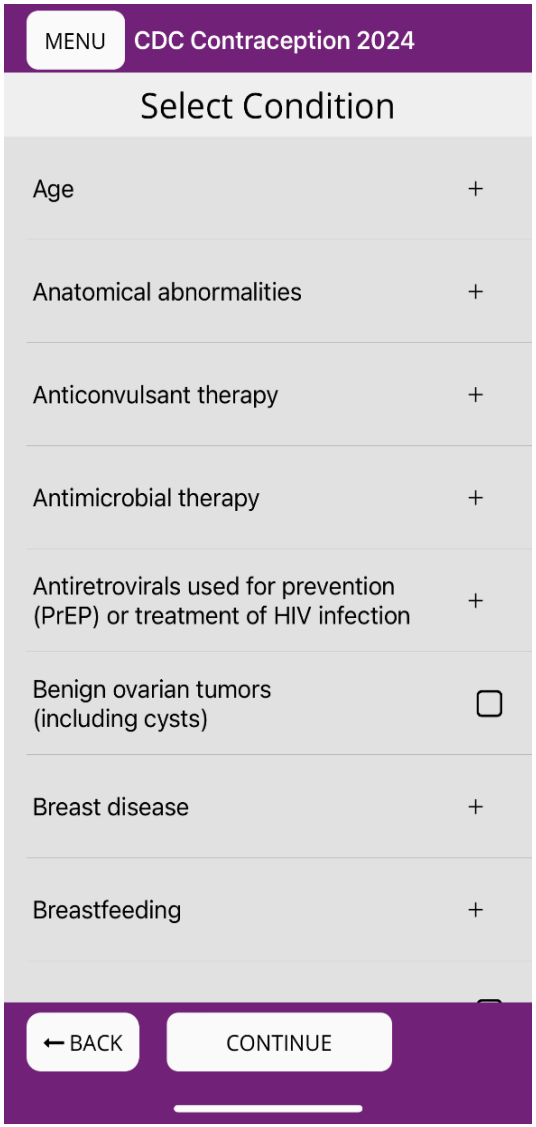
Using the US MEC/SPR to Support Contraceptive Decision Making

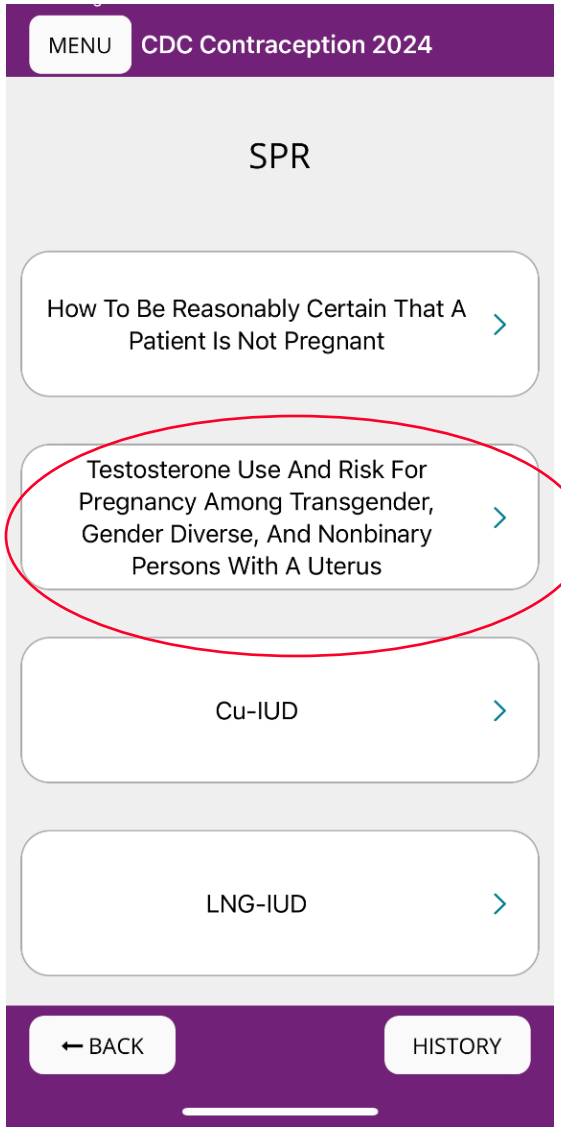
US MEC
US SPR

- 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, and
  - Respects the decision to discontinue or not to use contraception

