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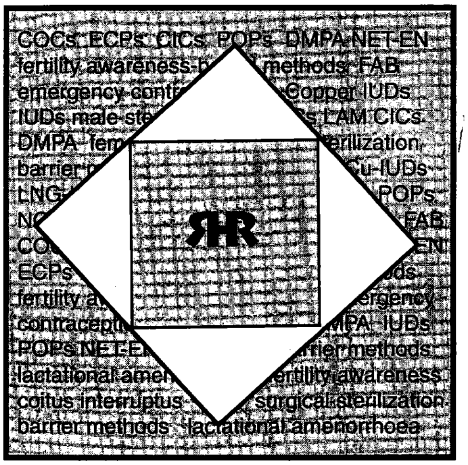
IMPROVING ACCESS TO QUALITY CARE IN FAMILY PLANNING



MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

second edition

RHR Reproductive Health and Research
World Health Organization, Geneva

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Representatives of these agencies and organizations, together with other individuals, served as experts at a meeting that achieved consensus on medical eligibility criteria for initiating and continuing use of the contraceptive methods dealt with in this report. We would like to express our deep appreciation to all of them for contributing their time and expertise towards the consensus building process.

The evidence on which the decisions in this document were based was in large part obtained from a systematic review of the literature conducted and summarized by Dr KM Curtis and Ms CE Chrisman, who also provided substantial support to Secretariat. Additional evidence was provided in a background paper by Dr JJ Schlesselman and Dr TMM Farley. Dr H Peterson was overall coordinator of the project. We would like to express our deep appreciation to these individuals as well as to Dr J Shelton for his continuing support of this endeavour.

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Executive summary

This document is one important step in a process for improving access to quality of care in family planning by reviewing the medical eligibility criteria for selecting methods of contraception. It updates the first edition of *Improving access to quality care in family planning: medical eligibility criteria for contraceptive use*, published in 1996, and summarizes the main recommendations of a scientific Working Group meeting held at the World Health Organization, Geneva, 8-10 March 2000. (Please see Annex I for the list of participants.) The Working Group brought together 32 participants from 17 countries, including representatives of several agencies and organizations. The document provides recommendations for appropriate medical eligibility criteria based on the latest clinical and epidemiological data and is intended to be used by policy-makers, family planning programme managers and the scientific community. It aims to provide guidance to national family planning/reproductive health programmes in the preparation of guidelines for service delivery of contraceptives. It should not be seen or used as the actual guidelines but rather as a reference.

The document covers the following family planning methods: low-dose combined oral contraceptives (COCs), combined injectable contraceptives (CICs), progestogen-only pills (POPs), depot medroxyprogesterone acetate (DMPA), norethisterone enanthate (NET-EN), Norplant implants I and II (NOR), emergency contraceptive pills (ECPs), copper intrauterine devices (Cu-IUDs), levonorgestrel-releasing IUDs (LNG-IUDs), copper-IUD for emergency contraception (E-IUD), barrier methods(BARR), fertility awareness-based methods (FAB), coitus interruptus (CI), lactational amenorrhoea method (LAM), and female and male sterilization (STER).

Overview

> “Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other relevant consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number and spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.” (para. 95, Beijing Platform for Action, 1995)

Reproductive and sexual health care including family planning services and information is recognized not only as a key intervention for improving the health of women and children but also as a human right. All individuals have the right to access, choice, and the benefits of scientific progress in the selection of family planning methods. A rights-based approach to the provision of contraceptives assumes a holistic view of clients, which includes taking into account clients' sexual and reproductive health care needs and considering all appropriate eligibility criteria in helping clients choose and use a family planning method.

Over the past 30 years, there have been significant advances in the development of new contraceptive technologies, including transitions from high-dose to low-dose estrogen combined oral contraceptives, and from inert to copper and levonorgestrel-releasing IUDs. However, current policies and health care practices in some countries are based on scientific studies of contraceptive products that are no longer in wide use, on long-standing theoretical concerns that have never been substantiated, or on the personal preference or bias of service providers. These outdated policies or practices many times result in limitations to both the quality of, and the access to, family planning services for clients. This document is intended to update the medical eligibility criteria used in the provision of all hormonal contraceptives, IUDs, barrier methods, fertility awareness-based methods, coitus interruptus, lactational amenorrhoea method, male and female sterilization, and emergency contraception.

Advances in scientific knowledge, research and development in recent decades have resulted in an increasingly wider choice of new contraceptive methods and improvements in the safety and effectiveness of existing methods. However, the full range of modern family planning methods still remains unavailable to at least 350 million couples worldwide, many of whom wish to space or prevent another pregnancy, despite their individual right to the benefits of scientific progress. Even when family planning methods are accessible and individuals wish to space or limit births, family planning services are often under-used. Many factors contribute to the gap between access to, and use of, services. In addition to many logistic, social and behavioural obstacles to meeting the contraceptive needs and wishes of individuals and couples, there may be obstacles that stem from the structure, organization or procedures of the health system that can be immediately corrected. To meet people's needs and close the existing large gap in quality services, reproductive health care providers, programmes and contraceptive suppliers will need to expand rapidly over the next several years, and information will need to be disseminated about new contraceptive developments, appropriateness of methods and introduction strategies.

Thus, WHO is giving priority to improving access to high-quality care in family planning through a variety of strategies. These include: ensuring that women's and men's rights and perspectives are taken into account in the planning, management and evaluation of services; promoting the widest availability of different contraceptive methods so that people may select what is most appropriate to their needs and circumstances; ensuring that contraceptive counselling and service delivery will

be based on eligibility criteria that are supported by a scientific rationale; and conducting research to develop new family planning methods, and improve existing ones.

Delivery of care in accordance with the client's human and reproductive rights is fundamental to quality of care. The development of international norms for the medical eligibility criteria for contraceptive methods is only one aspect of improving the quality of reproductive health care. Many family planning programmes have included screening, treatment and follow-up procedures that reflect high standards of public health and clinical practice but should not be seen as eligibility requirements for specific contraceptive methods. These procedures include the screening and treatment of cervical cancer, anaemia and sexually transmitted infections (STIs), and the promotion of breastfeeding and cessation of smoking. Such procedures should be strongly encouraged if the human and material resources are available to carry them out, but they should not be seen as prerequisites for the acceptance and use of family planning methods when they are not necessary to establish eligibility for the use or continuation of a particular method.

While this document primarily addresses medical eligibility criteria for contraceptive use, considerations of social, behavioural, and other non-medical criteria, particularly client preference, must be taken into account. To provide contraceptive choices to clients in a way that respects and fulfils their human rights necessitates enabling clients to make informed choices for themselves. Women's choices, however, are often imposed or limited by direct or indirect social, economic and cultural factors. From the women's point of view, choices are made in a particular time, society and cultural context; choices are complex, multifactorial and subject to change. Decision-making for contraceptive methods usually requires the need to make trade-offs among the different methods, with advantages and disadvantages of specific contraceptive methods according to individual circumstances, perceptions, and interpretations. In the provision of high-quality family planning services, providers must respect client's reproductive rights including facilitating choice and access through the promotion of contraceptive decision-making in the context of women's lives.

Issues of service quality and access that affect method use

While this document chiefly addresses medical eligibility criteria, there are many other considerations in the appropriate provision of contraceptive methods. WHO will be examining, in depth, these programmatic and service delivery concerns, in various programme settings, during the next phase of this initiative. However, it is critical, even at this stage, to bear in mind the following service delivery criteria which are universally relevant to the initiation and follow-up of all contraceptive method use.

a) **Clients should be given adequate information in order to make an informed, voluntary choice of a contraceptive method. Information given to clients to help them make this choice should at least include: understanding of the relative effectiveness of the method; correct use 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.**

b) **For those methods that require surgical approaches, insertion, fitting and/or removal by a trained health provider (sterilization, Norplant implants, IUDs, diaphragms, cervical caps), appropriately trained personnel in adequately equipped facilities must**

be available in order for those methods to be offered, and appropriate infection prevention procedures must be followed.

c) **Adequate and appropriate equipment and supplies need to be maintained and held in stock (for example, contraceptive commodities, equipment and supplies for infection prevention procedures).**

d) **Service providers should be provided with guidelines (or client cards or other screening tools) to enable them to appropriately screen clients for conditions in which use of certain contraceptive methods would carry unacceptable health risks.**

e) **Service providers must be trained in providing family planning counselling to help clients make informed and voluntary decisions about their fertility. Counselling is a key element in quality of care and is also an important part of both initiation and follow-up visits and should respond to clients needs not only in contraception but also related to sexuality and the prevention of STIs, including infection with the human immunodeficiency virus (HIV).**

Effectiveness of methods

Contraceptive choice is in part dependent on the effectiveness of the contraceptive method in preventing unplanned pregnancy, which, in turn, is dependent for some methods not only on the protection afforded by the method itself, but also on how consistently and correctly it is used (Table 1). Both consistent and correct use can vary greatly with such characteristics as age, income, users' desire to prevent or delay pregnancy, and culture. Methods that depend on consistent and correct use by clients have a wide range of effectiveness. Most men and women tend to be more effective users as they become more experienced with a method. However, programmatic aspects also have a profound effect on how effectively the method will be used.

Programmes must therefore ensure that the factors contributing to the effective use of contraceptive methods are adequately addressed. These include:

- **information for clients on consistent and correct use**
- **technical competence, counselling and ongoing support by providers**
- **accessibility, acceptability and affordability of services to ensure ongoing quality of care and availability of methods.**

In the context of contraceptive choice and method effectiveness, clients should be helped to understand:

- the relative effectiveness of available methods to help them to make an informed choice of the method; and

- the negative effects of unwanted pregnancies on the health and well-being of individuals and families and the potentially serious health risk of pregnancy for women with certain pre-existing medical conditions.

Table 1. Effectiveness of family planning methods[†]

Effectiveness group	Family planning method	Pregnancies per 100 women in first 12 months of use	
		As commonly used	Used correctly & consistently
Always very effective	Norplant implants	0.1	0.1
	Vasectomy	0.2	0.1
	Combined injectables[‡]	0.3	0.3
	DMPA and NET-EN injectables	0.3	0.3
	Female sterilization	0.5	0.5
	TCu-380A IUD	0.8	0.6
	Progestogen-only oral contraceptives (during breastfeeding)	1	0.5
Effective as commonly used Very effective when used correctly and consistently	Lactational amenorrhoea method	2	0.5
	Combined oral contraceptives	6–8	0.1
	Progestogen-only oral contraceptives (not during breastfeeding)	[§]	0.5[§§]
Only somewhat effective as commonly used Effective when used correctly and consistently.	Male condoms	14	3
	Coitus interruptus[§§]	19	4
	Diaphragm with spermicide	20	6
	Fertility awareness-based methods	20	1–9
	Female condoms	21	5
	Spermicides	26	6
	Cap		
	Nulliparous women	20	9
	Parous women	40	26
	No method	85	85

Key:	0–1	Very effective	2–9	Effective	10–30	Somewhat effective

Notes:

† Adapted from Hatcher RA, Rinehart W, Blackburn R, Geller JS and Shelton JD. *The essentials of contraceptive technology*. Baltimore, Johns Hopkins University School of Public Health, Population Information Program, 1997.

‡ UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Facts about once-a-month injectable contraceptives: Memorandum from a meeting. *Bulletin of the World Health Organization* 1993; 70(6):677-689.

§ Outside the context of breastfeeding, progestogen-only contraceptives are somewhat less effective than combined oral contraceptives. See Hatcher RA, Trussell J, Stewart F, Cates Jr W, Stewart GK, Guest F, Kowal D. *Contraceptive technology (17th edition)*. New York, Ardent Media Inc., 1998.

§§ Data source: Hatcher RA, Trussell J, Stewart F, Cates Jr W, Stewart GK, Guest F, Kowal D. *Contraceptive technology (17th edition)*. New York, Ardent Media Inc., 1998.

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

Women with conditions that may make pregnancy an unacceptable health risk should be advised that, because of their relatively higher typical-use failure rates, sole use of barrier methods for contraception, and behaviour-based methods of contraception may not be the most appropriate choice for them. These conditions are noted in Table 2.

Table 2. Conditions that expose a woman to increased risk as a result of unintended pregnancy

High blood pressure (systolic >160 mmHg or diastolic >100 mmHg)†
Diabetes: insulin-dependent; with nephropathy/retinopathy/neuropathy or other vascular disease; or of > 20 years' duration
Ischaemic heart disease
Stroke
Complicated valvular heart disease
Breast cancer
Endometrial or ovarian cancer
STI
HIV/AIDS
Severe (decompensated) cirrhosis
Malignant liver tumours (hepatoma)
Malignant gestational trophoblastic disease
Sickle cell disease
Schistosomiasis with fibrosis of the liver
Tuberculosis

Note:

† Throughout this document, blood pressure measurements are given in mm/Hg. 9To convert to kPa, multiply by 0.1333. For example, 120/80 mm Hg = 16.0/10.7 kPa.

Return to fertility

The use of contraceptive methods, with the exception of male and female sterilization, does not result in an irreversible change in fertility. Return to fertility is immediate with all methods, with the exception of DMPA and NET-EN; the median delay in return to fertility with these methods is 10 and 6 months respectively from the date of the last injection, regardless of the duration of their use. Male and female sterilization should be regarded as permanent methods. No other methods result in permanent infertility.

STIs and contraception: Dual protection

While the development of international norms for contraceptive provision is essential for quality of care in services, the social and cultural context of each client must also be considered. In this regard, the problems of exposure to STIs, including HIV, deserve special consideration because of the equal importance of preventing pregnancy and preventing transmission of infection. When a risk of STI/HIV transmission exists, it is important that health care providers strongly recommend **dual protection** to all persons at significant risk, either through the simultaneous use of condoms with other methods or through the consistent and correct use of condoms alone for both pregnancy prevention and disease prevention. Women and men seeking contraceptive advice must always be reminded of the importance of condom use for preventing the transmission of STI/HIV. Male latex condoms are proven to protect against STI/HIV when used consistently and correctly.

Method of work

This document builds on a process initiated in 1994 that culminated in the 1996 publication of the document, *Improving access to quality care in family planning: medical eligibility criteria for contraceptive use*. In the initial process, which was created to reach agreement on appropriate eligibility criteria for widely used contraceptive methods, a number of agencies and organizations collaborated in an in-depth review of the epidemiological and clinical evidence relevant to medical eligibility criteria of well established contraceptive methods. The process involved comparing the eligibility criteria used by different agencies for various contraceptives, preparing summaries of published medical and epidemiological literature relevant to medical eligibility criteria, and preparing a draft classification for review by a larger group of experts and agencies. Two scientific Working Group meetings were organized by WHO, in March 1994 and May 1995, to review the background classifications and to formulate recommendations for revising medical eligibility criteria for all currently available contraceptive methods, and the document, *Improving access to quality care in family planning: medical eligibility criteria for contraceptive use*, followed in 1996.

This first revision of the 1996 document is based on the recommendations of a scientific Working Group meeting held at WHO on 8–10 March 2000, that brought together 32 participants from 17 countries, including representatives of several agencies and organizations. The Working Group reviewed new evidence since the last Working Group meetings in 1994 and 1995. This new evidence was primarily obtained from a systematic review of the most recent literature, which was conducted to identify and summarize new evidence for medical eligibility criteria of contraceptive methods. A search of the MEDLINE database yielded all primary studies published in English, from January 1995 through January 2000, that described use of contraceptive methods among women with certain conditions (e.g., the risk of stroke for women with migraines who used COCs). The purpose of the systematic review was to identify direct evidence for the appropriateness of contraceptive method use by women with selected conditions. Information on indirect evidence or theoretical considerations was not obtained.

