Assessment and Diagnostic Guideline: Contraceptive Management

A comprehensive contraceptive management assessment is client-centred and includes obtaining informed consent, taking a health history, and completing physical assessment components. When assessing the type of contraception that best meets a client's needs, the Certified Practice Registered Nurse in Contraceptive Management (referred to as RN(c)s in this document) takes into consideration the preferences of the client, clinical assessment, and their own clinical judgment. The best method of contraception for an individual is one that is effective, safe, and used correctly and consistently. Individuals must make choices about their contraceptive methods in the context of their own needs, attitudes, social, and cultural circumstances (Bourns, 2018; SOGC, 2015). Additional considerations should also include best practice recommendations for effectiveness, contraindications, side effects, non-contraceptive benefits, availability, costs, and the desires and prior experiences of the client.

RN(C)s are required to draw from their standards of practice, clinical experience, nursing knowledge, and clinical reasoning to identify and prioritize relevant information about each client. RN(C)s work from a trauma-informed, culturally safe, person-centred perspective, using diversity, equity, and inclusion lenses while engaging in assessment practices and protecting client privacy and confidentiality as required by BCCNM practice standards.

Intended Client Outcomes

- Client receives safe and effective contraception.
- Unintended pregnancies are prevented through the provision of safe and effective contraception.
- Sexual health education is provided to enhance the client's capacity to manage their sexual and reproductive health care.

Indications

RN(C)s may prescribe, dispense, administer, insert, or remove contraception when indicated by a client who is seeking a reliable, reversible method of contraception.

Hormonal contraception is further indicated for a number of menstrual/monthly bleeding-related conditions or symptoms and the non-contraceptive benefits that they confer (Cason et al., 2023). However, clients seeking or using hormonal contraception solely for purposes other than contraception must be referred for a client-specific order or transfer of care (see examples below)

Other common benefits of hormonal contraception include, but are not limited to (Cason et al., 2023)

- Decreased acne
- Improvement in some menstrual/monthly bleeding-related conditions such as primary dysmenorrhea, ovarian cysts, and premenstrual/pre-monthly bleeding syndrome

In the absence of contraindications, and with precautions in mind, the choice of contraception is based on client preferences. The RN(C) can assist the client by asking the following sample questions (Hatcher et al., 2018):

- How important is it that you prevent pregnancy (efficacy)?
- Which method do you think you would like to use or try?
- How convenient do you want the method to be?
- Do you want to use your contraception daily, weekly, monthly, or longer?
- Will you be able to use the method as intended (e.g., take the pills daily, return for regular injection)?
- How important is it to have a discreet method of birth control?
- Are you comfortable touching your own genitals (e.g., ring, internal condom)?
- Can you afford the method you wish to use, or can you access a program to assist with the cost (e.g., Pharmacare, extended health benefits)?
- Are you or will you be using a birth control method that provides protection against sexually transmitted infections (STIs)?
- How quickly do you want to be able to return to fertility?

Relative and Absolute Contraindications

RN(C)s may prescribe, dispense, administer, insert, or remove contraception autonomously based on individual client assessment and within the *US Medical Eligibility Criteria* (US MEC) Categories 1 and 2 (Nguyen et al., 2024).

US MEC categories 3 and 4 require a consult and/or referral (Nguyen et al. 2024).

For complete guidance, see Nguyen et al. 2024.

Informed Consent Specific to Contraceptive Management

RN(C)s must follow the *BCCNM Consent Practice Standard (2020)* when assessing informed consent with clients who want to access contraception, which includes the following:

- Assess the client's ability to provide consent for contraception, including risks and benefits of procedures related to the administration or insertion of contraceptives (i.e. implants or IUCs).
- Understand the legal requirements for determining if a minor can provide valid consent (Government of British Columbia, 1996).
- Know who may give consent if your minor client cannot.