2024 US MEC/SPR App

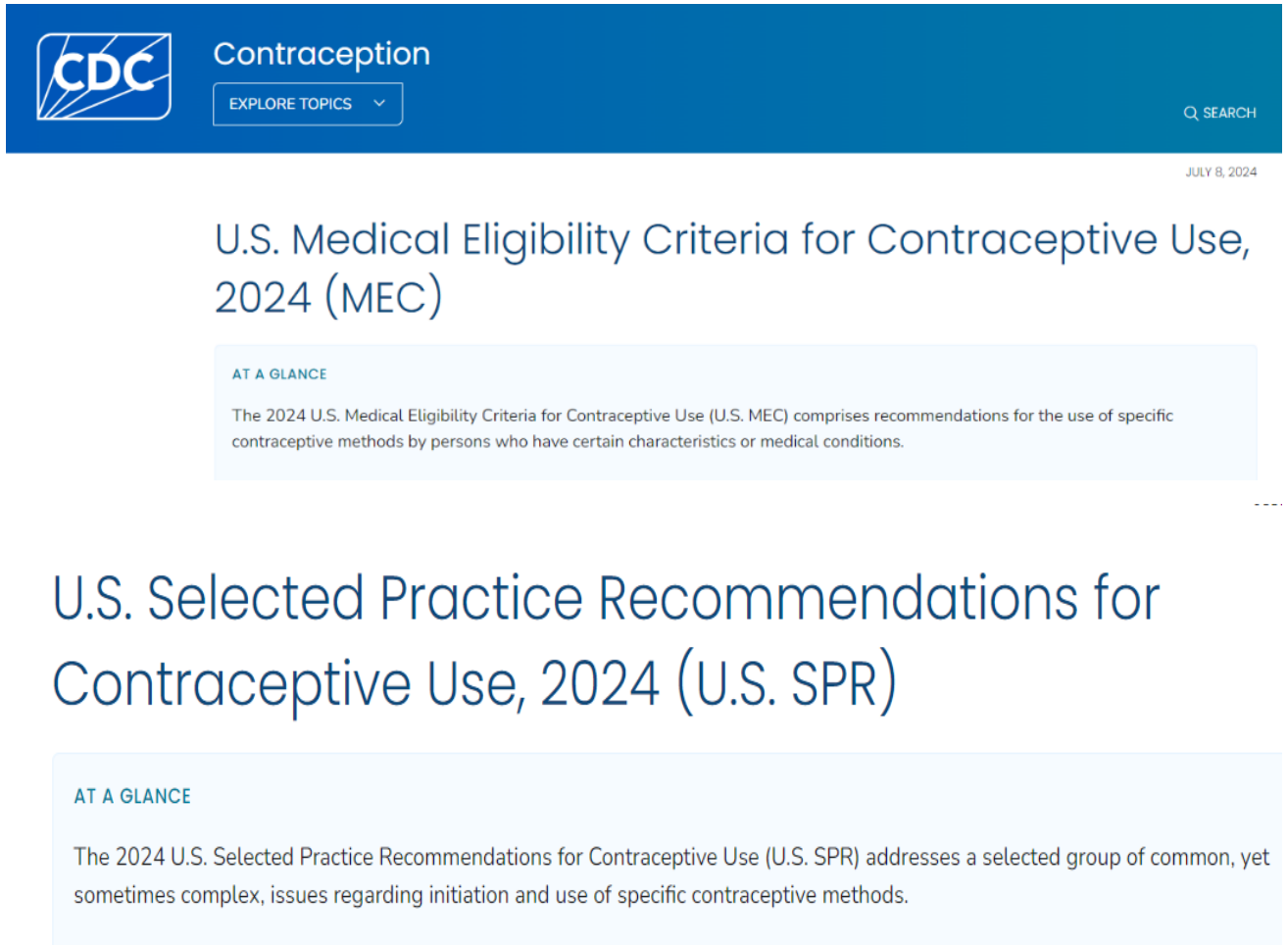






2024 MEC/SPR: Online Access

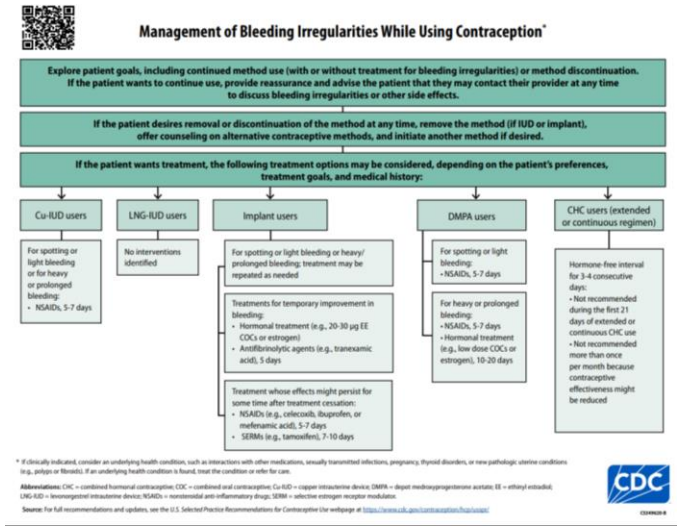
US MEC
US SPR

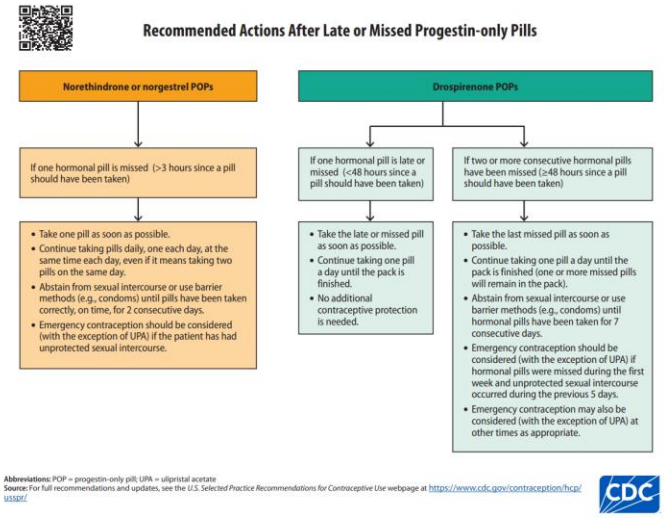


- https://www.cdc.gov/contraception/hcp/contraceptive-guidance/

Updated US MEC/SPR Provider Tools

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





For accessible version, please see the summary of classifications at https://www.cdc.gov/contraception/hcp/usmec/.

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

Updated in 2024. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/contraception/hcp/usmec/. Most contraceptive methods do not protect against STIs. Consistent and correct use of the external (male) latex condom reduces the risk of STIs and HIV.
Please see NIH guidelines for up to date recommendations on hormonal contraception and ARVs: https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview?view=full#table-3 and https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview?view=full.

