WHO
Using the 2015 Medical Eligibility Criteria for contraceptive use and the MEC wheel

Petrus Steyn
Scientist, WHO/ SRH/ CFC

Twitter @HRPresearch

World Health Organization

human reproduction programme hrp
research for impact
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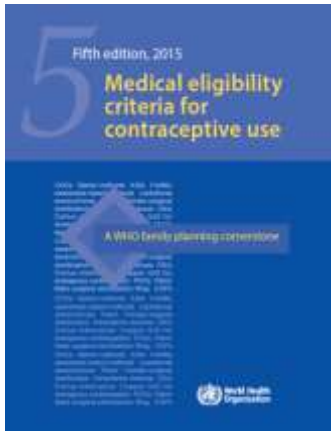
Outline of the presentation

- Medical eligibility criteria (MEC) for contraceptive use 5th ed

- MEC Wheel

Family planning guidelines and tools: constant updates, constant demand

Medical Eligibility Criteria

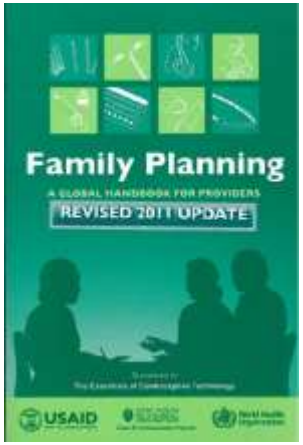


5th edition

Decision-Making Tool
(to be updated)

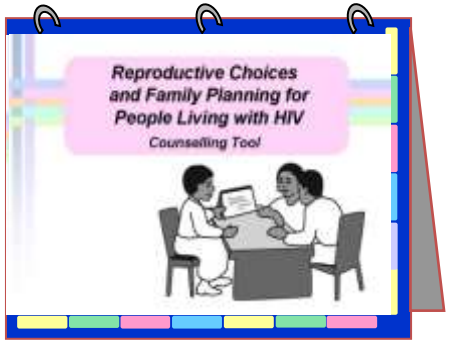
Selected Practice Recommendations

3rd edition in 2016



Global Handbook
To be updated in 2016

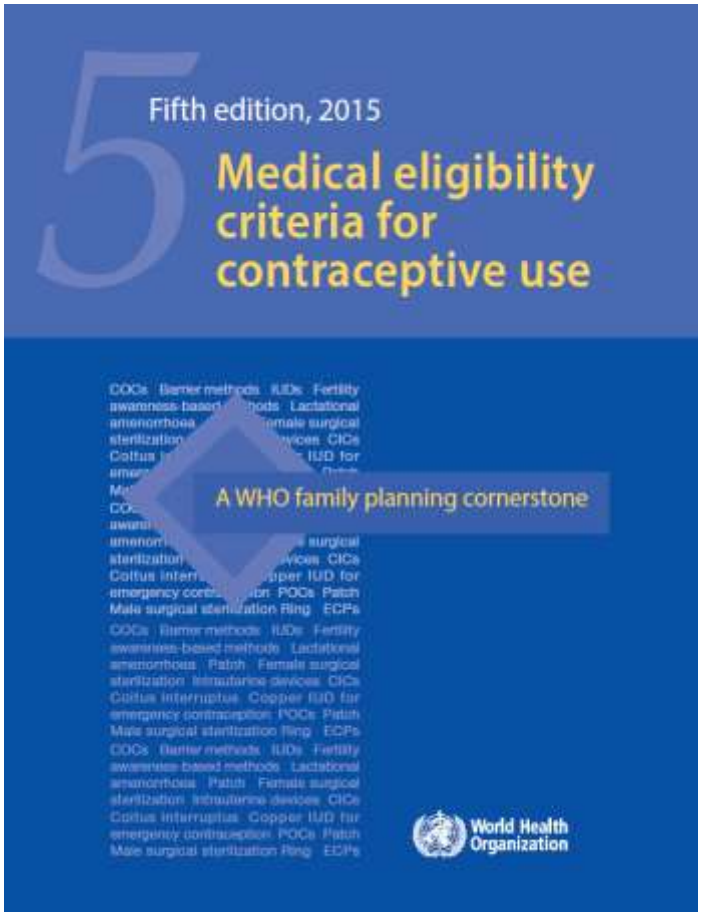
The Medical Eligibility Criteria (MEC) Wheel (new)



Reproductive Choices and Family Planning for People with HIV *(to be updated)*

Guide to family planning for community health care providers and their clients (to be updated)

Medical eligibility criteria for contraceptive use (MEC)