Health History

Before initiating or continuing a hormonal contraceptive, a thorough health history is taken or reviewed that includes (Hatcher et al., 2018; Hatcher et al., 2019):

- Potential contraindications include past medical history, medical conditions, medication use, allergies, tobacco use (smoking), and breast/chest feeding
- Assessment for strong family history consistent with inherited thrombophilia, such as unprovoked venous thromboembolism (VTE) in a first or second degree relative under the age of 50
- Assessment of menstrual/monthly bleeding patterns that might assist in determining possible benefits of hormonal contraceptive use
- Last menstrual/monthly bleeding pattern
- Current or past use of contraception, including any difficulties using the method and/or side effects
- Potential for existing pregnancy and need for pregnancy testing
- Assessment of unexplained vaginal/genital bleeding including recommendations for additional investigations or referrals
- Assessment of sexual activity, including risk factors for STIs and potential need for emergency contraception

Physical Assessment

The physical assessment includes:

- Initial blood pressure measurement for initiation of all hormonal contraception and at least annually thereafter (Hatcher et al., 2018; Hatcher et al., 2019; Black et al.,2017; Nguyen et al., 2024).
- Cervical cancer screening, STI screening, breast/chest exams, although important for overall reproductive health, are not mandatory for the provision of hormonal contraception and should not be a requirement to receive contraception (Black et al., 2017; Nguyen et al., 2024).

Diagnostic Testing/Investigations

No specific diagnostic tests or investigations are required for initiation of hormonal contraception (Black et al., 2017; Curtis et al., 2024).

Urine pregnancy testing may be indicated if the client is considered at risk for an existing pregnancy (Black et al., 2016; Black et al., 2017).

Precautions and Considerations

Timing of administration is important for effective contraception (Black et al., 2016; Black et al., 2017):

- **Quick start** of a hormonal contraceptive is recommended as it demonstrates improved adherence, especially in youth.
- Delaying initiation of hormonal contraception (e.g., Sunday start or start with next menstrual/monthly bleeding pattern) could increase the risk that a client forgets to start, chooses not to start, or becomes pregnant while awaiting initiation.
- Inconsistent use of contraception can result in unintended pregnancy.
- Consider the use of back-up method(s) for 7 days (Cason et al., 2023) and/or emergency contraception (Levonorgestrel or Ulipristal acetate) when initiating hormonal contraception, and in situations of missed or late doses. Counsel the patient around other options, including emergency contraception intrauterine devices (EC IUD).
- Expense and accessibility can affect a person's ability to use contraception effectively.
- Youth have been shown to be less tolerant of medication side effects and therefore, tend to have higher discontinuation rates. Education and counselling at the time of initiation and follow-up of hormonal contraception may help address youth-specific needs. This may include more frequent follow-up visits, such as at three months.

Client Education

Use of contraception is more likely to be successful when client education includes (Black et al., 2016; Black et al., 2017; Hatcher et al., 2018; Hatcher et al., 2019):

- How the method works to prevent pregnancy
- How to use the method(s) of contraception
- Initiation of contraceptive method and time for onset of contraception (e.g., recommend quick start, first day of next menstrual/monthly bleeding pattern)
- Estimated return to fertility after discontinuing contraception
- Storage of contraceptive products
- Use of appropriate back-up method(s) and emergency contraception
- Drug, supplement, and traditional medicine interactions and the need to consult with a health care provider when taking other medications
- Discussion that hormonal contraception is a medication and should be disclosed to health care providers when asked
- Some types of contraceptive methods do not protect against STIs
- Recognizing and taking appropriate action for:
    - transitional and ongoing side effects
    - Possible serious side effects (e.g., ACHES: abdominal pain, chest pain, headache, eye problems and severe leg pain)
    - Method failure or complications
    - Missed or late doses, including the need for repeat doses if vomiting occurs within two hours of ingestion of a contraceptive pill
- Accessing the contraception (e.g., ability to return to the clinic or purchase at the pharmacy)
- Planned follow-up:
    - As per Combined Hormonal Contraceptive (CHC) or Progestin-only Hormonal Contraceptive (POHC) DSTs
    - Such that the client can contact the clinic/health care provider or return with any questions
    - As needed by the client
- Consider multiple uses of teaching materials, including models, online sources, and printable visuals.

Breast/Chest-feeding

Hormonal contraceptives can be started when the person is medically eligible to use the method and if it is reasonably certain that they are not pregnant (Black et al., 2016; Curtis et al., 2024). See Combined Hormonal Contraceptive (CHC) or Progestin-

only Hormonal Contraceptive (POHC) DSTs for more information regarding initiation of contraception during the postpartum period.

Estrogen and progestin are excreted in breast milk/human milk in small quantities and are unlikely to have an effect on the baby (Hatcher et al., 2018; Nguyen et al., 2024).