KEY: 1 = No restriction (method can be used) | 2 = Advantages generally outweigh theoretical or proven risks | 3 = Theoretical or proven risks usually outweigh the advantages | 4 = Unacceptable health risk (method not to be used)

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									
Anemia, iron-deficiency		2		1		1		1		1		1	
Benign ovarian tumors	(*including cysts*)	1		1		1		1		1		1	
Breast disease	a. Undiagnosed mass	1		2*		2*		2*		2*		2*	
	b. Benign breast disease	1		1		1		1		1		1	
	c. Family history of cancer	1		1		1		1		1		1	
	d. Breast cancer‡												
	i. Current	1		4		4		4		4		4	
	ii. Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a. <21 days postpartum					2*		2*		2*		4*	
	b. 21 to <30 days postpartum												
	i. With other risk factors for VTE					2*		2*		2*		3*	
	ii. Without other risk factors for VTE					2*		2*		2*		3*	
	c. 30-42 days postpartum												
	i. With other risk factors for VTE					1*		2*		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	
Chronic kidney disease‡	a. Current nephrotic syndrome	1	1	2	2	2		3		2/4*		4	
	b. Hemodialysis	1	1	2	2	2		3		2/4*		4	
	c. Peritoneal dialysis	2	1	2	2	2		3		2/4*		4	
Cirrhosis	a. Compensated (*normal liver function*)	1		1		1		1		1		1	
	b. Decompensated‡ (*impaired liver function*)	1		2		2		3		2		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)‡	a. Current or history of DVT/PVE, receiving anticoagulant therapy (*therapeutic dose*)	2*		2*		2*		2*		2*		3*	
	b. History of DVT/PE, receiving anticoagulant therapy (*prophylactic dose*)												
	i. Higher risk for recurrent DVT/PE	2*		2*		2*		3*		2*		4*	
	ii. Lower risk for recurrent DVT/PE	2*		2*		2*		2*		2*		3*	
	c. History of DVT/PE, not receiving anticoagulant therapy												
	i. Higher risk for recurrent DVT/PE	1		2		2		3		2		4	
	ii. Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	d. Family history (*first-degree relatives*)	1		1		1		1		1		2	
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, or neuropathy‡	1		2		2		3		2		3/4*	
	d. Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy‡	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a. Asymptomatic	1		2		2		2		2		2	
	b. Symptomatic												
	i. Current	1		2		2		2		2		3	
	ii. Treated by cholecystectomy	1		2		2		2		2		2	
	iii. Medically treated	1		2		2		2		2		3	
Gestational trophoblastic disease (GTD)‡	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. Undectectable or non-pregnant β-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii. Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii. Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv. Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a. Nonmigraine (*mild or severe*)	1		1		1		1		1		1*	
	b. Migraine												
	i. Without aura (*includes menstrual migraine*)	1		1		1		1		1		2*	
	ii. With aura	1		1		1		1		1		4*	
History of bariatric surgery‡	a. Restrictive procedures	1		1		1		1		1		1	
	b. Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a. Pregnancy related	1		1		1		1		1		2	
	b. Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of pelvic surgery	(*see also Postpartum [including cesarean delivery]*)	1		1		1		1		1		1	
HIV	a. High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b. HIV infection					1*		1*		1*		1*	
	i. Clinically well receiving ARV therapy	1	1	1	1	*If on ARV, see also Drug Interactions.*							
	ii. Not clinically well or not receiving ARV therapy‡	2	1	2	1	*If on ARV, see also Drug Interactions.*							

CS 308904

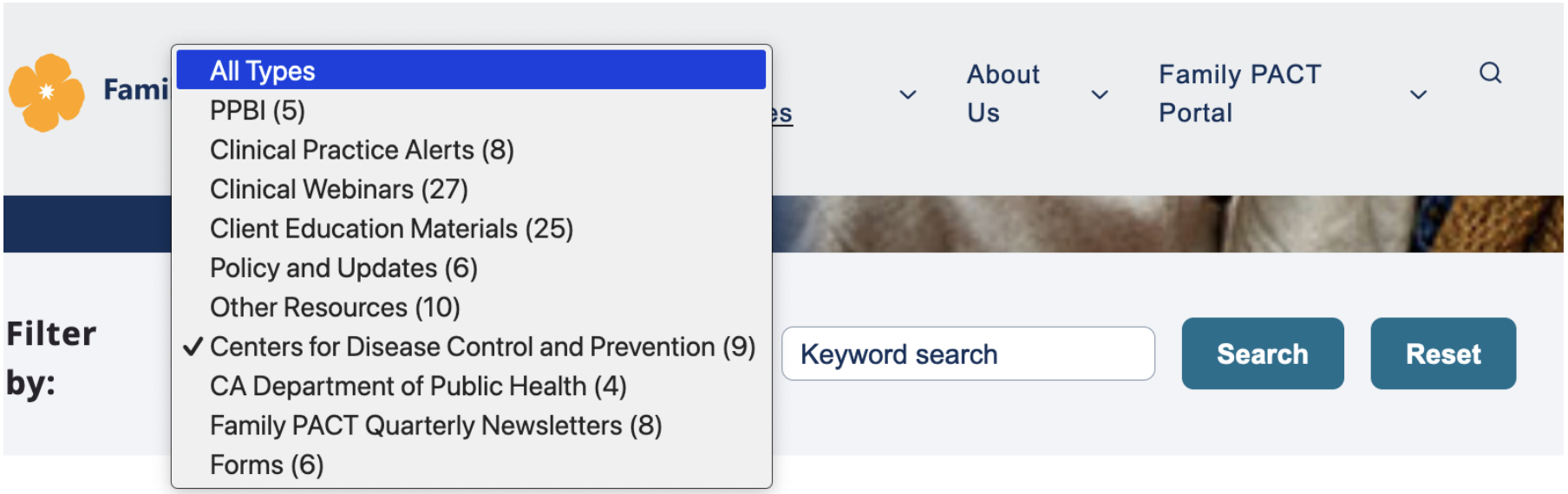
Abbreviations: ARV = antiretroviral; C = continuation of contraceptive method; CHC = combined hormonal contraceptive (pill, patch, and ring); COC = combined oral contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiation of contraceptive method; LNG-IUD = levonorgestrel intrauterine device; NA = not applicable; POP = progestin-only pill; P/R = patch/ring; SSRI = selective serotonin reuptake inhibitor; STI = sexually transmitted infection; VTE = venous thromboembolism. ‡Condition associated with increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/contraception/hcp/usmec/.