There are a limited number of studies that specifically address use of a contraceptive method by women with the conditions of interest. Thus, most of the decisions regarding eligibility criteria using new evidence were often necessarily based on extrapolations from studies that primarily included healthy women, as well as on theoretical considerations and expert opinion. Evidence

was particularly limited for newer products and for those with limited usage. The total body of evidence considered by the Working Group included:

- evidence based on direct studies or observations of the contraceptive method used by women (or men) with the condition;
- evidence derived from effects of the contraceptive method used by women (or men) without the condition;
- indirect evidence or theoretical concern based on studies of suitable animal models, human laboratory studies, or analogous clinical situations.

Programmatic implications of the classification were also considered by the Working Group.

The Working Group was charged with determining the eligibility criteria for each condition and method of contraception by selecting a category (1 through 4, as described below). Where changes in the eligibility criteria were made by the Working Group, the new evidence provided to the Group has been summarized and presented by the Secretariat under the heading “New evidence”, in the column labelled “New evidence/Comments”. Where changes in eligibility criteria were made based on considerations other than new evidence, the rationale for such changes has been summarized by the Secretariat under the heading “Comments”, in the column labelled “New evidence/Comments”. Comments also may have been provided by the Secretariat when the eligibility criteria for a condition did not change. These comments reflect key considerations, including programmatic implications.

The present document is intended to be used by policy-makers, family planning programme managers and the scientific community. It aims to provide guidance to national family planning/reproductive health programmes in the preparation of guidelines for service delivery of contraceptives. It should not be seen or used as the actual guidelines but rather as a reference.

Classification categories

The medical eligibility criteria in this document were based on the approach described above and aim to ensure an adequate margin of safety.

Each condition was defined as representing either an individual's characteristics (e.g., age, history of pregnancy) or a known pre-existing medical/pathological condition (e.g., diabetes, hypertension). It is expected that national and institutional health and service delivery environments will decide the most suitable means for screening for conditions according to their public health importance. Client history will often be the most appropriate approach.

The conditions affecting eligibility for the use of each contraceptive method were classified under one of the following four categories:

1. **A condition for which there is no restriction for the use of the contraceptive method.**
2. **A condition where the advantages of using the method generally outweigh the theoretical or proven risks.**

3. **A condition where the theoretical or proven risks usually outweigh the advantages of using the method.**

4. **A condition which represents an unacceptable health risk if the contraceptive method is used.**

Categories 1 and 4 are self-explanatory. Classification of a method/condition as category 2 indicates the method can generally be used, but careful follow-up may be required. However, provision of a method to a woman with a condition classified as category 3 requires careful clinical judgement 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. For a method/condition classified as category 3, use of that method is not usually recommended unless other more appropriate methods are not available or acceptable. Careful follow-up will be required.

NA denotes a condition for which a ranking was not given by the Working Group but on which comments have been provided.

The Working Group addressed medical criteria for the initiation and continuation of use of all methods evaluated.

The discussion on continuation of use criteria included only those conditions where criteria for continuation of a method differed from criteria for initiation of the method and those conditions which may have the same classification for continuation and initiation, but a different rationale. The issue of continuation criteria is clinically relevant whenever a woman develops the condition while she is using the method. A difference in category between initiation and continuation is denoted in the columns 'I=Initiation' and 'C=Continuation'.

On the basis of this classification system, the eligibility criteria for initiating and continuing use of a specific contraceptive method are presented in this document in a set of tables. The first column indicates the condition. Several conditions were subdivided to differentiate between varying degrees of the condition. The second column classifies the condition for initiation and/or continuation in one of the four categories described above. If necessary, the third column gives new evidence or comments regarding the classification, as described in the section above.

ELIGIBILITY CRITERIA FOR USE OF A CONTRACEPTIVE METHOD

TYPE OF CONTRACEPTIVE		
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/ COMMENTS**
Condition	Condition classified from 1 to 4	New evidence/Comments on the classification

The classifications for fertility awareness-based methods and surgical sterilization are described at the beginning of the relevant section.

A summary table is included at the end of the document covering medical eligibility criteria by condition for hormonal methods and IUDs. A summary of the conditions or categories that were revised for this edition is included at the end of this section.

Clients with multiple risks

When making decisions about contraception, both client and provider should assess thoroughly the client's general health and the presence of risk conditions. In the case of a client presenting more than one risk condition simultaneously, the category assigned to the risk conditions under each method may be changed to reflect the need for more caution. “Multiple cardiovascular risk factors” has been included as a specific condition.

How to use this document

This document is intended for adaptation at country and programme levels to reflect the diversity of situations and settings in which contraceptives are provided. In particular, the level of clinical knowledge and experience of various types of providers and the resources available at the service delivery point will have to be taken into consideration.

Professionals who are developing family planning service delivery guidelines may wish to consider a variation of the classification system used in this document. Where clinical judgement resources are limited, such as in community-based services, the four-category classification framework can be simplified into two categories. Thus the framework can be used both in situations where clinical judgement can be provided and in those where it is not available.

CLASSIFICATION	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstances	Yes (Use the method)
2	Generally use the method	Yes (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	No (Do not use the method)

Programmatic implications

The goal of this document is to provide policy- and decision-makers and the scientific community with a set of recommendations that can be used for developing or revising national guidelines on medical eligibility criteria for contraceptive use.

The document does not provide rigid guidelines but rather gives recommendations that provide a basis for rationalizing the provision of various contraceptives in view of the most up-to-date information available on the safety of the methods.

Because country situations and programme environments vary so greatly, it is inappropriate to set firm international guidelines on criteria for contraceptive use. However, it is expected that national programmes will use these recommendations as a reference tool, adapting them to develop their own contraceptive eligibility guidelines in the light of their national health policies, needs, priorities and resources. The intent is to help improve access to, and quality of, family planning services. These improvements must be made within the context of users' informed choice and medical safety. Adaptation is not always an easy task and is best done by those well-acquainted with the prevailing health situation, habits and culture.

Programmatic issues that need to be addressed include:

- 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.

In the application of the eligibility criteria to programmes, service delivery practices that are essential for the safe use of the contraceptive should be distinguished from practices that may be appropriate for good health care but are not related to use of the method. The promotion of good health care practices unrelated to safe contraception should be considered neither as a prerequisite nor as an obstacle to the provision of a contraceptive method, but as complementary to it.

As a next step, the recommendations on eligibility criteria need to be adapted so as to be applicable to providers at all levels of the service delivery system. Countries will need to determine how far and by what means it may be possible to extend their services to the more peripheral levels. This may involve upgrading both staff and facilities where feasible and affordable, or may require the extension of the skills of certain categories of health personnel or a modest addition of equipment and supplies, and redeployment of space. It will also be necessary to address questions of misperceptions sometimes held by providers and users on the risks and side-effects of the methods and to look closely at the needs and perspectives of women and men in the context of informed choice.

Clients with special needs

Medical eligibility criteria address contraceptive use by people with specific medical conditions. In addition, contraceptive provision to people with special needs requires further consideration. Individuals with a physical disability represent such a group. Decisions on appropriate contraception must take into account the nature of the disability, the expressed desires of the individual and the nature of the method. Decisions must be based on informed choice. Similar considerations should be given to individuals with mental disability or with serious psychiatric disease. Where the nature of the condition does not allow for informed choice, contraceptives should be provided only after full discussion with all parties including guardians or care-givers. The reproductive rights of the individual must be considered in any such decisions.

Adolescents

In general, adolescents are eligible to use any method of contraception and must have access to a variety of contraceptive choices. Age alone does not constitute a medical reason for denying any method to adolescents. While some concerns have been expressed regarding the use of certain contraceptive methods in adolescents (e.g., the use of progestogen-only injectables by those below 18 years), these concerns must be balanced against the advantages of avoiding pregnancy. It is clear that many of the same eligibility criteria that apply to older clients apply to young people. However, some conditions (e.g., cardiovascular disorders) that may limit use of some methods in older women do not generally affect young people since these conditions are rare in this age group. Social and behavioural issues should be important considerations in the choice of contraceptive methods by adolescents. For example, in some settings, adolescents are also at increased risk for STIs, including HIV. While adolescents may choose to use any one of the contraceptive methods available in their communities, in some cases, using methods that do not require a daily regimen may be more appropriate. Adolescents, married or unmarried, have also been shown to be less tolerant of side-effects and therefore have high discontinuation rates. Method choice may also be influenced by factors such as sporadic patterns of intercourse and the need to conceal sexual activity and contraceptive use. For instance, sexually active adolescents who are unmarried have very different needs from those who are married and want to postpone, space or limit pregnancy. Expanding the number of method choices offered can lead to improved satisfaction, increased acceptance and increased prevalence of contraceptive use. Proper education and counselling both before and at the time of method selection can help adolescents address their specific problems and make informed and voluntary decisions. Every effort should be made to prevent service and method cost from limiting the options available.

Summary and conclusions

Updating knowledge and providing consistency among eligibility criteria will contribute to improvements in the quality of family planning services. Updated eligibility criteria improve the competence and confidence of service providers as they assist clients with their contraceptive choices. This, in turn, may contribute to increased satisfaction and confidence among clients. Individuals' access to quality contraceptive services may also be improved. On the basis of updated criteria, many persons who were previously prevented from using a particular contraceptive method might consider using it. Current contraceptive screening procedures may be simplified to include only those that are essential for the safe provision of contraceptive services.

It is recognized that some of the eligibility criteria in this report will need to be reviewed in the light of new research findings from studies being completed and/or currently in progress. It is intended

that this document will be updated on a continual basis in order to reflect the latest scientific evidence and findings.

A summary of the classification changes or major condition modifications from the first edition is given in Table 3.

Table 3. Summary of changes from the first edition
(Conditions for which there was a classification change for one or more methods or a major modification to the condition description)

CONDITION	COC	CIC	POP	DMPA NET-EN	NOR	Cu-IUD	LNG-IUD
I = Initiation, **C** = Continuation							
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY							
PREGNANCY	NA	NA	NA	NA	NA	4	4
AGE	Menarche to <40=1 ≥40=2	Menarche to <40=1 ≥40=2	Menarche to <18=1 18-45=1 >45=1	Menarche to <18=2 18-45=1 >45=2	Menarche to <18=1 18-45=1 >45=1	Menarche to <20=2 ≥20=1	Menarche to <20=2 ≥20=1
SMOKING							
a) Age < 35	2	2	1	1	1	1	1
b) Age ≥ 35							
(i) <15 cigarettes/day	3	2	1	1	1	1	1
(ii) ≥15 cigarettes/day	4	3	1	1	1	1	1
OBESITY ≥30 kg/m^2 body mass index (BMI)	2	2	1	2	2	1	2
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	NA	NA	NA	NA	NA
CARDIOVASCULAR DISEASE							
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	3/4	2	3	2	1	2
HYPERTENSION							
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3	3	2	2	2	1	2

CONDITION	COC	CIC	POP	DMPA NET-EN	NOR	Cu-IUD	LNG-IUD
I = Initiation, **C** = Continuation							
Hypertension (Cont'd)							
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	1	2	1	1	1
c) Elevated blood pressure levels (properly taken measurements)							
(i) systolic 140-159 or diastolic 90-99	3	3	1	2	1	1	1
(ii) systolic ≥160 or diastolic ≥100	4	4	2	3	2	1	2
d) Vascular disease	4	4	2	3	2	1	2
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	2	1	1	1	1	1
DEEP VENOUS THROMBOSIS (DVT)/PULMONARY EMBOLISM (PE)							
a) History of DVT/PE	4	4	2	2	2	1	2
b) Current DVT/PE	4	4	3	3	3	1	3
c) Family history (first-degree relatives)	2	2	1	1	1	1	1
d) Major surgery							
(i) with prolonged immobilization	4	4	2	2	2	1	2
(ii) without prolonged immobilization	2	2	1	1	1	1	1
e) Minor surgery without immobilization	1	1	1	1	1	1	1

CONDITION	COC		CIC		POP		DMPA NET-EN		NOR		Cu-IUD		LNG-IUD	
I = Initiation, **C** = Continuation														
NEUROLOGIC CONDITIONS														
HEADACHES	**I**	**C**	**I**	**C**	**I**	**C**	**I**	**C**	**I**	**C**			**I**	**C**
a) Non migrainous (mild or severe)	1	2	1	2	1	1	1	1	1	1	1		1	1
b) Migraine														
(i) without focal neurologic symptoms														
Age <35	2	3	2	3	1	2	2	2	2	2	1		2	2
Age ≥35	3	4	3	4	1	2	2	2	2	2	1		2	2
(ii) with focal neurologic symptoms (at any age)	4	4	4	4	2	3	2	3	2	3	1		2	3
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS														
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)											**I**	**C**	**I**	**C**
Before evaluation	2		2		2		3		3		4	2	4	2
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2		2		1		2		2		1		2	
CERVICAL CANCER											**I**	**C**	**I**	**C**
(awaiting treatment)	2		2		1		2		2		4	2	4	2
BREAST DISEASE														
a) Undiagnosed mass	2		2		2		2		2		1		2	
b) Benign breast disease	1		1		1		1		1		1		1	
c) Family history of cancer	1		1		1		1		1		1		1	
d) Cancer														
(i) current	4		4		4		4		4		1		4	
(ii) past and no evidence of current disease for 5 years	3		3		3		3		3		1		3	

CONDITION	COC	CIC	POP	DMPA NET-EN	NOR	Cu-IUD		LNG-IUD	
I = Initiation, **C** = Continuation									
OVARIAN CANCER						**I**	**C**	**I**	**C**
	1	1	1	1	1	3	2	3	2
UTERINE FIBROIDS									
a) Without distortion of the uterine cavity	1	1	1	1	1	2		2	
b) With distortion of the uterine cavity	1	1	1	1	1	4		4	
PELVIC INFLAMMATORY DISEASE (PID)									
a) Past PID (assuming no current risk factors of STIs)						**I**	**C**	**I**	**C**
(i) with subsequent pregnancy	1	1	1	1	1	1	1	1	1
(ii) without subsequent pregnancy	1	1	1	1	1	2	2	2	2
b) PID-current or within the last 3 months	1	1	1	1	1	4	3	4	3
HIV/AIDS[1]									
HIGH RISK OF HIV	1	1	1	1	1	3		3	
HIV-POSITIVE	1	1	1	1	1	3		3	
AIDS	1	1	1	1	1	3		3	
GASTROINTESTINAL CONDITIONS									
GALL-BLADDER DISEASE									
a) Symptomatic									
(i) treated by cholecystectomy	2	2	2	2	2	1		2	
(ii) medically treated	3	2	2	2	2	1		2	
(iii) current	3	2	2	2	2	1		2	
b) Asymptomatic	2	2	2	2	2	1		2	

[1] Barrier methods, especially condoms, are always recommended for prevention of STI/HIV/PID.

CONDITION	COC	CIC	POP	DMPA NET-EN	NOR	Cu-IUD	LNG-IUD
I = Initiation, **C** = Continuation							
ANAEMIAS							
THALASSAEMIA	1	1	1	1	1	2	1

In addition, the following changes were made which are not included in the summary table:

1. Barrier methods

For spermicides, the condition “HIV-positive” has moved from a category 1 rating to a category 2; and the condition “AIDS” has also moved from a category 1 rating to a category 2.