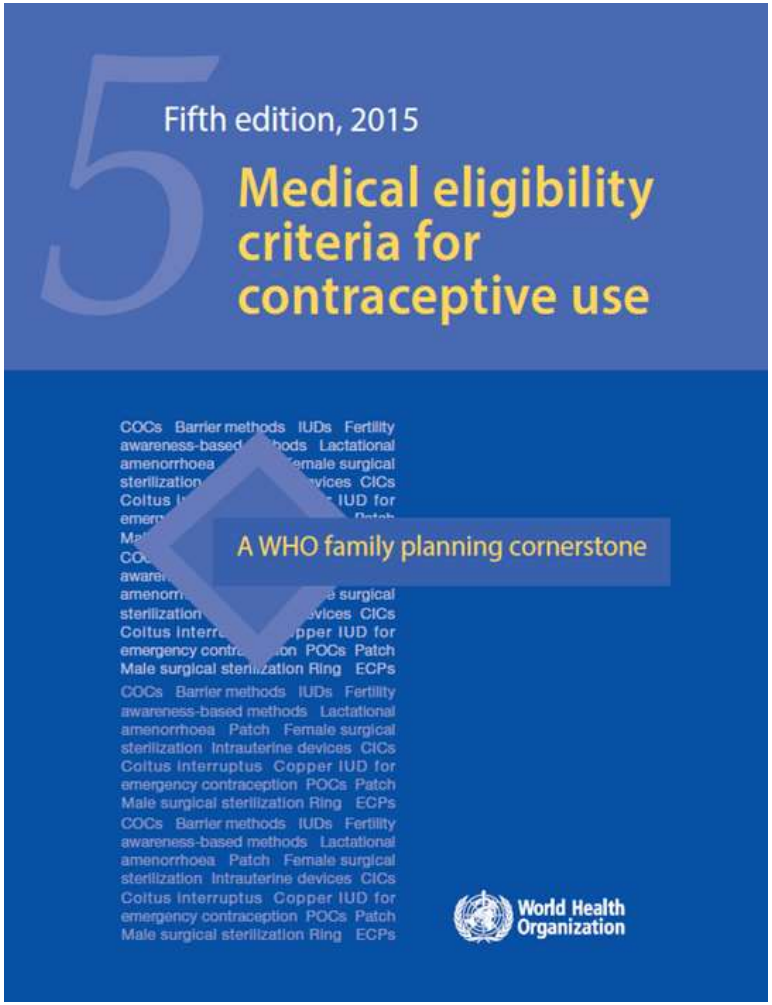


Previous editions
1996, 2000, 2004, 2009

Purpose: Who can safely use contraceptive methods?

- Offers ≈ 2000 recommendations for 25 methods
  - pre-existing medical conditions
  - personal characteristics
  - certain health problem
- Developed through consensus driven process during 3 consultations
  - Systematic review of scientific evidence
  - Adhered to WHO procedures for guideline development

Medical eligibility criteria for contraceptive use 5th ed.



- Executive summary (p 5)
- Part I – Development (p 13)
- Part II – Using the recommendation (p97)
- https://www.who.int/publications/i/item/9789241549158

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations (p 99)

- Reproductive and sexual health care as a human right
  - Delivery of care in accordance with the client's human and reproductive rights is fundamental to quality of care.
  - This document does not provide recommendations about which specific product or brand to use after selecting a particular type of contraceptive method.
  - Instead, it provides guidance for whether women with specific medical conditions or medically relevant physiological or personal characteristics are eligible to use various contraceptive methods.
  - Decisions about what methods to use should also take into account clinical judgment and user preferences.

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations (p 100)

- Issues of service quality and access that affect method use and choice
  - Clients should be given adequate information to help them make an informed, voluntary choice of a contraceptive method.
  - This information should at least include:
    - the relative effectiveness of the method;
    - correct usage of the method;
    - how it works;
    - common side-effects;
    - health risks and benefits of the method;
    - signs and symptoms that would necessitate a return to the clinic;
    - information on return to fertility after discontinuing method use; and
    - information on STI protection.

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations

- Issues of service quality and access that affect method use and choice
  - Effectiveness of method
  - Conditions that expose a woman to increased risk as a result of unintended pregnancy
  - Return to fertility
  - STIs and contraception: dual protection
- How to use this document

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations

Effectiveness of method (p 102)

Table 2.1 Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception and the percentage continuing use at the end of the first year, United States

	% of women experiencing an unintended pregnancy within the first year of use		% of women continuing use at one year[3]
Method (1)	Typical use[1] (2)	Perfect use[2] (3)	(4)
No method[4]	85	85	–
Spermicides[5]	28	18	42
Fertility awareness-based methods	24	–	47
Standard Days Method®[6]	–	5	–
TwoDay Method®[6]	–	4	–
Ovulation Method[6]	–	3	–
Sympto-thermal method	–	0.4	–
Withdrawal	22	4	46
Sponge	–	–	36

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations

Conditions that expose a woman to increased risk as a result of unintended pregnancy (p 101)

Box 2.1 Conditions that expose a woman to increased health risk as a result of unintended pregnancy

- Breast cancer
- Complicated valvular heart disease
- Diabetes: insulin-dependent; or with nephropathy/ retinopathy/neuropathy or other vascular disease; or of > 20 years' duration
- Endometrial or ovarian cancer
- Epilepsy
- High blood pressure (systolic > 160 mm Hg or diastolic > 100 mm Hg)[a]
- HIV (WHO stages 1–4)[b]
- Ischaemic heart disease
- Malignant gestational trophoblastic disease
- Malignant liver tumours (hepatoma) and hepatocellular carcinoma of the liver (HCA)
- Schistosomiasis with fibrosis of the liver
- Severe (decompensated) cirrhosis
- Sickle cell disease
- STI[b]
- Stroke
- Systemic lupus erythematosus (SLE)
- Thrombogenic mutations
- Tuberculosis

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations (p 105)

Medical eligibility criteria (MEC) categories for contraceptive use

Category 1	A condition for which there is no restriction for the use of the contraceptive method
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
Category 4	A condition which represents an unacceptable health risk if the contraceptive method is used

Table 2.2 Template of contraceptive method tables

Type of contraceptive			
Condition	Category		Clarifications/evidence
	I = initiation	C = continuation	
Condition	Condition classified as Category 1, 2, 3 or 4 Different categories are used for fertility awareness-based (FAB) methods and surgical sterilization; these are described at the beginning of the relevant sections.		Clarifications and evidence regarding the classification

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations

- Using the recommendations in practice
  - Categories 1 and 4
  - Category 2 indicates the method can generally be used, but careful follow-up may be required.
  - Category 3 requires careful clinical judgment and access to clinical services; for such a woman, the severity of the condition and the availability, practicality and acceptability of alternative methods should be taken into account.
- Where resources for clinical judgment are limited, such as in community-based services, the four-category classification framework can be simplified into two categories.