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

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†	1*		2*		2*		3*		2*		4*	
	c. Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*ulcerative colitis or Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease‡	Current and history of	1		2	3	2	3	3		2	3	4	
Liver tumors	a. Benign												
	i. Focal nodular hyperplasia	1		2		2		2		2		2	
	ii. Hepatocellular adenoma‡	1		2		2		3		2		4	
	b. Malignant† (*hepatocellular carcinoma*)	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. Without prolonged immobility	1		1		1		2		1		1	
	b. With prolonged immobility	1		1		1		2		1		3	
Obesity	a. Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2*	
	b. Menarche to <18 years and BMI ≥30 kg/m²	1		1		1		2		1		2*	
Ovarian cancer‡		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. Current	4	2*	4	2*	1		1		1		1	
	b. 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	
Peripartum cardiomyopathy‡	a. Normal or mildly impaired cardiac function												
	i. <6 months	2		2		1		2		1		4	
	ii. ≥6 months	2		2		1		2		1		3	
	b. Moderately or severely impaired cardiac function	2		2		2		3		2		4	
Postabortion ***(spontaneous or induced)***	a. First trimester abortion												
	i. Procedural (*surgical*)	1*		1*		1*		1*		1*		1*	
	ii. Medication	1*		1*		1*		1/2*		1*		1*	
	iii. Spontaneous abortion with no intervention	1*		1*		1*		1*		1*		1*	
	b. Second trimester abortion												
	i. Procedural (*surgical*)	2*		2*		1*		1*		1*		1*	
	ii. Medication	2*		2*		1*		1*		1*		1*	
	iii. Spontaneous abortion with no intervention	2*		2*		1*		1*		1*		1*	
	c. Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum ***(nonbreastfeeding)***	a. <21 days					1		2		1		4	
	b. 21 days to 42 days												
	i. With other risk factors for VTE					1		2		1		3*	
	ii. Without other risk factors for VTE					1		1		1		2	
	c. >42 days					1		1		1		1	
Postpartum ***(including cesarean delivery, breastfeeding, or nonbreastfeeding)***	a. <10 minutes after delivery of the placenta	2*		2*									
	b. 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c. ≥4 weeks	1*		1*									
	d. Postpartum sepsis	4		4									
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Rheumatoid arthritis	a. Not on immunosuppressive therapy	1		1		1		2		1		2	
	b. On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
Schistosomiasis	a. Uncomplicated	1		1		1		1		1		1	
	b. Fibrosis of the liver‡ (*if severe, see also Cirrhosis*)	1		1		1		1		1		1	
Sexually transmitted infections (STIs)	a. Current purulent cervicitis or chlamydial infection of 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 related to STIs	2*	2	2*	2	1		1		1		1	
Sickle cell disease‡		2		1		1		2/3*		1		4	
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‡	a. No graft failure	1	1	1	1	2		2/3*		2		2*	
	b. Graft failure	2	1	2	1	2		2/3*		2		4	
Stroke‡	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		2		1		3*	
Surgery	a. Minor surgery without immobilization	1		1		1		1		1		1	
	b. Major surgery												
	i. Without prolonged immobilization	1		1		1		1		1		2	
	ii. With prolonged immobilization	1		1		1		2		1		4	
Systemic lupus erythematosus‡	a. Positive (or unknown) antiphospholipid antibodies	1*	1*	2*		2*		3*	3*	2*		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*	
Thalassemia		2		1		1		1		1		1	
Thrombophilia†		1*		2*		2*		3*		2*		4*	
Thyroid disorders	Simple goiter, hyperthyroid, or hypothyroid	1		1		1		1		1		1	
Tuberculosis† *(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‡	1		1		1		2		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. Chronic	1		1		1		1		1		1	1
Drug Interactions													
Antiretrovirals (ARVs) used for prevention (PrEP) or treatment of HIV†	Fosamprenavir (FPV)	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
	All other ARVs are 1 or 2 for all methods												
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	

Access to Guidelines @ familypact.org



2024 U.S. MEC Updates

Family PACT

US MEC 2024: New Recommendations

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

- Addition of chronic kidney disease
  - Nephrotic syndrome
  - Hemodialysis
  - Peritoneal dialysis
- Inclusion of additional contraceptive methods since 2016
  - New formulations of combined pills, patches and vaginal rings
  - New formulations of progestin only pills
  - All four levonorgestrel IUDs
  - Vaginal pH modulator

Note: Twirla, Annovera, all four LNG IUDs, and Phexxi are FPACT benefits

US MEC 2024: Chronic Kidney Disease (CKD)

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

MEC Category 1/2

Chronic kidney disease
- With nephrotic syndrome
- On hemodialysis
- On peritoneal dialysis

Copper IUD, LNG-IUD, implant, barrier, norgestrel & norethindrone POP

MEC Category 3/4

Chronic kidney disease
- With nephrotic syndrome
- On hemodialysis
- On peritoneal dialysis

CHC, DMPA, DRSP POP (with known hyperkalemia)*

POP: Progestin-only pill
CHC: Combined hormonal contraception
DMPA: Depot medroxyprogesterone acetate
DRSP: Drospirenone
LNG: Levonorgestrel