Prescribing, Dispensing, Administering, Inserting and Removing

The dispensed hormonal contraceptive medication should be labelled with a client-specific label. Labels can be pre-printed but must be client-specific and include the information as outlined in the BCCNM *Medication Practice Standard (2023)*.

For specific criteria about the administration of depot-medroxyprogesterone acetate (DMPA), please refer to DST 802 – Care and Treatment Plan: Progestin-Only Hormonal Contraceptives.

For specific criteria about the insertion and removal of contraceptive implants, please refer to DST 802 – the Care and Treatment Plan: Progestin-Only Hormonal Contraceptives DST.

For specific criteria about the insertion and removal of intrauterine contraception, please refer to DST 803 Care and Treatment Plan: Intrauterine Contraceptives DST.

Expiry dates

- When expiry dates note only the month and year, the date is interpreted as the last day of the noted month (Hatcher et al., 2018).
- The expiry date is the date by which the client should finish the medication in that package.
- When prescribing and/or dispensing contraception, the RN(C) must calculate the number of doses required to ensure that the prescribed and/or dispensed method, if used as directed, will be completed prior to the stated expiry date.

Documentation

Document on the client's health record as per agency policy and as per the BCCNM *Medication Practice Standard (2023)* and *Documentation Practice Standard (2023).*

Monitoring and Follow-up

- Advise a client to return at any time to discuss concerns or if they want to change the method being used. No routine follow-up visit is required (Cason et al., 2023; Curtis et al., 2024).
- To improve continuation rates and enhance a client's abilities to obtain contraception when needed, health care providers should prescribe and/or dispense up to a one-year supply of contraception at the initial and return visits, or up to a two-year supply if the client is able to obtain and disclose a blood pressure measurement from an alternative source at least annually to the contraception provider (Cason et al., 2023).

Further Resources and Managing Side Effects

The RN(C), where applicable, is required to meet BCCNM practice standards, including but not limited to:

- BCCNM Registered Nurse (Certified Practice): Acting within Autonomous Scope of Practice (2025)
- BCCNM Consent Practice Standards (2020)
- BCCNM Medication Practice Standards (2023)
- BCCNM Registered Nurses (certified) Standards for Prescribing Medications (2025)

The following are considered foundational resources to contraceptive management practice:

- *U.S. Medical Eligibility Criteria for Contraceptive Use* (Nguyen et al., 2024)
- CDC Summary Chart of *U.S. Medical Eligibility Criteria for Contraceptive Use* (Nguyen et al., 2024)
- Contraceptive technology (22nd revised ed.) (Cason et al., 2023)

- *SOGC Canadian Contraception Consensus*
  - Chapter 1: Abstract and Summary Statements
  - Chapter 8: Progestin-Only Contraception (Black et al., 2016)
  - Chapter 9: Combined Hormonal Contraception (Black et al., 2017)
- *US CDC Selected Practice Recommendations for Contraceptive Use* (Curtis et al., 2024)
- 811 – HealthLink BC

References

More recent editions of any of the items in the References List may have been published since this DST was published. If you have a newer version, please use it.

Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., Mirosh, M., Norman, W., Pymar, H., Reid, R., Roy, G., Varto, H., Waddington, A., Wagner, M.S. & Whelen, A.M. (2016). Canadian contraception consensus (part 3 of 4): Chapter 8 – Progestin-only contraception. Journal of Obstetrics and Gynaecology of Canada, 38(3), 279-300. https://doi.org/10.1016/j.jogc.2015.12.003

Black, A., Guilbert, E., Costescu, D., Dunn, S., Fisher, W., Kives, S., Mirosh, M., Norman, W., Pymar, H., Reid, R., Roy, G., Varto, H., Waddington, A., Wagner, M.S. & Whelen, A.M. (2017). No. 329 – Canadian contraception consensus Part 4 of 4 Chapter 9: Combined hormonal contraception. Journal of Obstetrics and Gynaecology Canada, 39(4); 229-268. https://doi.org/10.1016/j.jogc.2016.10.005

Bourns, A. (2018). Guidelines for gender-affirming primary care with trans and non-binary patients. https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2019/12/Guidelines-FINAL-Dec-2019-iw2oti.pdf

British Columbia College of Nurses and Midwives (BCCNM). (2025). Registered nurse (certified practice): Acting within autonomous scope of practice. https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN_PS_CP_AutonomousSoP.pdf

British Columbia College of Nurses and Midwives (BCCNM). (2025). Registered nurses (certified) standards for prescribing medications. https://www.bccnm.ca/RN/ScopePractice/part4/section8/Pages/CP_prescribing.aspx