For diaphragms, the condition “Urinary tract infection” has moved from a category 1 rating to a category 2.

2. Surgical sterilization

The condition “Young age” has moved from a category A rating to a category C (see section on Surgical sterilization procedures).

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs)

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
PREGNANCY	NA	**Comments:** Use of COCs is not required. There is no known harm to the woman, the course of her pregnancy, or the fetus if COCs are accidentally used during pregnancy.
AGE		
a) Menarche to < 40 years	1	**Comments:** Theoretical concerns about the use of COCs among young adolescents have not been substantiated by scientific evidence.
b) ≥ 40 years	2	**Comments:** The risk of cardiovascular disease increases with age and may also increase with COC use. In the absence of other adverse clinical conditions, COCs can be used until menopause.
PARITY		
a) Nulliparous	1	**Comments:** There is no need for restriction of COC use based on parity.
b) Parous	1	
BREASTFEEDING		
a) < 6 weeks postpartum	4	**Comments:** There is some theoretical concern that the neonate may be at risk due to exposure to steroid hormones during the first 6 weeks postpartum. There is also some theoretical concern regarding the association between COC use up to 3 weeks postpartum and risk of thrombosis in the mother.
b) ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	**Comments**: In the first 6 months postpartum, use of COCs during breastfeeding diminishes the quantity of breast milk, decreases the duration of lactation, and may thereby adversely affect the growth of the infant.
c) ≥ 6 months postpartum	2	
POSTPARTUM (in non-breastfeeding women)		
a) < 21 days	3	**Comments:** Blood coagulation and fibrinolysis are essentially normalized by three weeks postpartum.
b) ≥ 21 days	1	

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
POST-ABORTION		
a) First trimester	1	**Comments:** COCs may be started immediately post-abortion.
b) Second trimester	1	
c) Immediate post-septic abortion	1	
PAST ECTOPIC PREGNANCY	1	**Comments:** The risk of future ectopic pregnancy is increased among women who have had an ectopic pregnancy in the past. COCs provide protection against ectopic pregnancy.
HISTORY OF PELVIC SURGERY	1	**Comments:** Prior pelvic surgery has no effect on COC use.
SMOKING		
a) Age < 35 years	2	**Comments:** Risk of cardiovascular events increases with increasing age and increasing number of cigarettes smoked per day.
b) Age ≥ 35 years		
(i) <15 cigarettes/day	3	
(ii) ≥15 cigarettes/day	4	
OBESITY ≥ 30 kg/m^2 body mass index (BMI)	2	**Comments:** Obesity is a risk factor for venous thromboembolism.
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	**Comments:** It is desirable to have blood pressure measurements taken before initiation of COC use. However, in some settings blood pressure measurements are unavailable. In many of these settings pregnancy morbidity and mortality risks are high, and COCs are one of the few methods widely available. In such settings, women should not be denied use of COCs simply because their blood pressure cannot be measured.
CARDIOVASCULAR DISEASE		
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	**Comments:** When a woman has multiple major risk factors, any of which alone would substantially increase the risk of cardiovascular disease, use of COCs may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of two risk factors assigned a category 2 may not necessarily warrant a higher category.

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
HYPERTENSION		
a) History of hypertension, where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3	**Comments:** Evaluation of cause and level of hypertension is recommended, as soon as feasible. For all categories of hypertension, classifications are based on the assumption that no other risk factors for cardiovascular disease exist. When multiple risk factors do exist, risk of cardiovascular disease may increase substantially.
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3	**Comments:** Women adequately treated for hypertension are at reduced risk of acute myocardial infarction and stroke as compared with untreated women. Although there are no data, COC users with adequately controlled and monitored hypertension should be at reduced risk of acute myocardial infarction and stroke compared with untreated hypertensive COC users.
c) Elevated blood pressure levels (properly taken measurements)		
(i) systolic 140-159 or diastolic 90-99	3	**New evidence:** Among women with hypertension, COC users are at increased risk of stroke and myocardial infarction compared with non-users.[1,2,3,4,5,6,7,8,9] The risk increases with incremental rises in blood pressure. **Comments:** A single reading of blood pressure level 140-159/90-99 is not sufficient to classify a woman as hypertensive.
(ii) systolic ≥160 or diastolic ≥100	4	
d) Vascular disease	4	**Comments:** Among women with underlying vascular disease, the increased risk of arterial thrombosis associated with COC use should be avoided.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	**New evidence:** Evidence suggests that women with a history of high blood pressure in pregnancy, who use COCs, may have an increased risk of myocardial infarction and venous thromboembolism, compared with COC users who did not have a history of high blood pressure during pregnancy.[6,9]

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)		
a) History of DVT/PE	4	**Comments:** The increased risk of venous thromboembolism associated with COCs should have little impact on healthy women, but may have substantial impact on women with a history of thromboembolism.
b) Current DVT/PE	4	
c) Family history of DVT/PE (first-degree relatives)	2	**Comments:** Some conditions which increase the risk of DVT/PE are heritable.
d) Major surgery		
(i) with prolonged immobilization	4	**Comments:** The degree of risk of DVT/PE associated with major surgery depends on the length of time that a woman is immobilized. There is no need to stop COCs prior to female surgical sterilization.
(ii) without prolonged immobilization	2	
e) Minor surgery without immobilization	1	
SUPERFICIAL VENOUS THROMBOSIS		
a) Varicose veins	1	**Comments:** Varicose veins are not risk factors for DVT/PE.
b) Superficial thrombophlebitis	2	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	**Comments:** Among women with underlying vascular disease, the increased risk associated with COC use should be avoided.
STROKE (history of cerebrovascular accident)	4	**Comments:** Among women with underlying vascular disease, the increased risk associated with COC use should be avoided.
KNOWN HYPERLIPIDAEMIAS	2/3	**Comments:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. While some types of hyperlipidaemias are risk factors for vascular disease, the category should be assessed according to the type, its severity, and the presence of other cardiovascular risk factors.

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation C=Continuation		**NEW EVIDENCE/COMMENTS**
VALVULAR HEART DISEASE			
a) Uncomplicated	2		
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	4		**Comments:** Among women with valvular heart disease, COC use may further increase the risk of arterial thrombosis; women with complicated valvular heart disease are at greatest risk.
NEUROLOGIC CONDITIONS			
HEADACHES	I	C	
a) Non migrainous (mild or severe)	1	2	**Comments:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not. Any new headaches or marked changes in headaches should be evaluated. Classification is for women without any other risk factors for stroke. Risk of stroke increases with age, hypertension and smoking.
b) Migraine			**New evidence:** Among women with migraines, women who also have focal neurologic symptoms have a higher risk of stroke than those without focal neurologic symptoms.[10,11] In addition, among women with migraines, those who use COCs have a 2 to 4-fold increased risk of stroke compared with women who do not use COCs.[1,2,11,12,13]
(i) without focal neurologic symptoms			
Age < 35	2	3	
Age ≥ 35	3	4	
(ii) with focal neurologic symptoms (at any age)	4	4	
EPILEPSY	1		**Comments:** If a woman is taking anti-epileptic medications, refer to the section on drug interactions. Certain anti-epileptic drugs lower COC efficacy.
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS			
VAGINAL BLEEDING PATTERNS			
a) Irregular pattern *without* heavy bleeding	1		**Comments:** Changes in menstrual bleeding patterns are common among healthy women.
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1		

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)		**Comments:** If pregnancy (or an underlying pathological condition such as pelvic malignancy) is suspected, it must be evaluated. There are no conditions that cause vaginal bleeding that will be worsened in the short term by use of COCs.
Before evaluation	2	
ENDOMETRIOSIS	1	**Comments:** COCs do not worsen, and may alleviate, the symptoms of endometriosis.
BENIGN OVARIAN TUMOURS (including cysts)	1	
SEVERE DYSMENORRHOEA	1	**Comments:** COC use may alleviate dysmenorrhoea.
TROPHOBLAST DISEASE		
a) Benign gestational trophoblastic disease	1	
b) Malignant gestational trophoblastic disease	1	
CERVICAL ECTROPION	1	**Comments:** Cervical ectropion is not a risk factor for cervical cancer, and there is no need for restriction of COC use.
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	**Comments:** There is some concern that COCs enhance the progression of CIN to invasive disease, particularly with long-term use.
CERVICAL CANCER (awaiting treatment)	2	**Comments:** There is some theoretical concern that COC use may affect prognosis of the existing disease. While awaiting treatment, women may use COCs. In general, treatment of this condition renders a woman sterile.
BREAST DISEASE		
a) Undiagnosed mass	2	**Comments:** The vast majority of breast masses in women of reproductive age are benign. Evaluation should be pursued as early as possible.
b) Benign breast disease	1	**Comments:** Eligibility for COC use is not affected by benign breast disease or a family history of breast disease.

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
c) Family history of cancer	1	
BREAST DISEASE (cont'd) d) Cancer		
(i) current	4	**Comments:** Breast cancer is a hormonally sensitive tumour, and the prognosis of women with current or recent breast cancer may worsen with COC use.
(ii) past and no evidence of current disease for 5 years	3	
ENDOMETRIAL CANCER	1	**Comments:** COC use reduces the risk of developing endometrial cancer. While awaiting treatment, women may use COCs. In general, treatment of this condition renders a woman sterile.
OVARIAN CANCER	1	**Comments:** COC use reduces the risk of developing ovarian cancer. While awaiting treatment, women may use COCs. In general, treatment of this condition renders a woman sterile.
UTERINE FIBROIDS		
a) Without distortion of the uterine cavity	1	**Comments:** COCs do not appear to cause growth of uterine fibroids.
b) With distortion of the uterine cavity	1	
PELVIC INFLAMMATORY DISEASE (PID)		
a) Past PID (assuming no current risk factors for STIs)		**Comments:** COCs may reduce the risk of PID among women with STIs, but do not protect against HIV or lower genital tract STIs.
(i) with subsequent pregnancy	1	
(ii) without subsequent pregnancy	1	
b) PID - current or within the last 3 months	1	

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
STIs		
a) Current or within 3 months (including purulent cervicitis)	1	**Comments:** COCs may reduce the risk of PID among women with STIs, but do not protect against HIV or lower genital tract STIs.
b) Vaginitis without purulent cervicitis	1	
c) Increased risk of STIs (e.g., multiple partners or partner who has multiple partners)	1	
HIV/AIDS		
HIGH RISK OF HIV	1	**Comments:** COCs may reduce the risk of PID among women with STIs, but do not protect against HIV or lower genital tract STIs. There is theoretical concern, but no consistent evidence, that COC use may increase the risk of HIV infection.
HIV-POSITIVE	1	
AIDS	1	
OTHER INFECTIONS		
SCHISTOSOMIASIS		
a) Uncomplicated	1	
b) Fibrosis of liver (if severe, see cirrhosis)	1	
TUBERCULOSIS		
a) Non-pelvic	1	**Comments:** Prognosis of tuberculosis is not affected by the use of COCs. However, if a woman is taking tuberculosis medications, refer to the section on drug interactions. Certain tuberculosis drugs lower COC efficacy.
b) Known pelvic	1	
MALARIA	1	

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
ENDOCRINE CONDITIONS		
DIABETES		
a) History of gestational disease	1	
b) Non-vascular disease		**Comments:** Although carbohydrate tolerance may change with COC use, the major concerns are vascular disease due to diabetes and additional risk of arterial thrombosis due to COC use.
(i) non-insulin dependent	2	
(ii) insulin dependent	2	
c) Nephropathy/ retinopathy/ neuropathy	3/4	**Comments:** The category should be assessed according to the severity of the condition.
d) Other vascular disease or diabetes of > 20 years' duration	3/4	**Comments:** The category should be assessed according to the severity of the condition.
THYROID		
a) Simple goitre	1	**Comments:** The condition is not relevant for eligibility for this contraceptive method, and there is no need for restriction of COC use.
b) Hyperthyroid	1	
c) Hypothyroid	1	
GASTROINTESTINAL CONDITIONS		
GALL-BLADDER DISEASE		
a) Symptomatic		**Comments:** COCs may cause a small increased risk of gall-bladder disease. There is also concern that COCs may worsen existing gall-bladder disease.
(i) treated by cholecystectomy	2	
(ii) medically treated	3	
(iii) current	3	
b) Asymptomatic	2	
HISTORY OF CHOLESTASIS		
a) Pregnancy-related	2	**Comments:** History of pregnancy-related cholestasis may predict an increased risk of developing COC-associated cholestasis.
b) Past COC-related	3	**Comments:** History of COC-related cholestasis predicts an

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
VIRAL HEPATITIS		
a) Active	4	**Comments:** COCs are metabolized by the liver, and their use may adversely affect women whose liver function is already compromised.
b) Carrier	1	
CIRRHOSIS		
a) Mild (compensated)	3	**Comments:** COCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised.
b) Severe (decompensated)	4	
LIVER TUMOURS		
a) Benign (adenoma)	4	**Comments:** COCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. In addition, COC use may enhance the growth of tumours.
b) Malignant (hepatoma)	4	
ANAEMIAS		
THALASSAEMIA	1	**Comments:** There is anecdotal evidence from countries where thalassaemia is prevalent that COC use does not worsen the condition.
SICKLE CELL DISEASE	2	**Comments:** COC use may affect coagulation, blood viscosity, or incidence or severity of painful sickle cell crises.
IRON DEFICIENCY ANAEMIA	1	**Comments:** COC use may decrease menstrual blood loss.
DRUG INTERACTIONS		
COMMONLY USED DRUGS WHICH AFFECT LIVER ENZYMES		
a) Certain antibiotics (rifampicin and griseofulvin)	3	**Comments:** Although the interaction between commonly-used liver enzyme inducers and COCs is not harmful to women, it is likely to reduce the efficacy of COCs. Use of other contraceptives should be encouraged for women who are long-term users of any of these drugs. Whether increasing the hormone dose of COCs is of benefit remains unclear.
b) Certain anticonvulsants (phenytoin, carbamezapine, barbiturates, primidone)	3	

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (COCs) ≤ 35 µg of ethinylestradiol	**COCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
OTHER ANTIBIOTICS (excluding rifampicin and griseofulvin)	1	

References for Low-Dose Combined Oral Contraceptives

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COMBINED INJECTABLE CONTRACEPTIVES (CICs)

Combined injectable contraceptives (CICs) provide for the release of a natural estrogen plus a progestogen and act through the inhibition of ovulation. Two CIC formulations are considered here:

1) **Cyclofem** = Medroxyprogesterone acetate 25mg plus estradiol cypionate 5mg

2) **Mesigyna** = Norethisterone enantate 50mg plus estradiol valerate 5mg

Because the estrogens in CICs may be more physiologic and may be less potent compared with the synthetic estrogens of COCs, the type and magnitude of estrogen-related side-effects associated with CICs may be different from those experienced by COC users. In fact, short-term studies of CICs have shown little effect on blood pressure, haemostasis and coagulation, lipid metabolism, and liver function in comparison with COCs. In addition, the parenteral administration of CICs eliminates the first-pass effect of the hormones on the liver.

However, CICs are a relatively new contraceptive method, and there are few epidemiological data on their long-term effects. There is also the concern that, while the effect of the hormonal load associated with COC and POP use can be reduced immediately by discontinuing their use, this is not the case with injectables, for which the effect continues for some time after the last injection.