* If known hyperkalemia, do not use DRSP POPs because of the risk for worsening K+ (MEC 4).
* For persons with CKD *without* known hyperkalemia (MEC 2), consider checking serum K+ during first cycle of DRSP POPs

US MEC 2024: *Updated* Recommendations

US MEC
US Medical Eligibility Criteria for Contraceptive Use, 2024

- Postpartum
- Post-abortion (including medication abortion)
- Cirrhosis
- Liver tumors: hepatocellular adenoma
- Solid organ transplant
- High risk for HIV (interim update previously published in 2017 and 2020)
- Systemic lupus erythematous (SLE): positive or unknown antibodies
- Sickle cell disease
- DVT/PE: on anticoagulation therapy
- Increased risk of DVT/PE (e.g., major surgery with prolonged immobilization, thrombophilia, superficial venous thrombosis, valvular heart disease, peripartum cardiomyopathy)

US MEC 2024: Updated Recommendations (Appendix A)

Less concern about safety

3/4 → 1/2

- Solid organ transplant, graft failure (IUD initiation)
- SLE, positive or unknown antibodies (LNG-IUD, implant, POP)
- Decompensated cirrhosis (LNG-IUD, implant, POP)
- Hepatocellular adenoma (LNG-IUD, implant, POP)

2 → 1

- High risk for HIV (IUDs)
- Solid organ transplant, no graft failure (IUDs)
- Major surgery with prolonged immobilization (LNG-IUD, implant, POP)

4 → 3

- DVT/PE on anticoagulation therapy (therapeutic dose) (CHCs)

More concern about safety

1/2 → 3/4

- Increased risk of VTE (DMPA)
- Sickle cell disease (CHCs, DMPA)
- Peripartum cardiomyopathy, impaired cardiac function

1 → 2

- Conditions with increased risk of VTE (DMPA)
- Postpartum, <10 minutes after delivery (IUDs)
- Postabortion, 1st trimester med abortion with mifepristone @ abortion initiation (DMPA)

Changes that reflect more concern about safety (DMPA)

1/2 → **3**

- H/o DVT/PE on AC (prophylactic dose), higher risk for recurrent VTE
- H/o DVT/PE not on AC, higher risk for recurrent VTE
- Thrombophilia
- Sickle cell disease (MEC 2/3)
- Peripartum cardiomyopathy, moderately or severely impaired cardiac function

1 → **2**

- Postpartum
  - BF, 30-42 days, with other risk factors for VTE
  - Non-BF, < 21 days
  - Non-BF, 21-42 days, with other risk factors for VTE
- Superficial venous thrombosis (acute or history)
- Valvular heart disease
- Peripartum cardiomyopathy, normal or mildly impaired cardiac function

2024 U.S. SPR Updates

Family PACT

US SPR 2024: *New and Updated*

US SPR
US Selected Practice Recommendations for Contraceptive Use, 2024

- Changes to align with updates to US MEC 2024
- *New* recommendations
  - Testosterone use and risk of pregnancy among transgender, gender diverse, and non-binary persons with a uterus
  - Self-administration of DMPA 104-SC (updated in 2021)
- *Updated* recommendations
  - Bleeding irregularities during implant use
  - Pain management for IUD placement
    - Detailed FamilyPACT webinar on this topic: Sept. 17, 2024
    - https://familypact.org/resources/addressing-and-preventing-pain-and-anxiety-with-iud-placement/

US SPR 2024: *New* Recommendations

US SPR
US Selected Practice Recommendations for Contraceptive Use, 2024

- *Testosterone Use* and Risk for Pregnancy
  - Counsel that testosterone use might not prevent pregnancy among transgender, gender diverse, and nonbinary persons with a uterus
  - Offer contraceptive counseling to those at risk of pregnancy
- *Subcutaneous Injectable Contraception*
  - DMPA-SC (104 mg) should be available for self-administration
  - Note: This is available by prescription from pharmacies for Family PACT clients
- *Medications for IUD Placement*
  - Covered in previous Family PACT webinar

When to Start Using Specific Contraceptive Methods

US SPR
US Selected Practice Recommendations for Contraceptive Use, 2024

Contraceptive method	When to start (if the provider is reasonably certain that the patient is not pregnant)*	Additional contraception (i.e., back-up) needed	Examination or test needed before initiation†
Cu-IUD	Anytime	Not needed	Bimanual examination and cervical inspection§
LNG-IUD	Anytime	If >7 days after menses started, abstain from sexual intercourse or use barrier methods (e.g., condoms) for 7 days.	Bimanual examination and cervical inspection§
Implant	Anytime¶	If >5 days after menses started, abstain from sexual intercourse or use barrier methods (e.g., condoms) for 7 days.	None
DMPA	Anytime¶	If >7 days after menses started, abstain from sexual intercourse or use barrier methods (e.g., condoms) for 7 days.	None
CHC	Anytime¶	If >5 days after menses started, abstain from sexual intercourse or use barrier methods (e.g., condoms) for 7 days.	Blood pressure measurement
Norethindrone or norgestrel POP	Anytime¶	If >5 days after menses started, abstain from sexual intercourse or use barrier methods (e.g., condoms) for 2 days.	None O-Pill
Drospirenone POP	Anytime¶	If >1 day after menses started, abstain from sexual intercourse or use barrier methods (e.g., condoms) for 7 days.	None Slynd

Case Study

Chronic Kidney Disease

Family PACT

Case 1: 28-year-old G_2P_2 with chronic kidney disease due to diabetic nephropathy, about to require hemodialysis