MEC Categories

CATEGORY	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstances	**Yes** (Use the method)
2	Generally use the method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	**No** (Do not use the method)
4	Method not to be used	

Where warranted, recommendations will differ if a woman is
starting a method (I = initiation) or
continuing a method (C = continuation)

Medical eligibility criteria for contraceptive use 5th ed. – Using the recommendations

- Programmatic implications
  - informed choice
  - elements of quality of care
  - essential screening procedures for administering the methods
  - provider training and skills
  - referral and follow-up for contraceptive use as appropriate
- Clients with special needs
  - People with disabilities
  - Adolescents

Medical eligibility criteria for contraceptive use 5th ed. – Summary of the changes (p 108)

- Recommendations in the MEC 5th edition enable programmes to further expand contraceptive choice

  - **Breastfeeding women have more contraceptive choices during the postpartum period**
  - Women living with HIV, including women taking ART have more contraceptive options
  - Four new methods of contraception added to the 5th edition
  - Adolescents can use all methods of contraception, including IUDs and implants

Breastfeeding and postpartum

Time period	Progestogen-only pill	DMPA/NET-EN injectable	Levorgestrel/ Etonogestrel implants
< 6 weeks postpartum	**2**	3	**2**
≥ 6 weeks postpartum	1	1	1

Time period	LNG-IUD
<48 hours including insertion immediately after cesearan section	not breastfeeding = 1 **breastfeeding = 2**
≥ 48 hours to < 4 weeks	3
≥ 4 weeks	1

- Evidence is reassuring that progestogen-only contraceptives do not compromise a woman's ability to breastfeed.
- Evidence is reassuring that progestogen-only contraceptives do not adversely affect infant health, growth, or development in the first year postpartum.
- Effects, or absence of effects, beyond the first year post-partum is not established.

Breastfeeding and postpartum

Table 2.4 Summary of changes from the fourth edition to the fifth edition of the MEC (changes are highlighted in bold)

Condition	COC/P/ CVR	CIC	POP	DMPA NET-EN	LNG/ ETG implants	Cu-IUD	LNG-IUD
Breastfeeding							
a) < 6 weeks postpartum	4	4	**2[a]**	3[a]	**2[a]**		
b) ≥ 6 weeks to < 6 months (primarily breastfeeding)	3	3	1	1	1		
c) ≥ 6 months postpartum	2	2	1	1	1		
Postpartum (non-breastfeeding women)							
a) < 21 days			1	1	1		
(i) without other risk factors for VTE	3[a]	3[a]					
(ii) with other risk factors for VTE	**4[a]**	**4[a]**					
b) ≥ 21 days to 42 days			1	1	1		
(i) without other risk factors for VTE	2[a]	2[a]					
(ii) with other risk factors for VTE	**3[a]**	**3[a]**					
c) ≥ 42 days	1	1	1	1	1		
Postpartum (breastfeeding or non-breastfeeding women, including after caesarean section)							
a) < 48 hours including insertion immediately after delivery of the placenta						1	**not BF=1; BF=2**
b) ≥ 48 hours to < 4 weeks						3	3
c) ≥ 4 weeks						1	1
d) Puerperal sepsis						4	4

COMBINED HORMONAL CONTRACEPTIVES (CHCs)

CHCs do not protect against sexually transmitted infections (STIs), including HIV. If there is a risk of STI/HIV, the correct and consistent use of condoms is recommended. When used correctly and consistently, condoms offer one of the most effective methods of protection against STIs, including HIV. Female condoms are effective and safe, but are not used as widely by national programmes as male condoms.

CONDITION	CATEGORY I = initiation, C = continuation				CLARIFICATIONS/EVIDENCE
	COC	P	CVR	CIC	
† recommendations reviewed for the MEC 5th edition, further details after this table * additional comments after this table	COC = combined oral contraceptive P = combined contraceptive patch CVR = combined contraceptive vaginal ring CIC = combined injectable contraceptive				
BREASTFEEDING †					Evidence: Clinical studies demonstrate conflicting results regarding effects on breastfeeding continuation or exclusivity in women exposed to COCs during lactation. No consistent effects on infant growth or illness have been reported *(121–126)*. Adverse health outcomes or manifestations of exogenous estrogen in infants exposed to combined contraceptives through breast-milk have not been demonstrated; however, studies have been inadequately designed to determine whether a risk of either serious or subtle long-term effects exists.
a) < 6 weeks postpartum	4	4	4	4	
b) ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	3	3	3	
c) ≥ 6 months postpartum	2	2	2	2	

POSTPARTUM (IN NON-BREASTFEEDING WOMEN)†

Although the risk of venous thromboembolism (VTE) is the same in breastfeeding and non-breastfeeding women, use of CHCs is generally not recommended prior to 6 months postpartum in women who are breastfeeding.

a) < 21 days					Clarification: For women up to 6 weeks postpartum with other risk factors for VTE, such as immobility, transfusion at delivery, BMI > 30 kg/m^2, postpartum haemorrhage, immediately post-caesarean delivery, pre-eclampsia or smoking, use of CHCs may pose an additional increased risk for VTE. Evidence: VTE risk is elevated during pregnancy and the postpartum period; this risk is most pronounced in the first 3 weeks after delivery, declining to near baseline levels by 42 days postpartum *(127–131)*. Use of CHCs, which increases the risk of VTE in healthy reproductive-age women, may pose an additional risk during this time *(132)*. Risk of pregnancy during the first 21 days postpartum is very low, but increases after that time in non-breastfeeding women; ovulation before first menses is common *(133)*.
i) without other risk factors for VTE	3	3	3	3	
ii) with other risk factors for VTE	4	4	4	4	
b) ≥ 21 days to 42 days					
i) without other risk factors for VTE	2	2	2	2	
ii) with other risk factors for VTE	3	3	3	3	
c) > 42 days	1	1	1	1	

Breastfeeding and postpartum (p 28)

- Part I
  - Explanation of development
  - Question 1: Among breastfeeding women, does initiation of combined hormonal contraceptives (CHCs) at < 6 weeks postpartum have negative effects on breastfeeding outcomes or infant outcomes, compared with no contraception or non-hormonal contraception? (Direct evidence)
  - PICO and databases searched
  - Recommendations
  - Remarks
  - Summary of the evidence
  - Quality of the evidence
  - Tables and references