The Working Group exercised some caution in assigning categories for CICs and generally took a position somewhere between the categories for COCs and POPs. However, for severe pathologies (e.g., ischaemic heart disease), the classification of conditions was the same as for COCs. The assigned categories should, therefore, be considered a preliminary, best judgement, which will be re-evaluated as new data become available.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
PREGNANCY	NA	**Comments:** Use of CICs is not required. There is no known harm to the woman, the course of her pregnancy, or the fetus if CICs are accidentally used during pregnancy.
AGE		
a) Menarche to < 40 years	1	**Comments:** Theoretical concerns about the use of CICs among young adolescents have not been substantiated by scientific evidence.
b) ≥ 40 years	2	**Comments:** The risk of cardiovascular disease increases with age and may also increase with CIC use.
PARITY		
a) Nulliparous	1	
b) Parous	1	
BREASTFEEDING		
a) < 6 weeks postpartum	4	**Comments:** There is some theoretical concern that the neonate may be at risk due to exposure to steroid hormones during the first 6 weeks postpartum. There is also some theoretical concern regarding the association between CIC use up to 3 weeks postpartum and risk of thrombosis in the mother.
b) ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	3	**Comments**: In the first 6 months postpartum, use of CICs during breastfeeding diminishes the quantity of breast milk, decreases the duration of lactation, and may thereby adversely affect the growth of the infant.
c) ≥ 6 months postpartum	2	
POSTPARTUM (in non-breastfeeding women)		
a) < 21 days	3	**Comments:** Blood coagulation and fibrinolysis are essentially normalized by 3 weeks postpartum.
b) ≥ 21 days	1	
POST-ABORTION		
a) First trimester	1	**Comments:** CICs may be started immediately post-abortion.
b) Second trimester	1	
c) Post-septic abortion	1	

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	**CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
PAST ECTOPIC PREGNANCY	1	**Comments:** CIC use may, like COC use, provide protection against ectopic pregnancy.
HISTORY OF PELVIC SURGERY	1	
SMOKING		
a) Age < 35 years	2	**Comments:** Risk of cardiovascular events increases with increasing age and increasing number of cigarettes smoked per day.
b) Age ≥ 35 years		
(i) <15 cigarettes/day	2	
(ii) ≥15 cigarettes/day	3	
OBESITY ≥ 30 kg/m^2 body mass index (BMI)	2	**Comments:** Obesity is a risk factor for venous thromboembolism.
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	**Comments:** It is desirable to have blood pressure measurements taken before initiation of CIC use. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and CICs may be one of the few methods available. In such settings, women should not be denied use of CICs simply because their blood pressure cannot be measured.
CARDIOVASCULAR DISEASE		
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	**Comments:** When a woman has multiple major risk factors, any of which alone would substantially increase the risk of cardiovascular disease, use of CICs may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of two risk factors assigned a category '2' may not necessarily warrant a higher category.
HYPERTENSION		
a) History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	3	**Comments:** Evaluation of cause and level of hypertension is recommended as soon as feasible. For all categories of hypertension, classifications are based on the assumption that no other risk factors for cardiovascular disease exist. When multiple risk factors do exist, risk of cardiovascular disease may increase substantially.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3	**Comments:** Women adequately treated for hypertension are at reduced risk of acute myocardial infarction and stroke as compared with untreated women. Although there are no data, CIC users with adequately controlled and monitored hypertension should be at reduced risk of acute myocardial infarction and stroke compared with untreated hypertensive CIC users.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
HYPERTENSION (cont'd)		
c) Elevated blood pressure levels (properly taken measurements)		**Comments:** Among women with hypertension, COC users are at increased risk of stroke and myocardial infarction compared with non-users. The risk increases with incremental rises in blood pressure. The extent to which risk with CICs is similar to COCs remains unclear.
(i) systolic 140-159 or diastolic 90-99	3	**Comments:** A single reading of blood pressure level 140-159/90-99 is not sufficient to classify a woman as hypertensive.
(ii) systolic ≥160 or diastolic ≥100	4	
d) Vascular disease	4	**Comments:** Among women with underlying vascular disease, the increased risk of arterial thrombosis associated with COC use should be avoided. The extent to which risk with CICs is similar to COCs remains unclear.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	**Comments:** Evidence suggests that women with a history of high blood pressure in pregnancy, who use COCs, may have an increased risk of myocardial infarction and venous thromboembolism compared with COC users with no history of high blood pressure during pregnancy. The extent to which risk with CICs is similar to COCs remains unclear.
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)		
a) History of DVT/PE	4	**Comments:** The increased risk of DVT/PE associated with COCs may also occur with CICs.
b) Current DVT/PE	4	
c) Family history of DVT/PE (first-degree relatives)	2	
d) Major surgery		
(i) with prolonged immobilization	4	
(ii) without prolonged immobilization	2	
e) Minor surgery without immobilization	1	

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
SUPERFICIAL VENOUS THROMBOSIS		
a) Varicose veins	1	**Comments:** Varicose veins are not risk factors for DVT/PE.
b) Superficial thrombophlebitis	2	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	**Comments:** Among women with underlying vascular disease or with a demonstrated predisposition to arterial thrombosis, the possible increased risk with COCs should be avoided. The extent to which risk with CICs is similar to COCs remains unclear.
STROKE (history of cerebrovascular accident)	4	**Comments:** Among women with underlying vascular disease or demonstrated predisposition to arterial thrombosis, the possible increased risk of thrombosis with COCs should be avoided. The extent to which risk with CICs is similar to COCs remains unclear.
KNOWN HYPERLIPIDAEMIAS	2/3	**Comments:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. Some types of hyperlipidaemias are risk factors for vascular disease. The category should be assessed according to the type and its severity.
VALVULAR HEART DISEASE		
a) Uncomplicated	2	
b) Complicated (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)	4	**Comments:** Among women with valvular heart disease, COC use may further increase the risk of arterial thrombosis; women with complicated valvular heart disease are at greatest risk. The extent to which risk with CICs is similar to COCs remains unclear.
NEUROLOGIC CONDITIONS		
HEADACHES	I / C	
a) Non migrainous (mild or severe)	1 / 2	**Comments:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not. Any new headaches or marked changes in headaches should be evaluated. Classification is for women without any other risk factors for stroke. Risk of stroke increases with age.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.		
CONDITION	**CATEGORY** I=Initiation C=Continuation		**NEW EVIDENCE/COMMENTS**
	I	C	
HEADACHES (cont'd)			
b) Migraine			**Comments:** Among women with migraines, women who also have focal neurologic symptoms have a higher risk of stroke than those without focal neurologic symptoms. In addition, among women with migraines, those who use COCs have a 2 to 4 fold increased risk of stroke compared to women who do not use COCs. The extent to which risk with CICs is similar to COCs remains unclear.
(i) without focal neurologic symptoms			
Age < 35	2	3	
Age ≥ 35	3	4	
(ii) with focal neurologic symptoms (at any age)	4	4	
EPILEPSY	1		**Comments:** The condition, as such, is not a concern. See section on drug interactions.
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS			
VAGINAL BLEEDING PATTERNS			
a) Irregular pattern *without* heavy bleeding	1		**Comments:** Changes in menstrual bleeding patterns are common among healthy women. CICs may decrease menstrual blood loss. Change in bleeding patterns with CICs may occur.
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1		
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)			**Comments:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated. There are no conditions that cause vaginal bleeding that will be worsened in the short term by use of CICs.
Before evaluation	2		
ENDOMETRIOSIS	1		
BENIGN OVARIAN TUMOURS (including cysts)	1		
SEVERE DYSMENORRHOEA	1		**Comments:** CIC use may alleviate dysmenorrhoea.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
TROPHOBLAST DISEASE		
a) Benign gestational trophoblastic disease	1	
b) Malignant gestational trophoblastic disease	1	
CERVICAL ECTROPION	1	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	**Comments:** There is some concern that combined hormonal methods enhance the progression of CIN to invasive disease, particularly with long-term use.
CERVICAL CANCER (awaiting treatment)	2	**Comments:** There is some theoretical concern that combined hormonal methods use may affect prognosis of the existing disease. While awaiting treatment, women may use CICs. In general, treatment of this condition renders a woman sterile.
BREAST DISEASE		
a) Undiagnosed mass	2	**Comments:** The vast majority of breast masses in women of reproductive age are benign.
b) Benign breast disease	1	
c) Family history of cancer	1	
d) Cancer		
(i) current	4	**Comments:** Breast cancer is a hormonally sensitive tumour, and the prognosis of women with current or recent breast cancer may worsen with CIC use.
(ii) past and no evidence of current disease for 5 years	3	
ENDOMETRIAL CANCER	1	**Comments:** It is not known whether CIC use reduces the risk of developing endometrial cancer, as is the case with COCs. While awaiting treatment, women may use CICs. In general, treatment of this condition renders a woman sterile.

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
OVARIAN CANCER	1	**Comments:** It is not known whether CIC use reduces the risk of developing ovarian cancer, as is the case with COCs. While awaiting treatment, women may use CICs. In general, treatment of this condition renders a woman sterile.
UTERINE FIBROIDS		
a) Without distortion of the uterine cavity	1	**Comments:** COCs do not appear to cause growth of uterine fibroids and CICs are not expected to.
b) With distortion of the uterine cavity	1	
PELVIC INFLAMMATORY DISEASE (PID)		
a) Past PID (assuming no current risk factors of STIs)		**Comments:** CICs do not protect against STIs/HIV.
(i) with subsequent pregnancy	1	
(ii) without subsequent pregnancy	1	
b) PID - current or within the last 3 months	1	
STIs		
a) Current or within the last 3 months (including purulent cervicitis)	1	**Comments:** CICs do not protect against STIs/HIV.
b) Vaginitis without purulent cervicitis	1	
c) Increased risk of STIs (e.g., multiple partners, or partner who has multiple partners)	1	
HIV/AIDS		
HIGH RISK OF HIV	1	**Comments:** CICs do not protect against STIs/HIV.
HIV-POSITIVE	1	

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
AIDS	1	
OTHER INFECTIONS		
SCHISTOSOMIASIS		
a) Uncomplicated	1	
b) Fibrosis of liver (if severe, see cirrhosis)	1	
TUBERCULOSIS		
a) Non-pelvic	1	**Comments:** Prognosis of tuberculosis is not affected by use of CICs (see Drug Interactions).
b) Known pelvic	1	
MALARIA	1	
ENDOCRINE CONDITIONS		
DIABETES		
a) History of gestational disease	1	
b) Non-vascular disease		
(i) non-insulin dependent	2	**Comments:** Although carbohydrate tolerance may change with CIC use, the major concerns are vascular disease and additional risk of arterial thrombosis.
(ii) insulin dependent	2	
c) Nephropathy/ retinopathy/ neuropathy	3/4	**Comments:** The category should be assessed according to the severity of the condition.
d) Other vascular disease or diabetes of >20 years' duration	3/4	
THYROID		
a) Simple goitre	1	**Comments:** The condition is not relevant for eligibility for this contraceptive method, and there is no need for restriction of CIC use.
b) Hyperthyroid	1	
c) Hypothyroid	1	

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
GASTROINTESTINAL CONDITIONS		
GALL-BLADDER DISEASE		
a) Symptomatic		
(i) treated by cholecystectomy	2	**Comments:** COCs may cause a small increased risk of gall-bladder disease. There is also concern that COCs may worsen existing gall-bladder disease. However, unlike COCs, CICs have been shown to have a minimal effect on liver function in healthy women, and have no first-pass effect on the liver.
(ii) medically treated	2	
(iii) current	2	
b) Asymptomatic	2	
HISTORY OF CHOLESTASIS		
a) Pregnancy-related	2	**Comments:** Unlike COCs, CICs have been shown to have a minimal effect on liver function in healthy women and have no first-pass effect on the liver. However, past COC-related cholestasis may predict future estrogen-related cholestasis in a small group of susceptible women.
b) Past COC or CIC related	2	
VIRAL HEPATITIS		
a) Active	3/4	**Comments:** Unlike COCs, CICs have been shown to have a minimal effect on liver function in healthy women and have no first-pass effect on the liver. However, because CICs are metabolized by the liver, they could, in theory, lead to adverse effects on women whose liver function is already compromised. In women with symptomatic viral hepatitis, CICs should be withheld until liver function returns to normal or 3 months after the woman becomes asymptomatic.
b) Carrier	1	
CIRRHOSIS		
a) Mild (compensated)	2	**Comments:** Unlike COCs, CICs have been shown to have a minimal effect on liver function in healthy women and have no first-pass effect on the liver. However, because CICs are metabolized by the liver, they could, in theory, lead to adverse effects on women whose liver function is already compromised.
b) Severe (decompensated)	3	
LIVER TUMOURS		

COMBINED INJECTABLE CONTRACEPTIVES (CICs)	**CICs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**NEW EVIDENCE/COMMENTS**
a) Benign (adenoma)	3	**Comments:** Unlike COCs, CICs have been shown to have a minimal effect on liver function in healthy women and have no first-pass effect on the liver. However, because CICs are metabolized by the liver, they could, in theory, lead to adverse effects on women whose liver function is already compromised.
b) Malignant (hepatoma)	3/4	
ANAEMIAS		
THALASSAEMIA	1	
SICKLE CELL DISEASE	2	
IRON DEFICIENCY ANAEMIA	1	**Comments:** CIC use may decrease menstrual blood loss.
DRUG INTERACTIONS		
COMMONLY USED DRUGS WHICH AFFECT LIVER ENZYMES		
a) Certain antibiotics (rifampicin and griseofulvin)	3	**Comments:** Commonly used liver enzyme inducers are likely to reduce the efficacy of CICs. Use of other contraceptives should be encouraged for women who are on long-term use of any of these drugs.
b) Anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone)	3	
OTHER ANTIBIOTICS (excluding rifampicin and griseofulvin)	1	

PROGESTOGEN-ONLY CONTRACEPTIVES

P = Progestogen-only pill (POP)
D/NE = Depot medroxyprogesterone acetate (DMPA)/norethisterone enantate (NET-EN)
NOR = Norplant and Norplant II implants

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY				
PREGNANCY	NA			**Comments:** Use of POCs is not required. There is no known harm to the woman, the course of her pregnancy, or the fetus if POCs are accidentally used during pregnancy. However, the relationship between DMPA use during pregnancy and its effects on the fetus remains unclear.
AGE				
a) Menarche to < 18 years	1	2	1	**Comments:** For women under 18 years of age, there are theoretical concerns regarding hypo-estrogenic effect particularly due to DMPA use.
b) 18 to 45 years	1	1	1	**New evidence:** Three studies of Norplant use, one in adolescents and two in adult women, showed no decrease in bone density with long-term use compared with non-users.[1,2,3]
c) > 45 years	1	2	1	**Comments:** For women greater than age 45, there are theoretical concerns regarding hypo-estrogenic effect particularly due to DMPA use, and whether these women will regain lost bone mass after discontinuation of DMPA.
PARITY				
a) Nulliparous	1	1	1	
b) Parous	1	1	1	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
BREASTFEEDING				
a) < 6 weeks postpartum	3	3	3	**Comments:** There is concern that the neonate may be at risk of exposure to steroid hormones during the first 6 weeks postpartum. However, in many of these settings pregnancy morbidity and mortality risks are high, and access to services is limited. POCs may be one of the few types of methods widely available and accessible to breastfeeding women immediately postpartum.
b) ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	1	1	1	**Comments:** No clinically measurable effects on the health or growth of breast-fed babies of women using POCs beginning at 6 weeks postpartum have been identified.
c) ≥ 6 months postpartum	1	1	1	
POSTPARTUM (in non-breastfeeding women)				
a) < 21 days	1	1	1	**Comments:** POCs may be safely used by non-breastfeeding women immediately postpartum.
b) ≥ 21 days	1	1	1	
POST-ABORTION				
a) First trimester	1	1	1	**Comments:** POCs may be safely used immediately post-abortion.
b) Second trimester	1	1	1	
c) Immediate post-septic abortion	1	1	1	
PAST ECTOPIC PREGNANCY	2	1	1	**Comments:** POPs have a higher absolute rate of ectopic pregnancy compared with other POCs, but still less than using no method.
HISTORY OF PELVIC SURGERY	1	1	1	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
SMOKING				
a) Age < 35 years	1	1	1	
b) Age ≥ 35 years				
(i) <15 cigarettes/day	1	1	1	
(ii) >15 cigarettes/day	1	1	1	
OBESITY ≥ 30 kg/m^2 body mass index (BMI)	1	2	2	**Comments:** There may be some concern regarding weight gain with some POCs, particularly for long-acting methods.
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	NA	**Comments:** It is desirable to have blood pressure measurements taken before initiation of POC use. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and POCs are one of the few types of methods widely available. In such settings, women should not be denied use of POCs simply because their blood pressure cannot be measured.
CARDIOVASCULAR DISEASE				
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	2	3	2	**Comments:** When multiple major risk factors exist, risk of cardiovascular disease may increase substantially. Some POCs may increase the risk of thrombosis, although this increase is substantially less than with COCs. The effects of DMPA and NET-EN may persist for some time after discontinuation.
HYPERTENSION				
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	2	2	2	**Comments:** It is desirable to have blood pressure measurements taken before initiation of POC use. However, in some settings blood pressure measurements are unavailable. In many of these settings pregnancy morbidity and mortality risks are high, and POCs are one of the few types of methods widely available. In such settings, women should not be denied use of POCs simply because their blood pressure cannot be measured.