- Wants to initiate a contraceptive method and is considering an IUD or hormonal method
- *Which methods can be used?*
  - Copper IUD
  - Levonorgestrel IUD
  - Implant
  - DMPA
  - Progestin-only pill
  - Combined hormonal contraceptive (pill, patch, ring)

Prevalence of CKD in the United States

- 14% of adults have CKD (2017-2020)
  - More common among women (15%) compared with men (13%)
  - Increasing prevalence of CKD with age:
    - 34% of adults aged 65 years or older
    - 12% of adults aged 45–64 years
    - 6% of adults aged 18–44 years
- Prevalence of CKD among reproductive-aged women is unknown
  - Global estimates range from 0.1-6%
  - 100,000 women aged 18–54 years in the US have end-stage kidney disease; about 13,000 were newly diagnosed in 2019

Pregnancy-related Morbidity and CKD

Pregnancy Counseling Considerations	Stage 1 CKD	Stage 2 CKD	Stage 3 CKD	Stage 4-5 CKD	Transplantation	Intensive HD
Progression of kidney disease	8%	13%	16%	20%	Loss of graft function possible with Scr > 1.5 mg/dL	NA
New-onset HTN	8%	18%	47%	50%	54%	12%
Worsening proteinuria or preeclampsia	21%	38%	87%	70%	25%-30%	20%
Average birth weight, g	2,967	2,484	2,226	1,639	2,572	2,118
Low birth weight (<2,500 g)	13%	18%	19%	50%	42%	44%
Average gestational age, wk	38	36	34	34	36	36
Preterm delivery						
<37 wk	24%	51%	78%	89%	50%	65%
<34 wk	7%	21%	38%	44%	20%	41%

Note: Data estimates are abstracted from references [6, 43, 44, 46].
Abbreviations: CKD, chronic kidney disease; HTN, hypertension; NA, not applicable; Scr, serum creatinine.

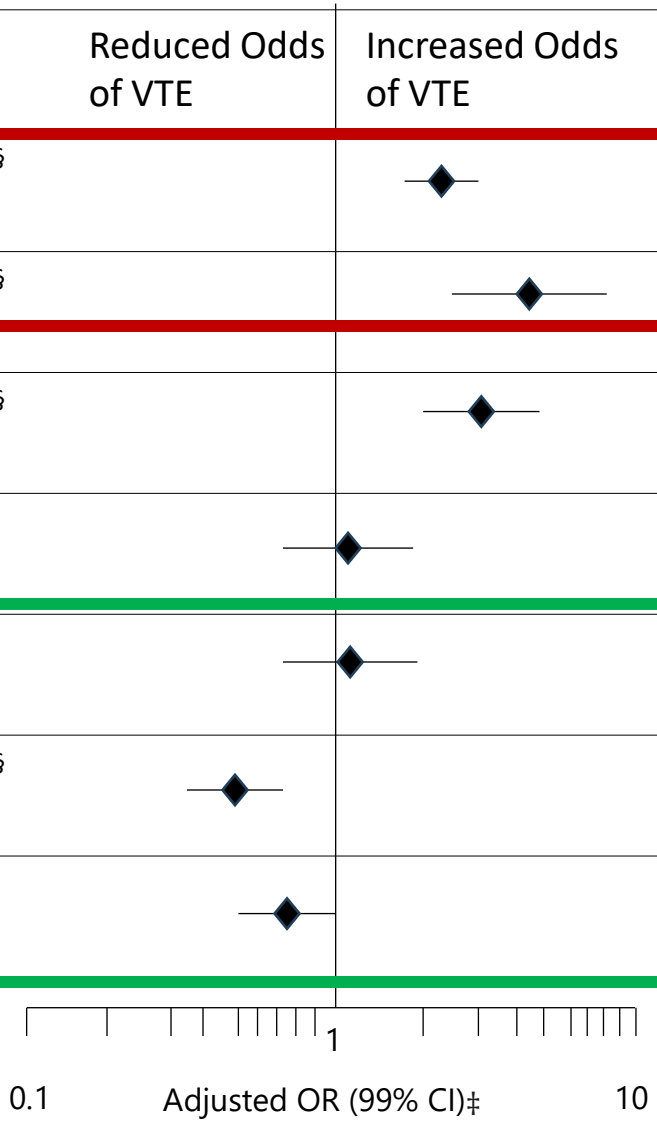
Burgner A, et al., 2019.

Hormonal Contraception and CKD

- Increased risk of thrombosis[1-8] with
  - Severe CKD
  - Use of dialysis
  - Nephrotic syndrome
- Increased risk of fracture with severe CKD and use of dialysis[9-14]
- No comparative studies on hormonal contraceptive use with current nephrotic syndrome, hemodialysis, or peritoneal dialysis
- However, *among persons with these conditions*
  - CHCs might further elevate thrombosis risk
  - DMPA might further elevate thrombosis and fracture risk

Risk of VTE with *Progestin-only Contraceptive* Use Among the General Population

Progestogen*	No. (%) Case Group	Control Group	Crude OR (99% CI)†	Adjusted OR (99% CI)†
DMPA	355 (1.66)	657 (0.61)	2.76 (2.42-3.14)§	2.37 (2.04-2.75)§
NETA	87 (0.41)	114 (0.11)	3.88 (2.93-5.12)§	3.00 (2.17-4.15)§
MPA	111 (0.52)	232 (0.22)	2.43 (1.94-3.05)§	1.98 (1.53-2.58)§
Prog	51 (0.24)	202 (0.19)	1.28 (0.94-1.75)	1.07 (0.75-1.54)
Implant	39 (0.18)	177 (0.17)	1.14 (0.80-1.61)	1.09 (0.74-1.61)
NET	131 (0.61)	724 (0.68)	0.92 (0.76-1.11)	0.57 (0.46-0.71)§
LNG-IUD	77 (0.36)	446 (0.42)	0.88 (0.69-1.13)	0.72 (0.54-0.96)