Medical eligibility criteria for contraceptive use 5th ed. – Summary of the changes

- Recommendations in the MEC 5th edition enable programmes to further expand contraceptive choice

  - Breastfeeding women have more contraceptive choices during the postpartum period
  - **Women living with HIV, including women taking ART have more contraceptive options**
  - Four new methods of contraception added to the 5th edition
  - Adolescents can use all methods of contraception, including IUDs and implants

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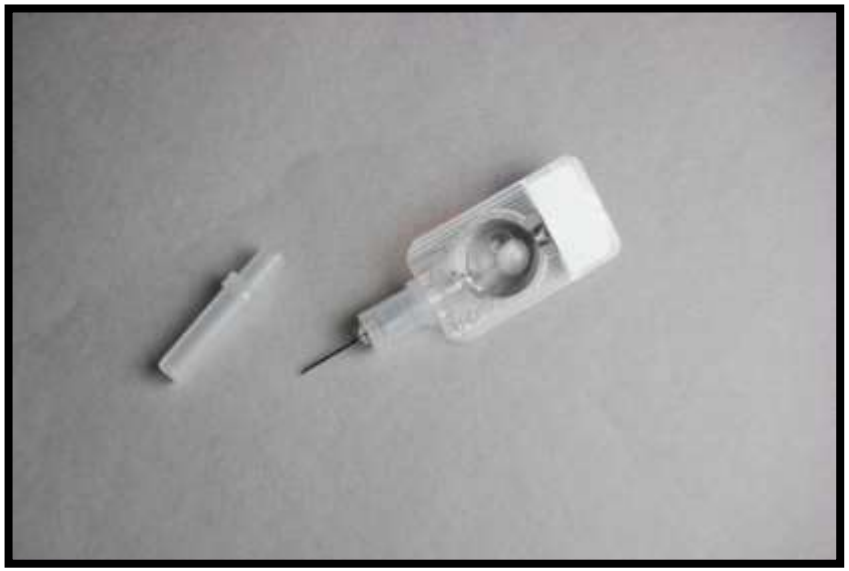
Methods of contraception

- Combined oral contraceptives
- Combined hormonal contraceptives (1 month injectables, patch, vaginal ring)
- Progestogen-only contraceptives (pills, implants, 2-3 month injectables)
  - DMPA subcutaneous (NEW method)
  - Sino-implant (II) (NEW method)
- Emergency contraceptive pills
  - Ulipristal acetate (NEW method)
- IUDs (copper bearing and levonorgestrel)
- Emergency IUD
- Barrier methods (condoms, spermicides & diaphragm)
- Fertility awareness-based methods
- Lactational amenorrhoea (LAM)
- Progesterone-releasing vaginal ring (NEW method)
- Coitus Interruptus
- Sterilization (male and female)

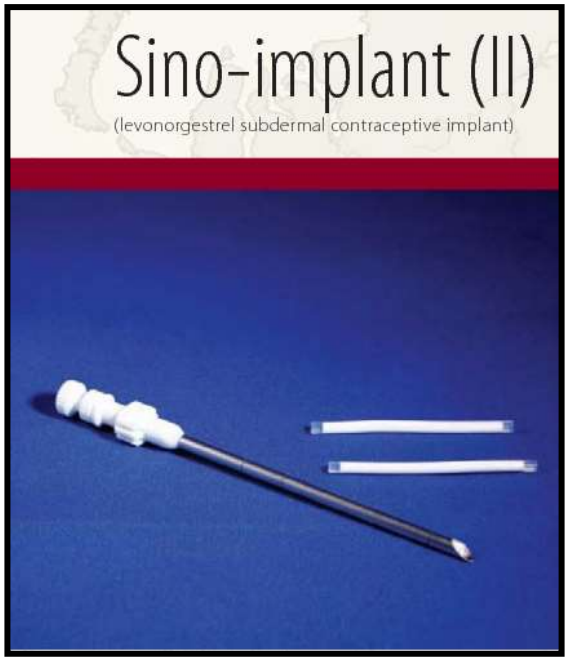
DMPA-subcutaneous injectable (DMPA SC)

- Depot medroxyprogesterone acetate is delivered subcutaneously (DMPA SC) at dose of 104 mg/0.65 mL
  - Also feasible for self-administration
- Guideline group determined all recommendations for DMPA SC should follow existing DMPA intramuscular injectable recommendations



Sino-implant (II)

- 2-rod, 150 mg LNG implant manufactured in China
- Guideline group determined that all Sino-implant (II) recommendations should follow existing LNG implant recommendations



Ulipristal Acetate (UPA)

- Delays ovulation
- Single dose and effective up to 120 hours
- All women can use UPA for emergency contraception
  - For example, women with the following conditions and/or characteristics can use UPA: migraine, breastfeeding, obesity, past ectopic pregnancy, taking certain medications, history of severe cardiovascular disease, rape, repeat EC use

Progesterone-releasing vaginal ring (PVR)

- Specifically designed for women who actively breastfeed (at least 4 episodes/day)
- Delivers daily low dose of natural progesterone
- Currently registered in at least 9 Latin American countries
- Women can use the PVR without restriction from 4 weeks post delivery

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Summary of MEC Recommendations for AGE

	COC	P	R	CIC	POP	POI	Implant	IUD Cu	IUD LNG
a) Menarche to < 40 years	1	1	1	1					
b) ≥ 40 years	2	2	2	2					
a) Menarche to < 18 years					1	2	1		
b) 18 to 45 years					1	1	1		
c) > 45 years					1	2	1		
a) Menarche to < 20 years								2	2
b) ≥ 20 years								1	1

Adolescents and IUD

	Cu-IUD	LNG-IUD
a) Menarche to < 20 years	2	2
b) ≥ 20 years	1	1

Evidence: Risks of pregnancy, infection and perforation are low among IUD users of any age. Heavy bleeding or removals for bleeding do not seem to be associated with age. Young women using Cu-IUDs may have an increased risk of expulsion compared with older Cu-IUD users.