British Columbia College of Nurses and Midwives (BCCNM). (2024). Section 8: Restricted activities for certified practice: Practice standard for registered nurses. https://www.bccnm.ca/RN/ScopePractice/part4/section8/Pages/Default.aspx

British Columbia College of Nurses and Midwives (BCCNM). (2023) Medication: Practice standard for registered nurses. https://www.bccnm.ca/RN/PracticeStandards/Pages/Medication.aspx

British Columbia College of Nurses and Midwives (BCCNM). (2023) Documentation: Practice standard for registered nurses. https://www.bccnm.ca/RN/PracticeStandards/Pages/Medication.aspx

British Columbia College of Nurses and Midwives (BCCNM). (2020). Consent: Practice standard for registered nurses. https://www.bccnm.ca/Rn/PracticeStandards/Pages/consent.aspx

Cason, P., Cwiak, C., Edelman, A., & Kowal, D. (2023). *Contraceptive technology* (22nd ed.). Jones & Bartlett Learning.

Curtis, K. M., Nguyen, A. T., Tepper, N. K., Zapata, L. B., Snyder, E. M., Hatfield-Timajchy, K., Kortsmit, K., Cohen, M. A., Whiteman, M. K., & Contributors (2024). U.S. Selected Practice Recommendations for Contraceptive Use, 2024. *MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports*, *73*(3), 1–77. https://doi.org/10.15585/mmwr.rr7303a1

Government of British Columbia (1996). Infant Act. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01

Hatcher, R.A., Nelson, A.L., Trussell, J., Cwiak, C., Cason, P., Policar, M.S., Aiken, A.R.A., Marrazzo, J. & Kowal, D. (2018). Contraceptive technology (21st ed.). Atlanta: Managing Contraception LLC.

Hatcher, R.A, Zieman, M., Lathrop, E., Haddad, L., & Allen, A.Z. (2019). Managing contraception 2019-2020: for your pocket (15th ed). Atlanta: Managing Contraception LLC.

Nguyen, A.T., Curtis, KM., Tepper, N.K., Kortsmit, K., Brittain, A.W., Snyder, E.M., Cohen, M.A., Zapata, L.B., & Whiteman, M.K. (2024). U.S. Medical Eligibility Criteria for Contraceptive Use, 2024. *Morbidity and Mortality Weekly Report, 73*(4):1–126. http://dx.doi.org/10.15585/mmwr.rr7304a1