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
HYPERTENSION (cont'd)				
b) Adequately controlled hypertension where blood pressure CAN be evaluated	1	2	1	
c) Elevated blood pressure levels (properly taken measurements)				**New evidence:** Limited evidence suggests that among women with hypertension, those who use POPs or progestogen-only injectables may have an increased risk of cardiovascular events compared with women who do not use these methods.[4]
(i) systolic140-159 or diastolic 90-99	1	2	1	
(ii) systolic $\geq$ 160 or diastolic $\geq$ 100	2	3	2	
d) Vascular disease	2	3	2	**Comments:** There is concern about DMPA and NET-EN with regard to the potential hypo-estrogenic effect and decreasing HDL levels. However, there is little concern about these effects with regard to POPs or Norplant. The effects of DMPA and NET-EN may persist for some time after discontinuation. **Comments:** Theoretically, POCs may increase the risk of thrombosis although this increase is substantially less than with COCs.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	1	1	1	
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)				
a) History of DVT/PE	2	2	2	**Comments:** Theoretically, POCs may increase the risk of thrombosis, although this increase is substantially less than with COCs.
b) Current DVT/PE	3	3	3	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
c) Family history of DVT/PE (first-degree relatives)	1	1	1	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.					
CONDITION	**CATEGORY** I=Initiation, C=Continuation					**NEW EVIDENCE/COMMENTS**
	P		**D/NE**	**NOR**		
DVT/PE (Cont'd) d) Major surgery						
(i) with prolonged immobilization	2		2	2		
(ii) without prolonged immobilization	1		1	1		
e) Minor surgery without immobilization	1		1	1		
SUPERFICIAL VENOUS THROMBOSIS						
a) Varicose veins	1		1	1		
b) Superficial thrombophlebitis	1		1	1		
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	**I**	**C**		**I**	**C**	
	2	3	3	2	3	**Comments:** There is concern regarding the hypo-estrogenic effect and reduced HDL levels, particularly among users of DMPA. The effects of DMPA and NET-EN may persist for some time after discontinuation.
STROKE (history of cerebrovascular accident)	**I**	**C**		**I**	**C**	
	2	3	3	2	3	**Comments:** There is concern regarding reduced HDL levels among POC users. Some POCs may increase the risk of arterial thrombosis, although this increase is substantially less than with COCs. The effects of DMPA and NET-EN may persist for some time after discontinuation.
KNOWN HYPERLIPIDAEMIAS	2		2	2		**Comments:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. Some types of hyperlipidaemias are risk factors for vascular disease.

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**						
CONDITION	**CATEGORY** I=Initiation, C=Continuation						**NEW EVIDENCE/COMMENTS**
	P		**D/NE**		**NOR**		
VALVULAR HEART DISEASE							
a) Uncomplicated	1		1		1		
b) Complicated (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)	1		1		1		
NEUROLOGIC CONDITIONS							
HEADACHES	**I**	**C**	**I**	**C**	**I**	**C**	
a) Non migrainous (mild or severe)	1	1	1	1	1	1	**Comments:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not. Any new headaches or marked changes in headaches should be evaluated. Classification is for women without any other risk factors for stroke. Risk of stroke increases with age.
b) Migraine							
(i) without focal neurologic symptoms							**Comments:** There is concern that severe headaches may increase in frequency with use of NET-EN, DMPA and Norplant: methods which cannot be discontinued immediately or whose effects persist for some time after discontinuation. In the case of headaches *with* focal neurologic symptoms, it may be prudent to attempt to improve the headache by discontinuing the progestogen.
Age < 35	1	2	2	2	2	2	
Age ≥ 35	1	2	2	2	2	2	
(ii) with focal neurologic symptoms (at any age)	2	3	2	3	2	3	
EPILEPSY	1		1		1		**Comments:** If a woman is taking anti-epileptic medications, refer to the section on drug interactions. Certain anti-epileptic drugs lower POC efficacy.
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS							
VAGINAL BLEEDING PATTERNS							

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
a) Irregular pattern *without* heavy bleeding	2	2	2	**Comments:** Irregular menstrual bleeding patterns are common among healthy women, in particular among adolescents.
VAGINAL BLEEDING PATTERNS (Cont'd)				
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2	2	2	**Comments:** POC use may induce an irregular bleeding pattern. Also, unusually heavy bleeding should raise the suspicion of serious underlying condition. **Comments:** Norplant use may induce irregular bleeding patterns, especially during the first 3-6 months, but these patterns may persist longer. The amount of blood loss is always reduced, which may be a desirable effect in many women.
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious underlying condition) Before evaluation	2	3	3	**Comments:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation. POCs may cause irregular bleeding patterns which may mask symptoms of underlying pathology. The effects of DMPA and NET-EN may persist for some time after discontinuation.
ENDOMETRIOSIS	1	1	1	
BENIGN OVARIAN TUMOURS (including cysts)	1	1	1	
SEVERE DYSMENORRHOEA	1	1	1	
TROPHOBLAST DISEASE				
a) Benign gestational trophoblastic disease	1	1	1	
b) Malignant gestational trophoblastic disease	1	1	1	
CERVICAL ECTROPION	1	1	1	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	1	2	2	**Comments:** There is some concern that long duration of POC use may enhance progression of CIN.
CERVICAL CANCER (awaiting treatment)	1	2	2	**Comments:** There is some theoretical concern that POC use may affect prognosis of the existing disease. This concern would be less for short duration of use. While awaiting treatment, women may use POCs. In general, treatment of this condition renders a woman sterile.
BREAST DISEASE				
a) Undiagnosed mass	2	2	2	**Comments:** The vast majority of breast masses in women of reproductive age are benign. Evaluation should be pursued as early as possible.
b) Benign breast disease	1	1	1	
c) Family history of cancer	1	1	1	
d) Cancer				
(i) current	4	4	4	**Comments:** Breast cancer is a hormonally sensitive tumour, and the prognosis of women with current or recent breast cancer may worsen with POC use.
(ii) past and no evidence of current disease for 5 years	3	3	3	
ENDOMETRIAL CANCER	1	1	1	**Comments:** While awaiting treatment, women may use POCs. In general, the treatment of this condition renders a woman sterile.
OVARIAN CANCER	1	1	1	**Comments:** While awaiting treatment, women may use POCs. In general, the treatment of this condition renders a woman sterile.
UTERINE FIBROIDS				
a) Without distortion of the uterine cavity	1	1	1	**Comments:** POCs do not appear to cause growth of uterine fibroids.
b) With distortion of the uterine cavity	1	1	1	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
PELVIC INFLAMMATORY DISEASE (PID)				
a) Past PID (assuming no current risk factors of STIs)				**Comments:** POCs do not protect against HIV or STIs.
(i) with subsequent pregnancy	1	1	1	
(ii) without subsequent pregnancy	1	1	1	
b) PID - current or within the last 3 months	1	1	1	
STIs				
a) current or within 3 months (including purulent cervicitis)	1	1	1	**Comments:** POCs do not protect against HIV or STIs.
b) Vaginitis without purulent cervicitis	1	1	1	
c) Increased risk of STIs (e.g., multiple partners or partner who has multiple partners)	1	1	1	
HIV/AIDS				
HIGH RISK OF HIV	1	1	1	**Comments:** POCs do not protect against HIV or STIs.
HIV-POSITIVE	1	1	1	**Comments:** While there are theoretical concerns based on animal models, data regarding the risks of HIV transmission in humans are inconsistent and data regarding disease progression are limited.
AIDS	1	1	1	
OTHER INFECTIONS				

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
SCHISTOSOMIASIS				
a) Uncomplicated	1	1	1	
b) Fibrosis of liver (if severe, see cirrhosis)	1	1	1	
TUBERCULOSIS				
a) Non-pelvic	1	1	1	
b) Known pelvic	1	1	1	
MALARIA	1	1	1	
ENDOCRINE CONDITIONS				
DIABETES				
a) History of gestational disease	1	1	1	
b) Non-vascular disease				
(i) non-insulin dependent	2	2	2	**Comments:** POCs may slightly influence carbohydrate metabolism.
(ii) insulin dependent	2	2	2	
c) Nephropathy/ retinopathy/ neuropathy	2	3	2	**Comments:** There is concern about the possible negative effect of DMPA and NET-EN on lipid metabolism, possibly affecting the progression of nephropathy, retinopathy or other vascular disease.
d) Other vascular disease or diabetes of >20 years' duration	2	3	2	**Comments:** There is concern regarding the potential hypo-estrogenic effect and decreasing HDL levels. Theoretically, POCs may increase the risk of thrombosis although this increase is substantially less than with COCs. The effects of DMPA and NET-EN may persist for some time after discontinuation.
THYROID				
a) Simple goitre	1	1	1	
b) Hyperthyroid	1	1	1	
c) Hypothyroid	1	1	1	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
GASTROINTESTINAL CONDITIONS				
GALL-BLADDER DISEASE				
a) Symptomatic				**New evidence:** Some POCs may cause a small increase in risk of gall-bladder disease. There is also concern that POCs may worsen existing gall-bladder disease.[5]
(i) treated by cholecystectomy	2	2	2	
(ii) medically treated	2	2	2	
(iii) current	2	2	2	
b) Asymptomatic	2	2	2	
HISTORY OF CHOLESTASIS				
a) Pregnancy-related	1	1	1	
b) Past COC-related	2	2	2	**Comments:** Theoretically, a history of COC-related cholestasis may predict subsequent cholestasis with POC use. However, this has not been documented.
VIRAL HEPATITIS				
a) Active	3	3	3	**Comments:** There is concern about the hormonal load associated with POC use in active liver disease, but it is less than for COCs.
b) Carrier	1	1	1	**Comments:** Although progestogens are metabolized by the liver, they appear to have little effect on liver function.
CIRRHOSIS				
a) Mild (compensated)	2	2	2	**Comments:** There is concern about hormonal load associated with POC use in active liver disease, but it is less than for COCs.
b) Severe (decompensated)	3	3	3	
LIVER TUMOURS				
a) Benign (adenoma)	3	3	3	**Comments:** POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. In addition, POC use may enhance the growth of tumours. This concern is similar to, but less than, that with COCs.

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
b) Malignant (hepatoma)	3	3	3	

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs)	**POCs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE/COMMENTS**
	P	**D/NE**	**NOR**	
ANAEMIAS				
THALASSAEMIA	1	1	1	
SICKLE CELL DISEASE	1	1	1	**Comments:** There is no need for restriction of POC use; in fact, DMPA may have a beneficial effect on sickle cell crises.
IRON DEFICIENCY ANAEMIA	1	1	1	**Comments:** Changes in the menstrual pattern associated with POC use have little effect on haemoglobin levels.
DRUG INTERACTIONS				
COMMONLY USED DRUGS WHICH AFFECT LIVER ENZYMES a) Antibiotics (rifampicin and griseofulvin) b) Anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone)	3 3	2 2	3 3	**Comments:** Commonly used liver enzyme inducers are likely to reduce the efficacy of POPs and NOR. Use of other contraceptives should be encouraged for women who are using any of these drugs long-term. Whether increasing the hormone dose of POPs alleviates this concern remains unclear.
OTHER ANTIBIOTICS (excluding rifampicin and griseofulvin)	1	1	1	

References for Progestogen-Only Contraception

1. Cromer BA, Smith RD, Blair JM, Dwyer J, Brown RT. A prospective study of adolescents who choose among levonorgestrel implant (Norplant), medroxyprogesterone acetate (Depo-Provera), or the combined oral contraceptive pill as contraception. *Pediatrics* 1994;94:687-694.

2. Naessen T, Olsson S-E, Gudmundson J. Differential effects on bone density of progestogen-only methods for contraception in premenopausal women. *Contraception* 1995,52:35-39.

3. Petitti D, Piaggio G, Mehta S, Cravioto M, Meirik O for the WHO Study of Hormonal Contraception and Bone Health. Hormonal contraception and bone density: a cross-sectional study in an international population. *Obstetrics and Gynecology* 2000,5:736-744.

4. World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Hormone Contraception. Cardiovascular disease and use of oral and injectable progestogen-only contraceptives and combined injectable contraceptives. *Contraception* 1998;57:315-324.

5. Meirik O, Farley TMM, Sivin I, for the International Collaborative Post-Marketing Surveillance of Norplant. *Obstetrics & Gynecology* (submitted). Detailed papers to appear in *Contraception*.

EMERGENCY CONTRACEPTIVE PILLS (ECPs)

For COCs: Use of estrogen-levonorgestrel/ norgestrel-containing oral contraceptives (which total at least 100 µg ethinylestradiol per dose) given as two doses, 12 hours apart. Pills should be started within 72 hours of unprotected intercourse at any time* in the menstrual cycle to prevent pregnancy. The contraceptive efficacy appears to decline with time. The earlier after coitus the treatment is taken, the more effective it seems to be.

For levonorgestrel pills: Use of levonorgestrel-containing oral contraceptives (which total at least 750 µg levonorgestrel per dose) given as two doses, 12 hours apart. Pills should be started within 72 hours of unprotected intercourse at any time* in the menstrual cycle to prevent pregnancy. The contraceptive efficacy appears to decline with time. The earlier after coitus the treatment is taken, the more effective it seems to be, although the rate of decline in effectiveness cannot be precisely evaluated with available data.