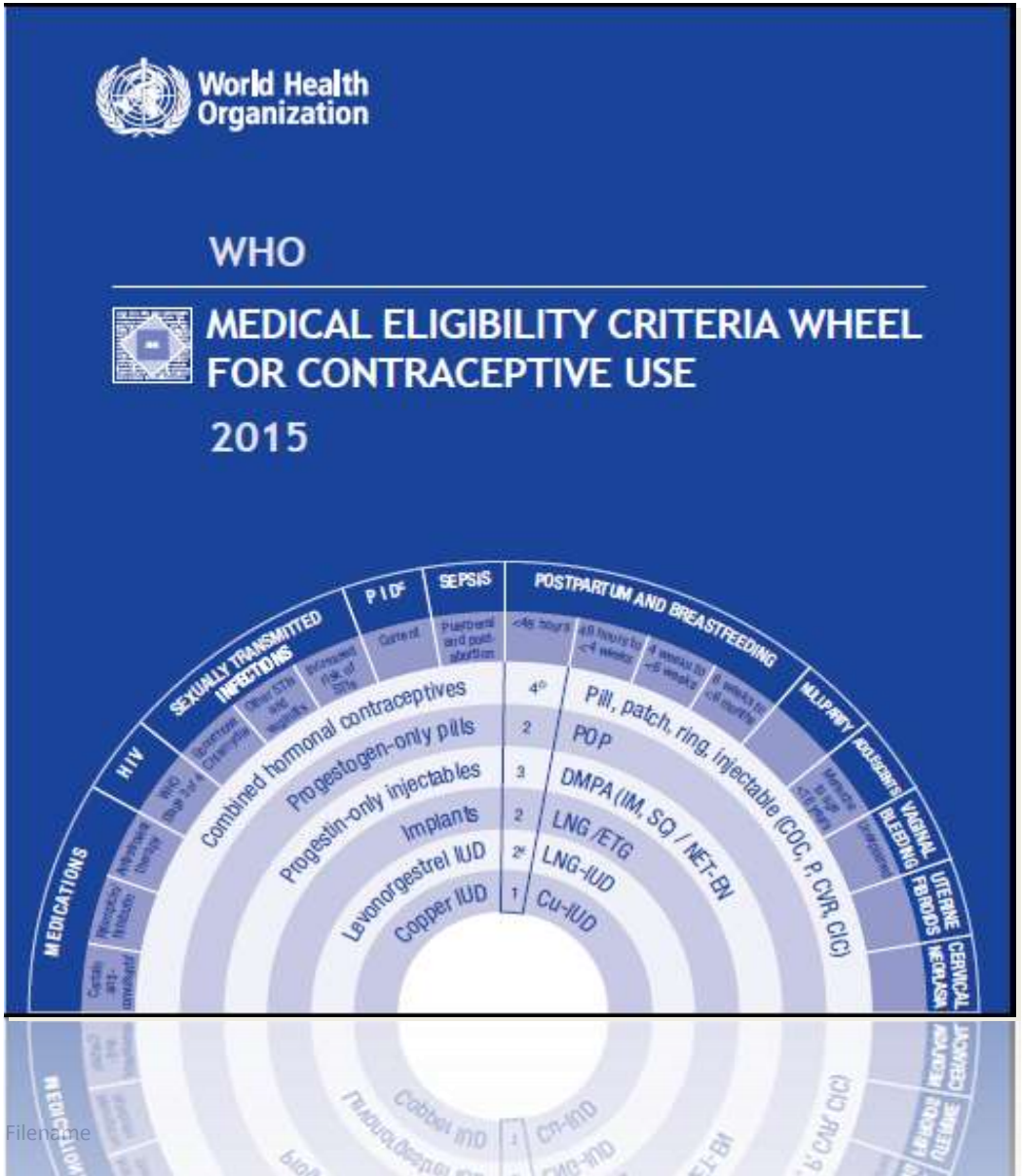
Adolescents and Emergency Contraception

- Adolescents and adult women of reproductive age may need emergency contraception at some point to avoid an unintended pregnancy.

- All women and girls, regardless of age, can use emergency contraceptive pills (combined hormonal, levonorgestrel or ulipristal acetate)
  - *There are no medical conditions for which the risks of ECP use outweigh any potential benefits.*