Hormonal Contraception and Thrombosis Risk with Other Medical Conditions

» *Combined hormonal contraception*

- COC: Increased risk with increasing age, obesity, smoking, hypertension, thrombogenic mutations, lupus, diabetes
- No evidence on most other thrombogenic conditions
- No evidence on patch or ring

» *Progestin-only contraception (POC)*

- DMPA: Increased risk of VTE with use postpartum, diabetes
- Other POC: Limited evidence generally finds no increased risk
- No evidence on most other thrombogenic conditions

US MEC 2024: Medical Conditions Related to CKD

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, or neuropathy‡	1		2		2		3		2		3/4*	
	d. Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	

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‡	1*		2*		2*		3*		2*		4*	
	c. Vascular disease	1*		2*		2*		3*		2*		4*	

I = initiate the method C = continue the method

US MEC 2024 Recommendation: CKD

Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
	I	C	I	C	I	C	I	C	I	C	I	C
a. Current nephrotic syndrome	1	1	2		2		3		2/ DRSP POP with known hyperkalemia 4*		4	
b. Hemodialysis	1	1	2		2		3		2/ DRSP POP with known hyperkalemia 4*		4	
c. Peritoneal dialysis	2	1	2		2		3		2/ DRSP POP with known hyperkalemia 4*		4	

- Clarification: Persons with known hyperkalemia should not use DRSP POPs because of risk for worsening K+ levels (Category 4).
- For persons with CKD without known hyperkalemia (Category 2), consider checking serum K+ during first cycle of DRSP POPs.

Case 1: 28-year-old G_2P_2 with chronic kidney disease due to diabetic nephropathy, about to require hemodialysis

» She is seeking to initiate a contraceptive method and is considering an IUD or hormonal method. What methods can be used?

• Copper IUD	US MEC 1
• Levonorgestrel IUD	US MEC 2
• Implant	US MEC 2
• Progestin-only pill	US MEC 2
• DMPA	US MEC 3
• DRSP POP with hyperkalemia	US MEC 4
• CHC (pill, patch, ring)	US MEC 4

Case Study

Sickle Cell Disease

Family PACT

Case 2: A 35-year-old G_3P_{1102} with sickle cell disease and history of hospitalizations for pain crises would like to initiate a contraceptive method and is considering an IUD or hormonal method

» Which methods can be used?

- Copper IUD
- Levonorgestrel IUD
- Implant
- DMPA
- Progestin-only pill
- Combined hormonal contraceptive (pill, patch, ring)

US MEC 2016: Sickle Cell Disease

Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
Sickle cell disease[a]	2	1	1	1	1	2

Reflects concern re: increased blood loss in a person already anemic

[a] Condition associated with increased risk for adverse health events as a result of pregnancy

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

Sickle Cell Disease

- Autosomal recessive disorders of beta globin mutations
- Sickling of red blood cells leads to venous stasis, blood hyperviscosity, vaso-occlusion, tissue infarction, and anemia
- Different genotypes with varying clinical severity
  - HbSS: Homozygous SCD, most common, usually most severe
- Prevalence in the US
  - Affects approximately 100,000 people in the United States
  - Occurs among about 1 out of every 365 Black or African American births and 1 out of every 16,300 Hispanic births

Rees DC, et al., 2010; Sickle Cell Disease | CDC

Sickle Cell Disease and Thrombosis

- Individuals with sickle cell disease are at increased risk for arterial and venous thrombosis[1-4]
  - 25% will have a stroke by age 45
  - 11% incidence of venous thromboembolism (VTE) by age 40 in a single-institution cohort study

[1] Noubiap JJ, et al., 2018; [2] Verduzco LA, et al., 2009; [3] Stein PD, et al., 2006; [4] Naik RP, et al., 2014.

Sickle Cell Disease and VTE Risk

- Increased concern for baseline risk of VTE, possibly PE more than DVT, among individuals with SCD
  - Meta-analysis of SCD and risk of VTE (10 included studies)[1]
  - Higher risk of VTE in adults with SCD, esp. if pregnant or postpartum, vs. general population and adults with *sickle trait*
  - Higher risk of PE than DVT
- Concern for high rate of *recurrent* VTE among those with SCD[2]
  - 1-yr cumulative incidence of recurrent: 13.2% (95% CI 11.0-15.5%)
  - 5-yr cumulative incidence of recurrent: 24.1% (95% CI 21.2-27.1%)

[1] Noubiap JJ, et al., 2018; [2] Brunson A, et al., 2019.

SCD and Venous Thromboembolism (VTE) Risk

- Increased concern for baseline risk of VTE, possibly pulmonary embolism (PE) more than deep venous thrombosis (DVT), among individuals with SCD
  - Meta-analysis of SCD and risk of VTE (10 included studies)[1]

Outcome	N studies	Population	Odds ratio (95%CI)	*P* value	H (95%CI)	I^2 (95%CI)	P heterogeneity	P Harbord test
SCD versus Control								
VTE	3	Adults	4.43 (2.62-7.48)	< .0001	1.0 (1.0-2.8)	0.0 (0.0-87.3)	.440	.467
DVT	1	Adults	1.12 (1.09-1.15)	< .0001	NA	NA	NA	NA
PE	2	Adults	3.66 (3.57-3.75)	< .0001	1.0	0.0	0.588	NA
VTE	1	Pregnant and PP women	33.16 (9.70-113.37)	< .0001	NA	NA	NA	NA
DVT	1	Pregnant women	30.66 (1.63-578.15)	.022	NA	NA	NA	NA

[1] Noubiap JJ, et al., 2018.