* Because ECPs are relatively benign and because of the difficulties in accurately calculating a woman's risk of pregnancy, ECPs are appropriate for use at any time during the menstrual cycle when a woman makes an informed choice to use them.

EMERGENCY CONTRACEPTION PILLS (ECPs) (including combined oral contraceptive pills and levonorgestrel contraceptive pills)	**ECPs do not protect against STI/HIV. If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
PREGNANCY	NA	**Comments:** Although this method is not indicated for a woman with a known or suspected pregnancy, there is no known harm to the woman, the course of her pregnancy, or the fetus if ECPs are accidentally used.
BREASTFEEDING	1	
HISTORY OF ECTOPIC PREGNANCY	1	
HISTORY OF SEVERE CARDIOVASCULAR COMPLICATIONS (ischaemic heart disease, cerebrovascular attack, or other thromboembolic conditions)	2	**Comments:** The duration of use of ECPs is less than that of regular use of COCs or POPs and thus would be expected to have less clinical impact.
ANGINA PECTORIS	2	**Comments:** The duration of use of ECPs is less than that of regular use of COCs or POPs and thus would be expected to have less clinical impact.
MIGRAINE	2	**Comments:** The duration of use of ECPs is less than that of regular use of COCs or POPs and thus would be expected to have less clinical impact.
SEVERE LIVER DISEASE (including jaundice)	2	**Comments:** The duration of use of ECPs is less than that of regular use of COCs or POPs and thus would be expected to have less clinical impact.
REPEATED ECP USE	1	**Comments:** Recurrent ECP use is an indication that the woman requires further counselling on other contraceptive options. Frequently repeated ECP use may be harmful for women with conditions classified as 2, 3 or 4 for COC, CIC or POC use.
RAPE	1	**Comments:** There are no restrictions for use of ECPs in cases of rape.

INTRAUTERINE DEVICES (IUDs)

Cu = Copper-bearing IUD
LNG = Levonorgestrel-releasing IUD (20 µg/24hours)

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
PREGNANCY	4	4	**Comments:** The IUD is not indicated during pregnancy and should not be used because of the risk of serious pelvic infection and septic spontaneous abortion.
AGE			
a) Menarche to < 20 years	2	2	**Comments:** There is concern both about the risk of expulsion due to nulliparity and risk of STIs due to sexual behaviour in younger age-groups.
b) ≥ 20 years	1	1	
PARITY			
a) Nulliparous	2	2	**Comments:** Nulliparity is related to an increased risk of expulsion.
b) Parous	1	1	
POSTPARTUM (breastfeeding or non-breastfeeding, including post-caesarean section)			
a) < 48 hours	2	3	**Comments:** There is an increased risk of expulsion for IUD insertion done within the first 48 hours postpartum. **Comments:** There is a lack of data on the local effects of LNG-IUDs on uterine involution. Concern that the neonate may be at risk due to exposure to steroid hormones during the first 6 weeks postpartum is the same as for other POCs.
b) 48 hours to < 4 weeks	3	3	**Comments:** There is an increased risk of perforation for IUD insertions done after 48 hours and up to 4 weeks postpartum.
c) ≥ 4 weeks	1	1	**Comments:** If breastfeeding, LNG-IUD is a category 3 until 6 weeks postpartum.
d) Puerperal sepsis	4	4	**Comments:** Insertion of an IUD may substantially worsen the condition.

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**	
POST-ABORTION			
a) First trimester	1	1	**Comments:** IUDs can be inserted immediately after first trimester spontaneous or induced abortion.
b) Second trimester	2	2	**Comments:** There is some concern about the risk of expulsion after second trimester abortion. There is a lack of data on the local effects of LNG-IUD on uterine involution.
c) Immediate post-septic abortion	4	4	**Comments:** Insertion of an IUD may substantially worsen the condition.
PAST ECTOPIC PREGNANCY	1	1	**Comments:** The absolute risk of ectopic pregnancy is extremely low due to the high effectiveness of IUDs. However, when a woman becomes pregnant during IUD use the relative likelihood of ectopic pregnancy is increased.
HISTORY OF PELVIC SURGERY (see postpartum, including caesarean section)	1	1	
SMOKING			
a) Age < 35 years	1	1	
b) Age ≥ 35 years			
(i) < 15 cigarettes/day	1	1	
(ii) ≥ 15 cigarettes/day	1	1	
OBESITY ≥ 30 kg/m^2 body mass index (BMI)	1	2	
ANATOMICAL ABNORMALITIES			
a) Distorted uterine cavity (any congenital or acquired uterine abnormality distorting the uterine cavity in a manner that is incompatible with IUD insertion)	4	4	**Comments:** In the presence of an anatomic abnormality that distorts the uterine cavity, proper IUD placement may not be possible.

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**	
ANATOMICAL ABNORMALITIES (Cont'd)			
b) Other abnormalities (including cervical stenosis or cervical lacerations) not distorting the uterine cavity or interfering with IUD insertion	2	2	
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	**Comments:** While a blood pressure measurement may be appropriate for good preventative health care, it is not materially related to safe and effective IUD use. Women should not be denied use of IUDs simply because their blood pressure cannot be measured.
CARDIOVASCULAR DISEASE			
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	1	2	**Comments:** When multiple major risk factors exist, risk of cardiovascular disease may increase substantially. Some progestogens may increase the risk of thrombosis, although this increase is substantially less than for COCs.
HYPERTENSION			
a) History of hypertension where blood pressure CANNOT be evaluated (Including hypertension in pregnancy)	1	2	**Comments:** There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.
b) Adequately controlled hypertension where blood pressure CAN be evaluated	1	1	

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**	
HYPERTENSION (cont'd)			
c) Elevated blood pressure levels (properly taken measurements)			
(i) systolic 140-159 or diastolic 90-99	1	1	
(ii) systolic ≥ 160 or diastolic ≥ 100	1	2	**Comments:** LNG use may decrease HDL levels.
d) Vascular disease	1	2	**Comments:** LNG use may decrease HDL levels.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	1	1	
DEEP VENOUS THROMBOEMBOLISM (DVT)/ PULMONARY EMBOLISM (PE)			
a) History of DVT/PE	1	2	**Comments:** Some progestogens may increase the risk of venous thrombosis, although this increase is substantially less than for COCs.
b) Current DVT/PE	1	3	
c) Family history of DVT/PE (first-degree relatives)	1	1	
d) Major surgery			
(i) with prolonged immobilization	1	2	
(ii) without prolonged immobilization	1	1	
e) Minor surgery without immobilization	1	1	

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**		
SUPERFICIAL VENOUS THROMBOSIS				
a) Varicose veins	1	1		
b) Superficial thrombophlebitis	1	1		
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	1	**I**	**C**	**Comments:** LNG may reduce HDL levels.
		2	3	
STROKE (history of cerebrovascular accident)	1	2		**Comments:** LNG may reduce HDL levels. Some progestogens may increase the risk of thrombosis, although this increase is substantially less than for COCs.
KNOWN HYPERLIPIDAEMIAS	1	2		**Comments:** Routine screening is not appropriate because of the rarity of the condition. Some types of hyperlipidaemias are a risk factor for vascular disease, which may be affected by LNG.
VALVULAR HEART DISEASE				
a) Uncomplicated	1	1		
b) Complicated (pulmonary hypertension, risk of arterial fibrillation, history of subacute bacterial endocarditis, on anti-coagulant treatment)	2	2		**Comments:** Prophylactic antibiotics to prevent endocarditis are advised for insertion.
NEUROLOGIC CONDITIONS				
HEADACHES	1	**I**	**C**	
a) Non migrainous (mild or severe)		1	1	

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**NEW EVIDENCE / COMMENTS**
	Cu		**LNG**		
Headaches (Cont'd) b) Migraine (i) without focal neurologic symptoms					**Comments:** There is concern that migraine headaches may increase with use of LNG-IUDs, although there is less concern than with POCs. Some POCs may increase the risk of thrombosis, although this increase is substantially less than with COCs. Any new headaches or marked changes in headaches should be evaluated.
Age < 35	1		2	2	
Age ≥ 35	1		2	2	
(ii) with focal neurologic symptoms (at any age)	1		2	3	
EPILEPSY	1		1		
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS					
VAGINAL BLEEDING PATTERNS			**I**	**C**	
a) Irregular pattern *without* heavy bleeding	1		1	1	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2		1	2	**Comments:** Unusually heavy bleeding should cause suspicion of a serious underlying pathology. LNG-IUD use may actually be indicated to correct heavy bleeding. LNG-IUD use may induce irregular bleeding patterns, especially during the first 3–6 months, but these patterns may persist longer. The amount of blood loss is always reduced, which may be a desirable effect in many women.
UNEXPLAINED VAGINAL BLEEDING (suspicion for serious condition)					**Comments:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation. There is no need to remove the IUD before evaluation.
	I	**C**	**I**	**C**	
Before evaluation	4	2	4	2	
ENDOMETRIOSIS	2		1		**Comments:** Copper IUD use may worsen dysmenorrhoea associated with the condition.
BENIGN OVARIAN TUMOURS (including cysts)	1		1		
SEVERE DYSMENORRHOEA	2		1		**Comments:** Dysmenorrhoea may intensify with copper IUD use. LNG-IUD use has been associated with reduction of dysmenorrhoea.

INTRAUTERINE DEVICES (IUDs)	IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**NEW EVIDENCE / COMMENTS**
	Cu		**LNG**		
TROPHOBLAST DISEASE					
a) Benign gestational trophoblastic disease	3		3		
b) Malignant gestational trophoblastic disease	4		4		**Comments:** There is an increased risk of perforation since the treatment for the condition may require multiple uterine curettages.
CERVICAL ECTROPION	1		1		
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	1		2		**Comments:** There is some theoretical concern that LNG-IUDs may enhance progression of CIN.
CERVICAL CANCER (awaiting treatment)	**I**	**C**	**I**	**C**	
	4	2	4	2	**Comments:** There is concern about the increased risk of infection and bleeding at insertion, which may make the condition worse. The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.
BREAST DISEASE					
a) Undiagnosed mass	1		2		
b) Benign breast disease	1		1		
c) Family history of cancer	1		1		
d) Cancer:					
(i) current	1		4		**Comments:** Breast cancer is a hormonally sensitive tumour. Concerns about progression of the disease may be less with LNG-IUDs than with COCs or higher-dose POCs.
(ii) past and no evidence of current disease for 5 years	1		3		
ENDOMETRIAL CANCER	**I**	**C**	**I**	**C**	
	4	2	4	2	**Comments:** There is concern about the increased risk of infection, perforation and bleeding at insertion, that may make the condition worse. The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

INTRAUTERINE DEVICES (IUDs)	IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**NEW EVIDENCE / COMMENTS**
	Cu		**LNG**		
OVARIAN CANCER	3	2	3	2	**Comments:** The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.
UTERINE FIBROIDS					
a) Without distortion of the uterine cavity	2		2		
b) With distortion of the uterine cavity	4		4		**Comments:** Pre-existing uterine fibroids that distort the uterine cavity may be incompatible with IUD insertion.
PELVIC INFLAMMATORY DISEASE (PID)					
	I	**C**	**I**	**C**	
a) Past PID (assuming no known current risk factors for STIs)					**Comments:** Barrier methods, especially condoms, are always recommended for prevention of STI/HIV/PID.
(i) with subsequent pregnancy	1	1	1	1	
(ii) without subsequent pregnancy	2	2	2	2	**Comments:** In women at low risk of STIs, IUD insertion poses little risk of PID. Current risk of STIs and desire for future pregnancy are relevant considerations.
b) PID - current or within the last 3 months	4	3	4	3	**Comments:** There is serious concern that IUD use may worsen current PID. Recent PID is a strong risk factor for subsequent PID. Continued use of an IUD depends on the client's current risk factors for STIs and PID and her informed choice.
STIs					
a) Current or within 3 months (including purulent cervicitis)	4		4		**Comments:** There is serious concern that IUD use increases risk of PID in women with current STIs, or who are at high risk of acquiring these infections.
b) Vaginitis without purulent cervicitis	2		2		**Comments:** Where background incidence of STIs is high, vaginitis may indicate an STI.
c) Increased risk of STIs (e.g., multiple partners or partner who has multiple partners)	3		3		

INTRAUTERINE DEVICES (IUDs)	IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**NEW EVIDENCE / COMMENTS**
	Cu		**LNG**		
HIV/AIDS					
HIGH RISK OF HIV	3		3		**Comments:** Women at high risk of HIV are also at high risk of other STIs.
HIV-POSITIVE	3		3		**Comments:** There are theoretical concerns about increased risks of STIs and PID and increased risks of transmission to uninfected partners, particularly for immunosuppressed women.
AIDS	3		3		
OTHER INFECTIONS					
SCHISTOSOMIASIS					
a) Uncomplicated	1		1		
b) Fibrosis of the liver (if severe, see cirrhosis)	1		1		
TUBERCULOSIS	**I**	**C**	**I**	**C**	
a) Non-pelvic	1	1	1	1	
b) Known pelvic	4	3	4	3	**Comments:** Insertion of an IUD may substantially worsen the condition.
MALARIA	1		1		
ENDOCRINE CONDITIONS					
DIABETES					
a) History of gestational disease	1		1		**Comments:** LNG use may slightly influence carbohydrate and lipid metabolism. Whether the amount of LNG released by the IUD causes such change is unclear.
b) Non-vascular disease					
(i) non-insulin dependent	1		2		
(ii) insulin dependent	1		2		
c) Nephropathy/ retinopathy/ neuropathy	1		2		
d) Other vascular disease or diabetes of >20 years' duration	1		2		**Comments:** Some progestogens may increase the risk of thrombosis, although this increase is substantially less than for COCs.

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**	
THYROID			
a) Simple goitre	1	1	
b) Hyperthyroid	1	1	
c) Hypothyroid	1	1	
GASTROINTESTINAL CONDITIONS			
GALL-BLADDER DISEASE			
a) Symptomatic			**New evidence:** Some progestogens may cause a small increase in risk of gall-bladder disease. There is also concern that progestogens may worsen existing gall bladder disease.[1]
(i) treated by cholecystectomy	1	2	
(ii) medically treated	1	2	
(iii) current	1	2	
b) Asymptomatic	1	2	
HISTORY OF CHOLESTASIS			
a) Pregnancy-related	1	1	
b) Past COC-related	1	2	**Comments:** There is concern that history of COC-related cholestasis may predict subsequent cholestasis with LNG use. Whether there is any risk with use of LNG-IUD is unclear.
VIRAL HEPATITIS			
a) Active	1	3	**Comments:** There is concern about hormonal load associated with LNG-IUD use in active liver disease, but it is less than for COCs.
b) Carrier	1	1	
CIRRHOSIS			
a) Mild (compensated)	1	2	**Comments:** There is concern about hormonal load associated with LNG-IUD use in active liver disease, but it is less than for COCs.
b) Severe (decompensated)	1	3	

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**NEW EVIDENCE / COMMENTS**
	Cu	**LNG**	
LIVER TUMOURS			
a) Benign (adenoma)	1	3	**Comments:** Progestogens are metabolized by the liver, and their use may adversely affect women whose liver function is compromised. In addition, progestogen use may enhance the growth of tumours. This concern is similar to, but less than, that for COCs.
b) Malignant (hepatoma)	1	3	
ANAEMIAS			
THALASSAEMIA	2	1	**Comments:** There is concern about an increased risk of blood loss with copper IUDs.
SICKLE CELL DISEASE	2	1	**Comments:** There is concern about an increased risk of blood loss with copper IUDs.
IRON DEFICIENCY ANAEMIA	2	1	**Comments:** There is concern about an increased risk of blood loss with copper IUDs.
DRUG INTERACTIONS			
COMMONLY USED DRUGS WHICH AFFECT LIVER ENZYMES			
a) Certain antibiotics (rifampicin and griseofulvin)	1	1	**Comments:** LNG-IUDs function chiefly by local levonorgestrel effect; systemic progestogen metabolism will not affect local efficacy.
b) Anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone)	1	1	
OTHER ANTIBIOTICS (excluding rifampicin and griseofulvin)	1	1	

References for Intrauterine Devices

1. Meirik O, Farley TMM, Sivin I, for the International Collaborative Post-Marketing Surveillance of Norplant. *Obstetrics & Gynecology* (submitted). Detailed papers to appear in *Contraception*.