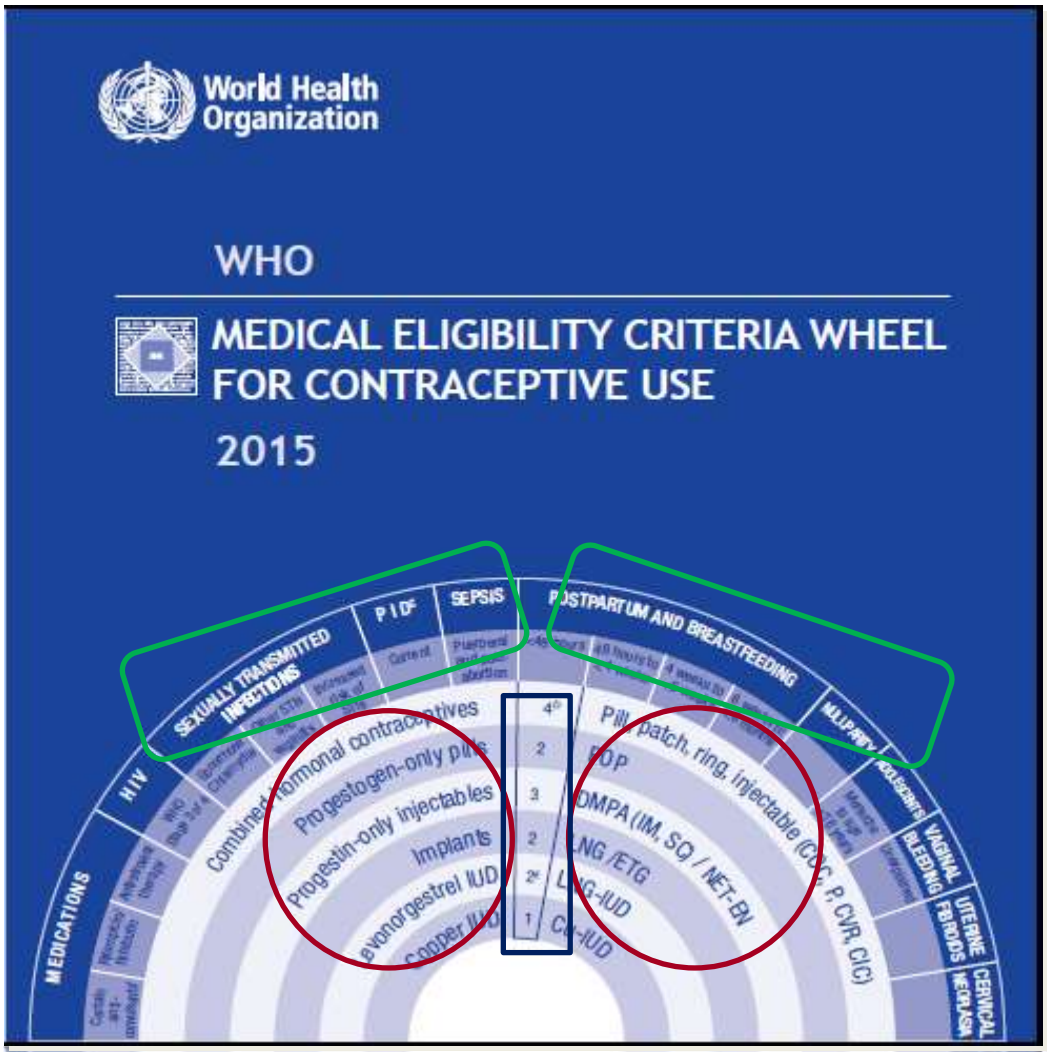
- Cu-IUD can be inserted within five days of unprotected intercourse for emergency contraception

MEC Wheel



- Contains the MEC for starting use of contraceptive methods

MEC Wheel



- Selected methods
- Medical or health conditions
- MEC category
- Comments

World Health Organization hrp

A	If condition develops while using method, can continue using it during treatment.
B	If very high likelihood of exposure to gonorrhoea or chlamydia =3.
C	If past pelvic inflammatory disease (PID) all methods =1, including IUDs.
D	If <3 wks, not breastfeeding & no other VTE risk factors =3.
E	If not breastfeeding =1.
F	If 3 to <6 wks, not breastfeeding & no other VTE risk factors =2, with other VTE risk factors =3.
G	If ≥6 wks & not breastfeeding =1.
H	If uterine cavity distorted preventing insertion =4.
I	Refers to hepatocellular adenoma (benign) or carcinoma/ hepatoma (malignant).
J	If adenoma CIC =3, if carcinoma/hepatoma CIC =3/4.
K	CIC =3.
L	If established on anticoagulation therapy =2.
M	If condition developed while on this method, consider switching to non-hormonal method.
N	Risk factors: older age, smoking, diabetes, hypertension, obesity & known dyslipidaemias.
O	If cannot measure blood pressure & no known history of hypertension, can use all methods. Either systolic or diastolic blood pressure may be elevated.
P	If age <18 yrs & obese DMPA/NET-EN =2.
Q	For insulin-dependent & non-insulin-dependent. If complicated or >20 yrs duration, COC/P/CVR, CIC =3/4; DMPA, NET-EN =3.
R	If <15 cigarettes/day CIC =2. If ≥15 cigarettes/day COC/P/CVR =4.
S	Aura is focal neurological symptoms, such as flickering lights. If no aura & age <35 COC/P/CVR, CIC =2, POP =1. If no aura & age ≥35 COC/P/CVR, CIC =3, POP =1.
T	Barbituates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate & lamotrigine.
U	If barbituates, carbamazepine, oxcarbazepine, phenytoin, primidone or topiramate CIC =2.
V	If lamotrigine =1.
W	DMPA =1, NET-EN =2.
X	CICs =2.
Y	If antiretroviral therapy with EFV, NVP, ATV/r, LPV/r, DRV/r, RTV: COC/P/CVR, CIC, POP, NET-ET, Implants =2; DMPA =1. For all NRTIs, ETR, RPV, RAL each method =1. See jacket for full names of medications.
Z	If WHO Stage 3 or 4 (severe or advanced HIV clinical disease) IUD =3.

Conditions that are category 1 and 2 for all methods (method can be used)

eproductive Conditions: Benign breast disease or undiagnosed mass • Benign ovarian tumours, including cysts • Dysmenorrhoea • Endometriosis • History of gestational diabetes • History of high blood pressure during pregnancy • History of pelvic surgery, including caesarean delivery • Irregular, heavy or prolonged menstrual bleeding (explained) • Past ectopic pregnancy • Past pelvic inflammatory disease • Post-abortion (no sepsis) • Postpartum ≥ 6 months