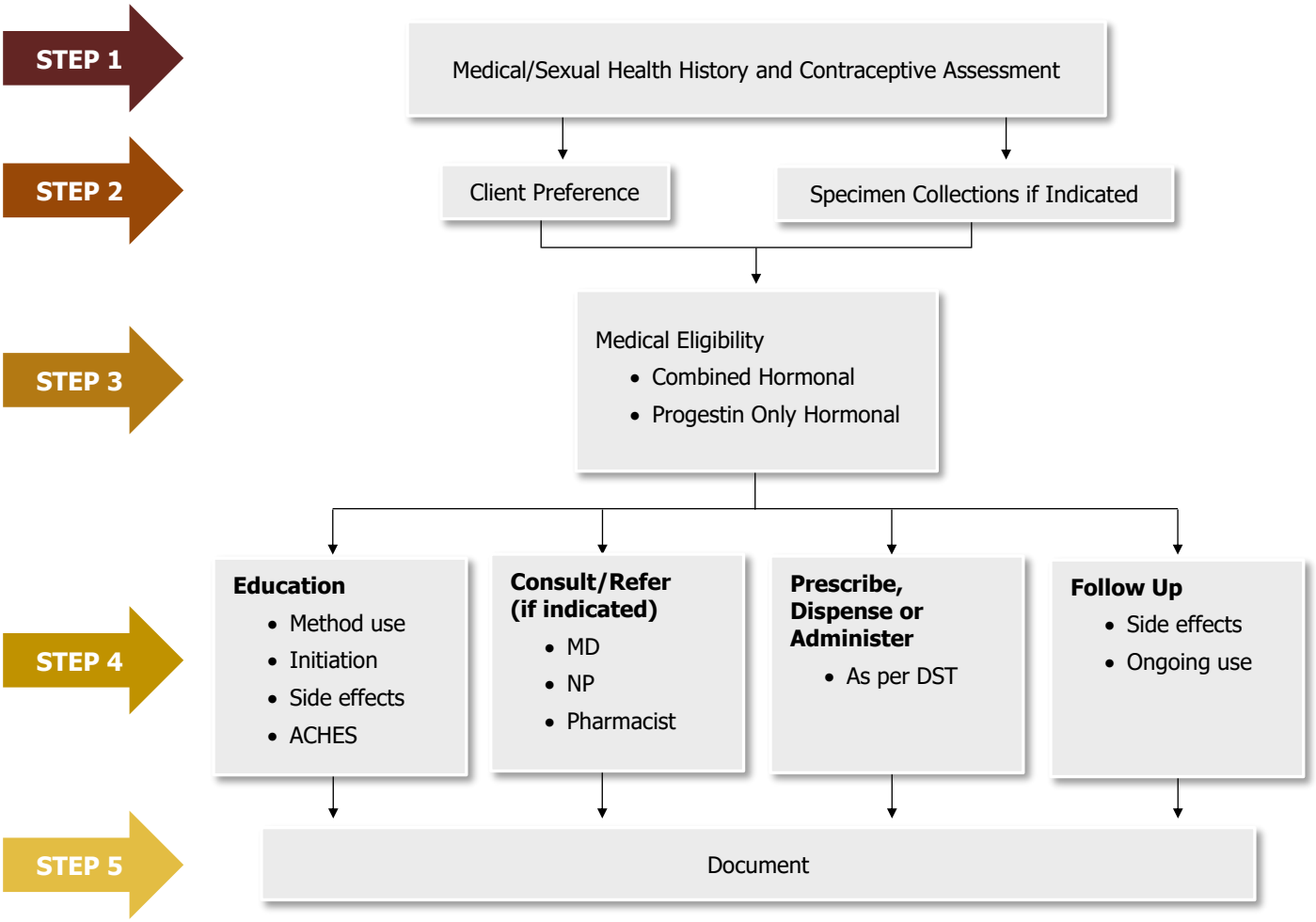
Society of Obstetricians and Gynecologists (SOGC). (2015). Canadian contraception consensus chapter 2: Contraceptive care and access. https://www.jogc.com/article/S1701-2163(16)39371-9/fulltext

Society of Obstetricians and Gynaecologists of Canada (SOGC). (2015). SOGC Clinical practice guidelines: Canadian contraception consensus (Part 1 of 4). https://doi.org/10.1016/S1701-2163(16)30033-0

World Health Organization (WHO). (2016). Selected practice recommendations for contraceptive use (3rd ed.). https://www.who.int/publications/i/item/9789241565400

Appendix 1

Decision-Making Pathway for CM Certified Nursing Practice



Appendix 2

US MEC Summary Chart: Quick Reference

It is the responsibility of the individual RN(C) to ensure they are using the most up-to-date version of the MEC when making clinical decisions. For complete guidance, see the *U.S. Medical Eligibility Criteria for Contraceptive Use* (Nguyen et al., 2024). Please see pages 10 and 11.

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 mildlyimpaired 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 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 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	

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 ß-hCG levels	**1***	**1***	**1***	**1***	**1***		**1***		**1***		**1***	
	ii. Decreasing ß-hCG levels	**2***	**1***	**2***	**1***	**1***		**1***		**1***		**1***	
	iii. Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	**2***	**1***	**2***	**1***	**1***		**1***		**1***		**1***	
	iv. Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	**4***	**2***	**4***	**2***	**1***		**1***		**1***		**1***	
Headaches	a. Nonmigraine (*mild or severe*)	**1**		**1**		**1**		**1**		**1**		**1***	
	b. Migraine												
	i. Without aura (*includes menstrual migraine*)	**1**		**1**		**1**		**1**		**1**		**2***	
	ii. With aura	**1**		**1**		**1**		**1**		**1**		**4***	
History of bariatric surgery‡	a. Restrictive procedures	**1**		**1**		**1**		**1**		**1**		**1**	
	b. Malabsorptive procedures	**1**		**1**		**1**		**1**		**3**		**COCs: 3** **P/R: 1**	
History of cholestasis	a. Pregnancy related	**1**		**1**		**1**		**1**		**1**		**2**	
	b. Past COC related	**1**		**2**		**2**		**2**		**2**		**3**	
History of high blood pressure duringpregnancy		**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.*							

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/.

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