COPPER IUD FOR EMERGENCY CONTRACEPTION

This method is highly effective for preventing pregnancy. A copper-releasing IUD (Cu-IUD) can be used within 5 days of unprotected intercourse as an emergency contraceptive. However, when the time of ovulation can be estimated, the Cu-IUD can be inserted beyond 5 days after intercourse, if necessary, as long as the insertion does not occur more than 5 days after ovulation.

The eligibility criteria for interval Cu-IUD insertion also apply for the insertion of Cu-IUDs as emergency contraception.

COPPER IUD FOR EMERGENCY CONTRACEPTION	**IUDs for emergency contraception do not protect against STI/HIV. If there is risk of STI/HIV, the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
PREGNANCY	4	**Comments:** The IUD is not indicated during pregnancy and should not be used because of the risk of serious pelvic infection and septic spontaneous abortion.
RAPE High risk of STI Low risk of STI	 3 1	**Comments:** There is serious concern that IUD use increases risk of PID in women with current STIs, or who are at high risk of acquiring these infections.

BARRIER METHODS

C = Male latex condoms, male polyurethane condoms, female condoms
S = Spermicide (film, tablets, foam, gel)
D = Diaphragm (with spermicide), cervical cap

BARRIER METHODS	**If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.				
CONDITION	**CATEGORY**			**NEW EVIDENCE/COMMENTS**
	C	**S**	**D**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY				
PREGNANCY	NA	NA	NA	**Comments:** None of these methods are relevant for contraception during known pregnancy. However, for women who continue to be at risk of STI/HIV during pregnancy, the correct and consistent use of condoms is recommended.
AGE				
a) Menarche to < 40 years	1	1	1	
b) ≥ 40 years	1	1	1	
PARITY				
a) Nulliparous	1	1	1	
b) Parous	1	1	2	**Comments:** There is a higher risk of failure than in nulliparous women.
BREASTFEEDING				
a) < 6 weeks postpartum	1	1	NA	**Comments:** Diaphragm and cap are unsuitable until uterine involution is complete.
b) ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding)	1	1	1	
c) ≥ 6 months postpartum	1	1	1	
POST-ABORTION				
a) First trimester	1	1	1	
b) Second trimester	1	1	1	**Comments:** Diaphragm and cap are unsuitable until 6 weeks after second trimester abortion.
c) Post-septic abortion	1	1	1	
PAST ECTOPIC PREGNANCY	1	1	1	
HISTORY OF PELVIC SURGERY	1	1	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY			NEW EVIDENCE/COMMENTS
	C	S	D	
SMOKING				
a) Age < 35	1	1	1	
b) Age ≥ 35				
(i) <15 cigarettes/day	1	1	1	
(ii) ≥15 cigarettes/day	1	1	1	
OBESITY ≥ 30 kg/m^2 body mass index (BMI)	1	1	1	**Comments:** Severe obesity may make diaphragm and cap placement difficult.
ANATOMICAL ABNORMALITIES	1	1	NA	**Comments:** The diaphragm cannot be used in certain cases of prolapse. Cap use is not appropriate for a client with a markedly distorted cervical anatomy.
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	NA	**Comments:** While a blood pressure measurement may be appropriate for good preventative health care, it is not required for safe and effective barrier method use. Women should not be denied use of barrier methods simply because their blood pressure cannot be measured.
CARDIOVASCULAR DISEASE				
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	1	1	1	
HYPERTENSION				
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	1	1	1	
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	1	1	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY			NEW EVIDENCE/COMMENTS
	C	S	D	
HYPERTENSION (cont'd)				
c) Elevated blood pressure levels (properly taken measurements)	1	1	1	
(i) systolic 140-159 or diastolic 90-99	1	1	1	
(ii) systolic ≥160 or diastolic ≥100	1	1	1	
d) Vascular disease	1	1	1	
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	1	1	1	
DEEP VENOUS THROMBOSIS (DVT) PULMONARY EMBOLISM (PE)				
a) History of DVT/PE	1	1	1	
b) Current DVT/PE	1	1	1	
c) Family history of DVT/PE (first degree relatives)	1	1	1	
d) Major surgery				
(i) with prolonged immobilization	1	1	1	
(ii) without prolonged immobilization	1	1	1	
e) Minor surgery without immobilization	1	1	1	
SUPERFICIAL VENOUS THROMBOSIS				
a) Varicose veins	1	1	1	
b) Superficial thrombophlebitis	1	1	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.			
Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.				
CONDITION	**CATEGORY**			**NEW EVIDENCE/COMMENTS**
	C	**S**	**D**	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	1	1	1	
STROKE (history of cerebrovascular accident)	1	1	1	
KNOWN HYPERLIPIDAEMIAS	1	1	1	**Comments:** Screening is NOT necessary for safe use of contraceptive methods.
VALVULAR HEART DISEASE				
a) Uncomplicated	1	1	1	
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	1	1	2	**Comments:** Risk of urinary tract infection with the diaphragm may increase risk in a client with sub-acute bacterial endocarditis.
NEUROLOGIC CONDITIONS				
HEADACHES				
a) Non migrainous (mild or severe)	1	1	1	
b) Migraine				
(i) without focal neurologic symptoms				
Age < 35	1	1	1	
Age ≥ 35	1	1	1	
(ii) With focal neurologic symptoms (at any age)	1	1	1	
EPILEPSY	1	1	1	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS				
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)				**Comments:** The condition should be evaluated and treated.
Before evaluation	1	1	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.			
Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.				
CONDITION	**CATEGORY**			**NEW EVIDENCE/COMMENTS**
	C	**S**	**D**	
ENDOMETRIOSIS	1	1	1	
BENIGN OVARIAN TUMOURS (including cysts)	1	1	1	
SEVERE DYSMENORRHOEA	1	1	1	
TROPHOBLAST DISEASE				
a) Benign gestational trophoblastic disease	1	1	1	
b) Malignant gestational trophoblastic disease	1	1	1	
CERVICAL ECTROPION	1	1	1	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	1	1	1	**Comments:** Repeated and high-dose use of nonoxynol-9 can cause vaginal and cervical irritation or abrasions. **Comments:** *The cap is not recommended*. There is no restriction for diaphragm use.
CERVICAL CANCER (awaiting treatment)	1	2	1	**Comments:** Repeated and high-dose use of nonoxynol-9 can cause vaginal and cervical irritation or abrasions. **Comments:** *The cap is not recommended*. There is no restriction for diaphragm use.
BREAST DISEASE				
a) Undiagnosed mass	1	1	1	
b) Benign breast disease	1	1	1	
c) Family history of cancer	1	1	1	
d) Cancer				
(i) current	1	1	1	
(ii) past and no evidence of current disease for 5 years	1	1	1	
ENDOMETRIAL CANCER	1	1	1	
OVARIAN CANCER	1	1	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY			NEW EVIDENCE/COMMENTS
	C	S	D	
UTERINE FIBROIDS				
a) Without distortion of the uterine cavity	1	1	1	
b) With distortion of the uterine cavity	1	1	1	
PELVIC INFLAMMATORY DISEASE (PID)				
a) Past PID (assuming no current risk factors of STIs)				
(i) with subsequent pregnancy	1	1	1	
(ii) without subsequent pregnancy	1	1	1	
b) PID current or within the last 3 months	1	1	1	
STIs				
a) Current or within 3 months (including purulent cervicitis)	1	1	1	
b) Vaginitis without purulent cervicitis	1	1	1	
c) Increased risk of STIs (e.g., multiple partners or partner who has multiple partners)	1	1	1	
HIV/AIDS				
HIGH RISK OF HIV	1	2	1	**Comments:** Repeated and high-dose use of the spermicide nonoxynol-9 can cause vaginal and cervical irritation or abrasions which may increase risk of HIV transmission.
HIV-POSITIVE	1	2	1	
AIDS	1	2	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.			
Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.				
CONDITION	**CATEGORY**			**NEW EVIDENCE/COMMENTS**
	C	**S**	**D**	
OTHER INFECTIONS				
SCHISTOSOMIASIS				
a) Uncomplicated	1	1	1	
b) Fibrosis of liver	1	1	1	
TUBERCULOSIS				
a) Non-pelvic	1	1	1	
b) Known pelvic	1	1	1	
MALARIA	1	1	1	
HISTORY OF TOXIC SHOCK SYNDROME	1	1	3	**Comments:** Toxic shock syndrome has been reported in association with contraceptive sponge and diaphragm use.
URINARY TRACT INFECTION	1	1	2	**Comments:** There is a potential increase of urinary tract infection with diaphragms and spermicides.
ENDOCRINE CONDITIONS				
DIABETES				
a) History of gestational disease	1	1	1	
b) Non-vascular disease				
(i) non-insulin dependent	1	1	1	
(ii) insulin dependent	1	1	1	
c) Nephropathy/retinopathy/ neuropathy	1	1	1	
d) Other vascular disease or diabetes of > 20 years' duration	1	1	1	
THYROID				
a) Simple goitre	1	1	1	
b) Hyperthyroid	1	1	1	
c) Hypothyroid	1	1	1	

BARRIER METHODS	If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY			NEW EVIDENCE/COMMENTS
	C	S	D	
GASTROINTESTINAL CONDITIONS				
GALL-BLADDER DISEASE				
a) Symptomatic				
(i) treated by cholecystectomy	1	1	1	
(ii) medically treated	1	1	1	
(iii) current	1	1	1	
b) Asymptomatic	1	1	1	
HISTORY OF CHOLESTASIS				
a) Pregnancy-related	1	1	1	
b) Past COC-related	1	1	1	
VIRAL HEPATITIS				
a) Active	1	1	1	
b) Carrier	1	1	1	
CIRRHOSIS				
a) Mild (compensated)	1	1	1	
b) Severe (decompensated)	1	1	1	
LIVER TUMOURS				
a) Benign (adenoma)	1	1	1	
b) Malignant (hepatoma)	1	1	1	
ANAEMIAS				
THALASSAEMIA	1	1	1	
SICKLE CELL DISEASE	1	1	1	
IRON DEFICIENCY ANAEMIA	1	1	1	

BARRIER METHODS	**If there is risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**			
Women with conditions which make pregnancy an unacceptable risk should be advised that barrier methods for pregnancy prevention may not be appropriate for those who cannot use them consistently and correctly because of their relatively-higher typical-use failure rates.				
CONDITION	**CATEGORY**			**NEW EVIDENCE/COMMENTS**
	C	**S**	**D**	
DRUG INTERACTIONS				
COMMONLY USED DRUGS WHICH AFFECT LIVER ENZYMES a) Certain antibiotics (rifampicin and griseofulvin)	1	1	1	
b) Anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone				
OTHER ANTIBIOTICS (excluding rifampicin and griseofulvin)	1	1	1	
ALLERGY TO LATEX	3	1	3	**Comments:** This does not apply to plastic condoms/diaphragms.

FERTILITY AWARENESS-BASED METHODS

Fertility awareness-based (FAB) methods of family planning involve identification of the fertile days of the menstrual cycle, whether by observing fertility signs such as cervical secretions and basal body temperature, or by monitoring cycle days. FAB methods can be used in combination with abstinence or barrier methods during the fertile time. If barrier methods are used, refer to the section on barrier methods (BARR)

There are no medical conditions which become worse because of use of FAB methods. In general, these methods can be provided without concern for health effects to people who choose them. However, there are a number of conditions that make their use more complex. The existence of these conditions suggests that (1) use of these methods should be delayed until the condition is corrected or resolved or (2) they will require special counselling, and a more highly trained provider is generally necessary to ensure correct use.

Definitions

SYM	Symptoms-based methods	FAB methods based on observation of fertility signs (e.g., cervical secretions, basal body temperature) such as the Cervical Mucus Method, the Symptothermal Method, and the Two Day Method.
CAL	Calendar-based methods	FAB methods based on calendar calculations such as the Calendar Rhythm Method and the Standard Days Method.
A	Accept	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C	Caution	The method is normally provided in a routine setting, but with extra preparation and precautions. For FAB methods, this usually means that special counselling may be needed to ensure correct use of the method by a woman in this circumstance.
D	Delay	Use of this method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.
NA	Not applicable	

FERTILITY AWARENESS-BASED METHODS	**Fertility awareness-based methods do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**

Women with conditions which make pregnancy an unacceptable risk should be advised that fertility awareness-based methods may not be appropriate for them because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY		NEW EVIDENCE/COMMENTS
	SYM	CAL	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
PREGNANCY	NA		**Comments:** FAB methods are not relevant during pregnancy.
LIFE STAGE			
a) Post-menarche	C	C	**Comments:** Menstrual irregularities are common in post-menarche and peri-menopause and may complicate the use of FAB methods.
b) Peri-menopause	C	C	
BREASTFEEDING			
a) < 6 weeks postpartum	D	D	**Comments:** Women who are primarily breastfeeding and are amenorrhoeic are unlikely to have sufficient ovarian function to produce detectable fertility signs and hormonal changes during the first 6 months postpartum. However, the likelihood of resumption of fertility increases with time postpartum and with substitution of breast milk by other foods.
b) ≥ 6 weeks	C	D	
c) After menses begin	C	C	**Comments:** When the woman notices fertility signs (particularly cervical secretions), she can use a symptoms-based method. When she has had 3 postpartum menses, she can use a calendar-based method. Prior to that time, a barrier method should be offered if the woman plans to use a FAB method later. **Comments:** FAB methods during breastfeeding may be less effective than when not breastfeeding.
POSTPARTUM (in non-breastfeeding women)			
a) < 4 weeks	D	D	**Comments:** Non-breastfeeding women are not likely to have sufficient ovarian function to either require a FAB method or to have detectable fertility signs or hormonal changes prior to 4 weeks postpartum. Although the risk of pregnancy is low, a method appropriate for the postpartum period should be offered.