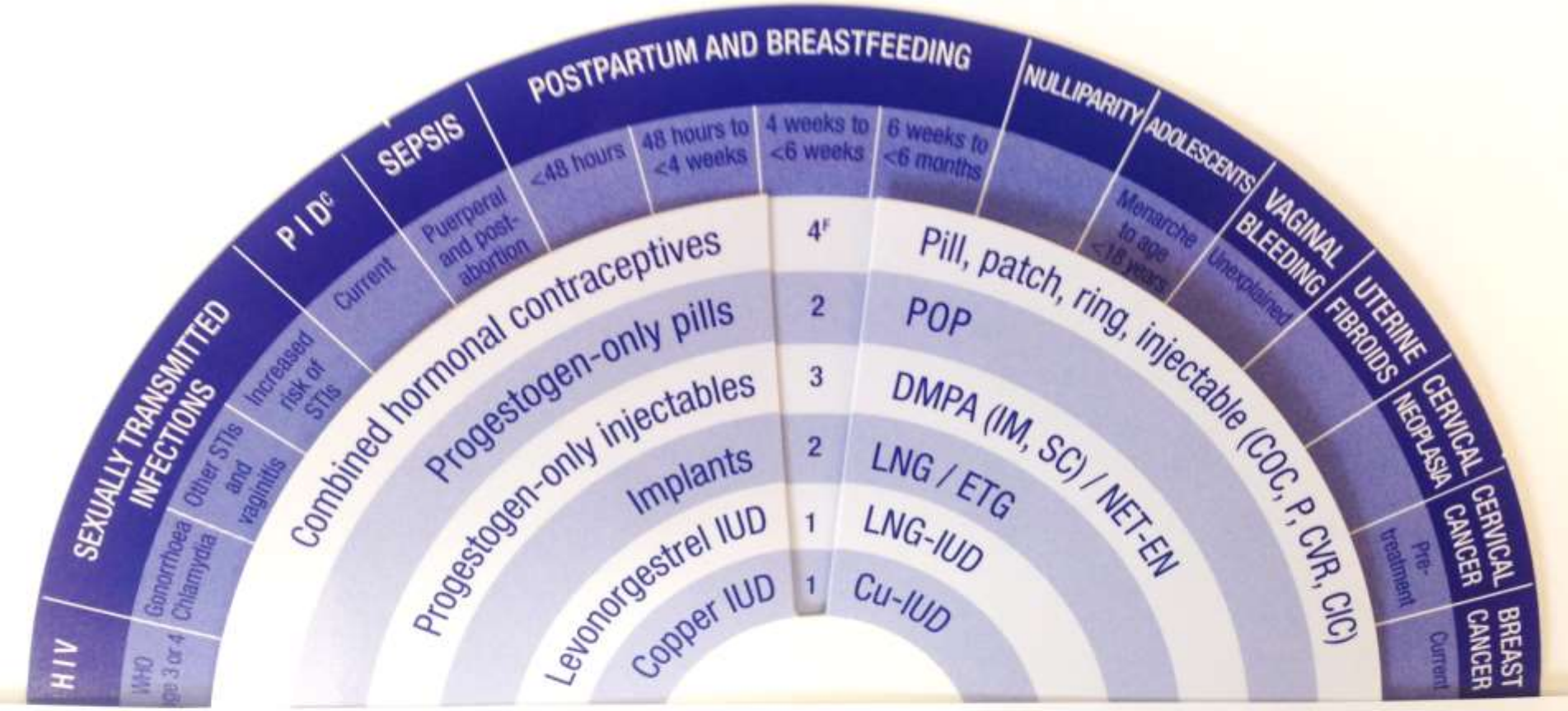
Medical Conditions: Depression • Epilepsy • HIV asymptomatic or mild clinical disease (WHO Stage 1 or 2) • Iron-deficiency anaemia, sickle-cell disease and thalassaemia • Malaria • Mild cirrhosis • Schistosomiasis (bilharzia) • Superficial venous disorders, including varicose veins • Thyroid disorders • Tuberculosis (non-pelvic) • Uncomplicated valvular heart disease • Viral hepatitis (carrier or chronic)

Other: Adolescents • Breast cancer family history • Venous thromboembolism (VTE) family history • High risk for HIV • Surgery without prolonged immobilization • Taking antibiotics (excluding rifampicin/rifabutin)

With few exceptions, all women can safely use emergency contraception, barrier and behavioural methods of contraception, including lactational amenorrhoea method; for the complete list of recommendations, please see the full document.

"Combined" is a combination of ethinyl estradiol & a progestogen.

CIC: combined injectable contraceptive **COC**: combined oral contraceptive pill
Cu-IUD: copper intrauterine device **CVR**: combined contraceptive vaginal ring
DMPA (IM, SC): depot medroxyprogesterone acetate, intramuscular or subcutaneous
ETG: etonogestrel **LNG**: levonorgestrel **LNG-IUD**: levonorgestrel intrauterine device


HIV
SEXUALLY TRANSMITTED INFECTIONS
PID[C]
SEPSIS
POSTPARTUM AND BREASTFEEDING
NULLIPARITY
ADOLESCENTS
VAGINAL BLEEDING
UTERINE FIBROIDS
CERVICAL NEOPLASIA
CERVICAL CANCER
BREAST CANCER
WHO stage 3 or 4
Gonorrhoea Chlamydia
Other STIs and vaginitis
Increased risk of STIs
Current
Puerperal and post-abortion
<48 hours
48 hours to <4 weeks
4 weeks to <6 weeks
6 weeks to <6 months
Menarche to age <18 years
Unexplained
Pre-treatment
Current
Combined hormonal contraceptives
Progestogen-only pills
Progestogen-only injectables
Implants
Levonorgestrel IUD
Copper IUD
4[F]
2
3
2
1
1
Pill, patch, ring, injectable (COC, P, CVR, CIC)
POP
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LNG / ETG
LNG-IUD
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Y	If antiretroviral therapy with EFV, NVP, ATV/r, LPV/r, DRV/r, RTV: COC/P/CVR, CIC, POP, NET-ET, Implants =2; DMPA =1. For all NRTIs, ETR, RPV, RAL each method =1. See jacket for full names of medications.
Z	If WHO Stage 3 or 4 (severe or advanced HIV clinical disease) IUD =3.