Summary of Evidence: Sickle Cell Disease

Outcome	Studies	Results
Stroke	1	1 secondary analysis of a large prospective cohort of OC vs no OC: • Increased absolute risk of stroke (combined ischemic and hemorrhagic) - 1.6 vs 0.4/100 person-years, p=0.03 • Once adjusted for CVD confounders, HR no longer statistically significant for risk of any, ischemic, or hemorrhagic stroke
Venous thrombosis	2	Low prevalence of thrombosis among hormonal contraceptive users but no relative risk examined
Pain	6	• Generally, POC and CHC did not increase frequency of pain (e.g., bone pain, pain crises) • DMPA may decrease risk of pain crises and dysmenorrhea
Osteopenia	2	2 small studies with generally no increased risk of lower BMD or osteopenia among hormonal contraceptive users; risk not stratified by contraceptive type

BMD: bone mineral density; CVD: cardiovascular; HR: hazard ratio.

Revised US MEC 2024 : Sickle Cell Disease

Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
Sickle cell disease[a]	2	1	1	2/3[b]	1	4

[a] Condition associated with increased risk for adverse health events from pregnancy

[b] *Category should be assessed re: severity of the condition and risk for thrombosis*

Reminder: 2016

Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
Sickle cell disease[a]	2	1	1	1	1	2

US Medical Eligibility Criteria for Contraceptive Use, 2024 (US MEC) | Contraception | CDC

Case 2: A 35-year-old G_3P_{1102} with sickle cell disease and history of hospitalizations for pain crises would like to initiate a contraceptive method and is considering an IUD or hormonal method

» Which methods can be used?

- Levonorgestrel IUD — US MEC 1
- Implant — US MEC 1
- Progestin-only pill — US MEC 1
- Copper IUD — US MEC 2
- DMPA — US MEC 2/3*
- CHC (pill, patch, ring) — US MEC 4

*Category should be assessed re: severity of the condition and risk for thrombosis

Take It Home

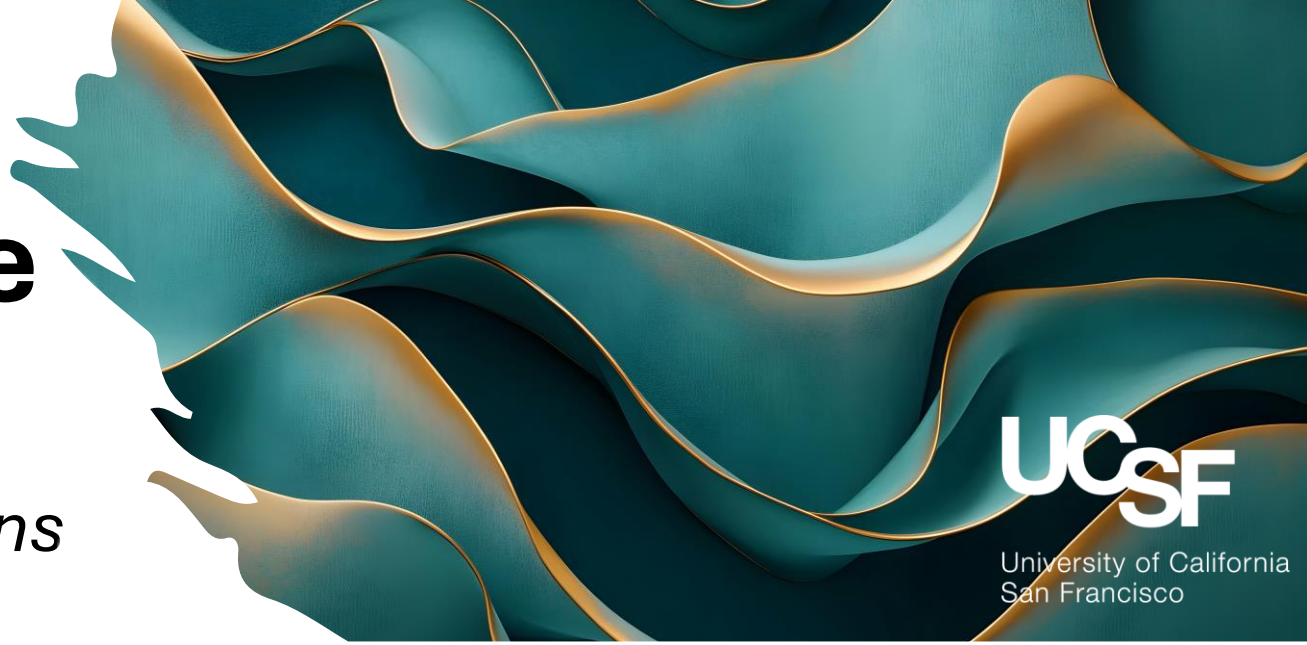
- The CDC US MEC and SPR can help reduce barriers to access and use of contraception
- Most people can safely use most methods
- Counseling should be non-coercive and respect autonomy
- Most MEC category updates are related to the effect of DMPA on increasing the risk venous and arterial complications

Take It Home

- Most methods can be used in people with CKD *except* those that
  - Increase risk of VTE and arterial complications (CHC-4, DMPA-3),
  - Increase K^+ levels (DRSP POPs *with* hyperkalemia (MEC-4)
- Most methods can be used in people with sickle cell disease *except* those that increase the risk of VTE and arterial complications
  - CHC MEC-4, DMPA MEC-2/3
- SPR update: pain reduction for IUD placement
  - Cervical blocks work
  - The client is in charge

Reproductive Health Hotline (ReproHH)

For clinicians by clinicians



Free | Confidential | Nationwide | 8 am – 4 pm PT

1-844-ReproHH
(1-844-737-7644)

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Thanks to:

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Questions?

DHCS