Conditions that are category 1 and 2 for all methods (method can be used)

eproductive Conditions: Benign breast disease or undiagnosed mass • Benign ovarian tumours, including cysts • Dysmenorrhoea • Endometriosis • History of gestational diabetes • History of high blood pressure during pregnancy • History of pelvic surgery, including caesarean delivery • Irregular, heavy or prolonged menstrual bleeding (explained) • Past ectopic pregnancy • Past pelvic inflammatory disease • Post-abortion (no sepsis) • Postpartum ≥ 6 months

Medical Conditions: Depression • Epilepsy • HIV asymptomatic or mild clinical disease (WHO Stage 1 or 2) • Iron-deficiency anaemia, sickle-cell disease and thalassaemia • Malaria • Mild cirrhosis • Schistosomiasis (bilharzia) • Superficial venous disorders, including varicose veins • Thyroid disorders • Tuberculosis (non-pelvic) • Uncomplicated valvular heart disease • Viral hepatitis (carrier or chronic)

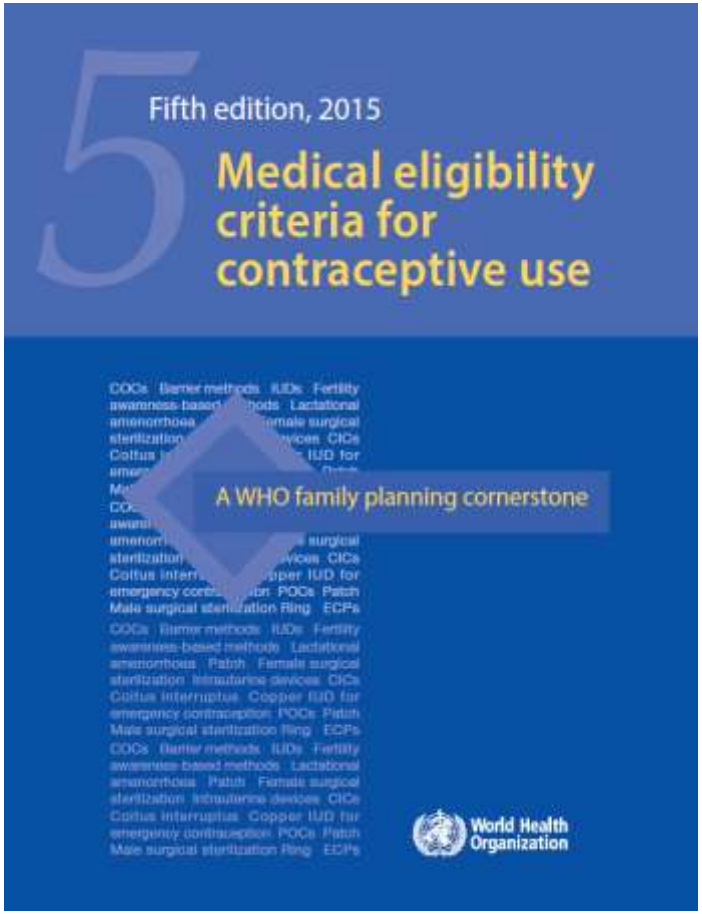
Other: Adolescents • Breast cancer family history • Venous thromboembolism (VTE) family history • High risk for HIV • Surgery without prolonged immobilization • Taking antibiotics (excluding rifampicin/rifabutin)

With few exceptions, all women can safely use emergency contraception, barrier and behavioural methods of contraception, including lactational amenorrhoea method; for the complete list of recommendations, please see the full document.

"Combined" is a combination of ethinyl estradiol & a progestogen.

CIC: combined injectable contraceptive **COC**: combined oral contraceptive pill
Cu-IUD: copper intrauterine device **CVR**: combined contraceptive vaginal ring
DMPA (IM, SC): depot medroxyprogesterone acetate, intramuscular or subcutaneous
ETG: etonogestrel **LNG**: levonorgestrel **LNG-IUD**: levonorgestrel intrauterine device

Summary

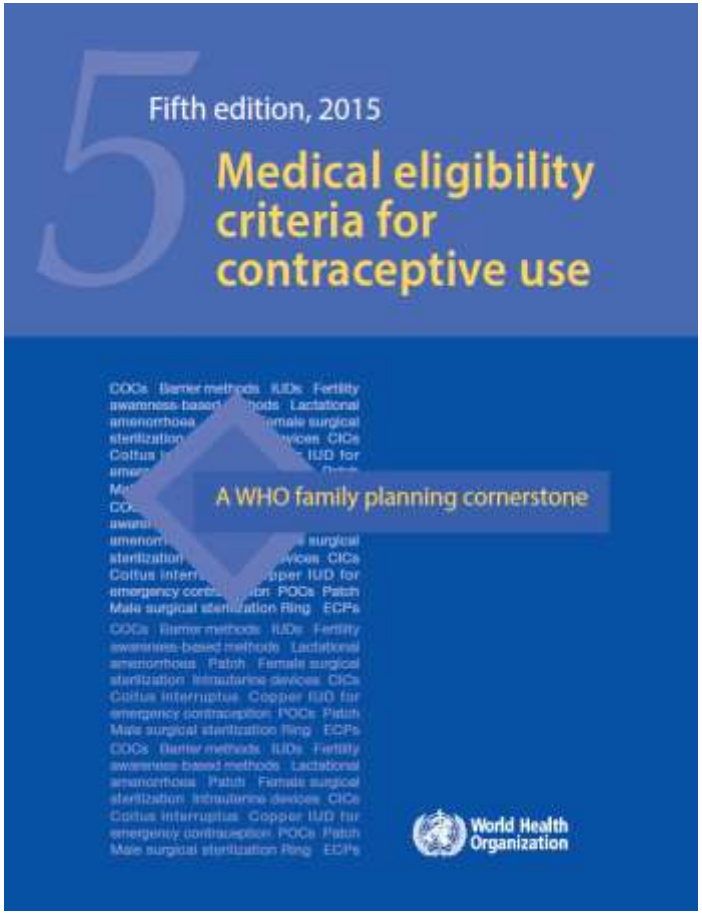


Purpose: Who can safely use contraceptive methods?

Target audience: policy-makers, family planning programme managers and the scientific community.

Guidance and reference: interpretation that reflects the diversity of situations and settings in which contraceptives are provided.

Summary



Part 1: Development of the Medical eligibility criteria for contraceptive use, fifth edition

Part II: Using the recommendations

MEC wheel

Thank You!

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