FERTILITY AWARENESS-BASED METHODS	**Fertility awareness-based methods do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**

Women with conditions which make pregnancy an unacceptable risk should be advised that fertility awareness-based methods may not be appropriate for them because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY		NEW EVIDENCE/COMMENTS
	SYM	CAL	
Postpartum (Cont'd) b) ≥ 4 weeks	A	D	**Comments:** Non-breastfeeding women are likely to have sufficient ovarian function to produce detectable fertility signs and/or hormonal changes at this time; likelihood increases rapidly with time postpartum. Women can use calendar-based methods as soon as they have completed 3 postpartum menses. Methods appropriate for the postpartum period should be offered prior to that time.
POST-ABORTION	C	D	**Comments:** Post-abortion women are likely to have sufficient ovarian function to produce detectable fertility signs and/or hormonal changes at this time; likelihood increases rapidly with time post-abortion. Women can use calendar-based methods as soon as they have completed 3 post-abortion menses. Methods appropriate for the postabortion period should be offered prior to that time.
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS			
IRREGULAR VAGINAL BLEEDING	D	D	**Comments:** Presence of this condition makes FAB methods unreliable. Therefore, barrier methods should be recommended until the bleeding pattern is compatible with proper method use. The condition should be evaluated and treated as necessary.
VAGINAL DISCHARGE	D	A	**Comments:** Because vaginal discharge makes recognition of cervical secretions difficult, the condition should be evaluated and treated if needed prior to providing methods based on cervical secretions.
OTHER			
USE OF DRUGS WHICH AFFECT CYCLE REGULARITY, HORMONES AND/OR FERTILITY SIGNS	C/D	C/D	**Comments:** Use of certain mood-altering drugs such as lithium, tricyclic antidepressants, and anti-anxiety therapies, as well as certain antibiotics and anti-inflammatory drugs, may alter cycle regularity or affect fertility signs. The condition should be carefully evaluated and a barrier method offered until the degree of effect has been determined or the drug is no longer being used.

FERTILITY AWARENESS-BASED METHODS	**Fertility awareness-based methods do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**

Women with conditions which make pregnancy an unacceptable risk should be advised that fertility awareness-based methods may not be appropriate for them because of their relatively-higher typical-use failure rates.

CONDITION	CATEGORY		NEW EVIDENCE/COMMENTS
	SYM	CAL	
DISEASES WHICH ELEVATE BODY TEMPERATURE			
a) Chronic diseases	C	A	**Comments:** Elevated temperature levels may make basal body temperature difficult to interpret, but there is no effect on cervical secretions. Thus the use of a method that relies on temperature should be delayed until the acute disease abates. Temperature-based methods are not appropriate for women with chronically-elevated temperatures. In addition, some chronic diseases interfere with cycle regularity, making calendar-based methods difficult to interpret.
b) Acute diseases	D	A	

LACTATIONAL AMENORRHOEA METHOD

The lactational amenorrhoea method does not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
Women with conditions which make pregnancy an unacceptable risk should be advised that the lactational amenorrhoea method may not be appropriate for them because of its relatively higher typical-use failure rates.

The Bellagio Consensus provided the scientific basis for defining the conditions under which breastfeeding can be used safely and effectively for birth-spacing purposes, and programmatic guidelines were developed for the use of lactational amenorrhoea in family planning. These guidelines include the following three criteria, all of which must be met to ensure adequate protection from an unplanned pregnancy: **1) Amenorrhoea; 2) Fully or nearly fully breastfeeding;** and **3) Less than six months postpartum**.

The main indications for breastfeeding remain the need to provide an ideal food for the infant and to protect it against disease. There are no medical conditions in which the use of lactational amenorrhoea is restricted and there is no documented evidence of its negative impact on maternal health. However, certain conditions or obstacles which affect breastfeeding may also affect the duration of amenorrhoea, making this a less useful choice for family planning purposes. These include**:**

HIV infection

Breastfeeding should be promoted, protected, and supported in all populations, for all women who are HIV-negative or of unknown HIV status. Women who are known to be HIV-positive should be counselled about all infant feeding methods and the risks involved, make an informed choice, and be supported in their choice.

Medication used during breastfeeding

In order to protect infant health, breastfeeding is not recommended for women using such drugs as: anti-metabolites, bromocriptine, certain anticoagulants, corticosteroids (high doses), cyclosporin, ergotamine, lithium, mood-altering drugs, radioactive drugs, and reserpine.

Conditions affecting the newborn

Congenital deformities of the mouth, jaw or palate; newborns who are small-for-date or premature and needing intensive neonatal care; and certain metabolic disorders of the infant all can make breastfeeding difficult.

COITUS INTERRUPTUS

Coitus interruptus does not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms should be recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
Women with conditions that make pregnancy an unacceptable risk should be advised that coitus interruptus may not be appropriate for them because of its relatively higher typical-use failure rates

Coitus interruptus (CI), also known as withdrawal, is a traditional family planning method in which the man completely removes his penis from the vagina, and away from the external genitalia of the female partner, **before** he ejaculates. CI prevents sperm from entering the woman's vagina, thereby preventing contact between spermatozoa and the ovum.

This method may be appropriate for couples:

- who are highly motivated and able to use this method effectively;
- with religious or philosophical reasons for not using other methods of contraception;
- who need contraception immediately and have entered into a sexual act without alternative methods available;
- who need a temporary method while awaiting the start of another method;
- who have intercourse infrequently.

Some benefits of CI are that the method, if used correctly, does not affect breastfeeding and is always available for primary use or use as a back-up method. In addition, CI involves no economic cost or use of chemicals. There are no health risks associated directly with CI. Men and women who are at high risk of STI/HIV infection should use a condom with each act of intercourse.

CI is unforgiving of incorrect use, and its effectiveness depends on the willingness and ability of the couple to use withdrawal with every act of intercourse.

SURGICAL STERILIZATION PROCEDURES

Considering the irreversibility or permanence of sterilization procedures, special care must be taken to assure a voluntary informed choice of the method by the client. Particular attention must be given in the case of young people, nulliparous women, and men who have not yet been fathers, and in clients with mental health problems, including depressive conditions. All women should be counselled about the permanence of sterilization and the availability of alternative, long-term, highly effective methods; this is of extra concern for young people. The national laws and existing norms for the delivery of sterilization procedures must be considered in the decision process.

There is no medical condition that would absolutely restrict a person's eligibility for sterilization. Some conditions and circumstances indicate that certain precautions should be taken.

The classification of conditions into the different categories is based on an in-depth review of the epidemiological and clinical evidence relevant to medical eligibility. The programmatic implications of these updated medical criteria are still to be addressed taking into account the various levels of service delivery. However, for the particular case of sterilization procedures, the following category definitions were developed.

DEFINITIONS

A	Accept	There is no medical reason to deny sterilization to a person with this condition.
C	Caution	The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
D	Delay	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
S	Special	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

A. Female surgical sterilization

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
PREGNANCY	D	
YOUNG AGE	C	**New evidence:** Studies show that up to 20% of women sterilized at a young age later regret this decision, and that young age is the strongest predictor of regret that can be identified before sterilization.[1,2] **Comments:** All women should be counselled about the permanency of sterilization and the availability of alternative, long-term, highly effective methods. This is of extra concern for young women.
PARITY		
a) Nulliparous	A	**Comments:** Counselling requires special care to ensure that an informed choice is being made.
b) Parous	A	
BREASTFEEDING	A	**Comments:** There is no impact on lactation if local anaesthesia is used and separation of mother and child is minimized.
POSTPARTUM		
a) < 7 days	A	**Comments:** Sterilization can be safely performed immediately postpartum.
7 to < 42 days	D	**Comments:** There is an increased risk of complications when the uterus has not fully involuted.
≥ 42 days	A	
b) Pre-eclampsia/ eclampsia		
(i) mild pre-eclampsia	A	
(ii) severe pre-eclampsia/ eclampsia	D	**Comments:** There are increased anaesthesia-related risks.
c) Prolonged rupture of membranes: 24 hours or more	D	**Comments:** There are increased risks of postoperative infection.
d) Puerperal sepsis, intrapartum or puerperal fever	D	**Comments:** This may indicate systemic or local infection; there is an increased risk of postoperative infection.
e) Severe antepartum or postpartum haemorrhage	D	**Comments:** The woman may be anaemic and unable to tolerate further blood loss (see section below).

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
POSTPARTUM (Cont'd)		
f) Severe trauma to the genital tract: cervical or vaginal tear at time of delivery	D	**Comments:** There may have been significant blood loss and anaemia. The procedure may be very painful.
g) Uterine rupture or perforation	S	**Comments:** There may have been significant blood loss or damage to abdominal contents, which may increase the risk of infection. If exploratory surgery or laparoscopy is conducted and the patient is stable, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
POST-ABORTION		
a) Uncomplicated	A	
b) Post-abortal sepsis or fever	D	**Comments:** This condition may substantially increase the risk of post-sterilization infection.
c) Severe post-abortal haemorrhage	D	**Comments:** The woman may be anaemic and unable to tolerate further blood loss.
d) Severe trauma to the genital tract: cervical or vaginal tear at time of abortion	D	**Comments:** The woman may be anaemic and unable to tolerate further blood loss. The procedure may be more painful.
e) Uterine perforation	S	**Comments:** There may have been significant blood loss or damage to abdominal contents, thereby increasing the risk of infection. If exploratory surgery or laparoscopy is conducted, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
f) Acute haematometra	D	**Comments:** The woman may be anaemic and unable to tolerate further blood loss.
PAST ECTOPIC PREGNANCY	A	
SMOKING		
a) Age < 35 years	A	
b) Age ≥ 35 years		
(i) <15 cigarettes/day	A	
(ii) ≥15 cigarettes/day	A	

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
OBESITY $\geq$ 30 kg/m^2 body mass index (BMI)	C	**Comments:** The procedure may be more difficult. There is an increased risk of wound infection and disruption. The condition may require general anaesthesia and may limit respiratory function.
CARDIOVASCULAR DISEASE		
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	S	**Comments:** The woman may be at high risk for complications associated with anaesthesia and surgery.
HYPERTENSION		
a) History of hypertension, where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	C	**Comments:** Blood pressure should be controlled before surgery. **Comments:** There are increased anaesthesia-related risks and an increased risk of cardiac arrhythmia. Blood pressure may be very labile and difficult to control in the early postpartum period. Appropriate monitoring of blood pressure intraoperatively is necessary.
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	C	
c) Elevated blood pressure levels (properly taken measurements)		
(i) systolic 140-159 or diastolic 90-99	C	
(ii) systolic $\geq$160 or diastolic $\geq$100	S	
d) Vascular disease	S	
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	A	

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)		
a) History of DVT/PE	A	**Comments:** To reduce the risk of DVT/PE, early ambulation is recommended.
b) Current DVT/PE	D	
c) Family history of DVT/PE (first-degree relatives)	A	
d) Major surgery		
(i) with prolonged immobilization	D	
(ii) without prolonged immobilization	A	
e) Minor surgery without immobilization	A	
SUPERFICIAL VENOUS THROMBOSIS		
a) Varicose veins	A	
b) Superficial thrombophlebitis	A	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE		
a) Current ischaemic heart disease	D	**Comments:** The woman is at high risk for complications associated with anaesthesia and surgery.
b) History of ischaemic heart disease	C	
STROKE (history of cerebrovascular accident)	C	
KNOWN HYPERLIPIDAEMIAS	A	**Comments:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. Some types of hyperlipidaemias are risk factors for vascular disease. The category should be assessed according to the type and its severity.

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
VALVULAR HEART DISEASE		
a) Uncomplicated	C	**Comments:** The woman requires prophylactic antibiotics.
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	S	**Comments:** The woman is at high risk for complications associated with anaesthesia and surgery. If she has unstable atrial fibrillation or current subacute bacterial endocarditis, the procedure should be delayed.
NEUROLOGIC CONDITIONS		
HEADACHES		
a) Non migrainous (mild or severe)	A	
b) Migraine		
(i) without focal neurologic symptoms		
Age < 35	A	
Age ≥ 35	A	
(ii) with focal neurologic symptoms (at any age)	A	
EPILEPSY	C	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS		
VAGINAL BLEEDING PATTERNS		
a) Irregular pattern *without* heavy bleeding	A	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	A	
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)		**Comments:** The condition must be evaluated before the procedure is performed.
Before evaluation	D	
ENDOMETRIOSIS	S	

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
BENIGN OVARIAN TUMOURS (including cysts)	A	
SEVERE DYSMENORRHOEA	A	
TROPHOBLAST DISEASE		
a) Benign gestational trophoblastic disease	A	
b) Malignant gestational trophoblastic disease	D	
CERVICAL ECTROPION	A	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	A	
CERVICAL CANCER (awaiting treatment)	D	**Comments:** In general, the treatment renders a woman sterile.
BREAST DISEASE		
a) Undiagnosed mass	A	
b) Benign breast disease	A	
c) Family history of cancer	A	
d) Cancer		
(i) current	C	
(ii) past and no evidence of current disease for 5 years	A	
ENDOMETRIAL CANCER	D	**Comments:** In general, the treatment renders a woman sterile.
OVARIAN CANCER	D	**Comments:** In general, the treatment renders a woman sterile.
UTERINE FIBROIDS		**Comments:** Depending on the size and location of the fibroids, it might be difficult to localize the tubes and mobilize the uterus.
a) Without distortion of the uterine cavity	C	
b) With distortion of the uterine cavity	C	

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
PELVIC INFLAMMATORY DISEASE (PID)		
a) Past PID (assuming no current risk factors for STIs)		**Comments:** A careful pelvic examination must be performed to rule out recurrent or persistent infection and to determine the mobility of the uterus.
(i) with subsequent pregnancy	A	
(ii) without subsequent pregnancy	C	
b) PID - current or within the last 3 months	D	**Comments:** PID can lead to an increased risk of post-sterilization infection or adhesions.
STIs		
a) Current (including purulent cervicitis)	D	**Comments:** There is an increased risk of postoperative infection.
b) Within the last 3 months	A	**Comments:** If no symptoms persist following treatment, sterilization may be performed.
c) Vaginitis without purulent cervicitis	A	
d) Increased risk of STIs	A	
HIV/AIDS		
HIGH RISK OF HIV	A	**Comments:** No routine screening is needed. Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures. The use of condoms is recommended following sterilization.
HIV-POSITIVE	A	
AIDS	S	**Comments:** If the woman is currently suffering an AIDS-related illness, the procedure should be delayed.
OTHER INFECTIONS		
SCHISTOSOMIASIS		
a) Uncomplicated	A	
b) Fibrosis of liver	C	**Comments:** Liver function may need to be evaluated.
TUBERCULOSIS		
a) Non-pelvic	A	
b) Known pelvic	S	
MALARIA	A	

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
ENDOCRINE CONDITIONS		
DIABETES		
a) History of gestational disease	A	**Comments:** If blood glucose is not well controlled, referral to a higher-level facility is recommended.
b) Non-vascular disease:		**Comments:** There is a possible decrease in healing and an increased risk of wound infection. Use of prophylactic antibiotics is recommended.
(i) non-insulin dependent	C	**Comments:** There is a risk of hypoglycaemia or ketoacidosis.
(ii) insulin dependent	C	
c) Nephropathy/ retinopathy/neuropathy	S	
d) Other vascular disease or diabetes of > 20 years' duration	S	
THYROID		
a) Simple goitre	A	
b) Hyperthyroid	S	**Comments:** The woman is at high risk for complications associated with anaesthesia and surgery.
c) Hypothyroid	C	
GASTROINTESTINAL CONDITIONS		
GALL-BLADDER DISEASE		
a) Symptomatic		
(i) treated by cholecystectomy	A	
(ii) medically treated	A	
(iii) current	D	
b) Asymptomatic	A	
HISTORY OF CHOLESTASIS		
a) Pregnancy-related	A	
b) Past COC-related	A	

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
VIRAL HEPATITIS		
a) Active	D	**Comments:** The woman is at high risk for complications associated with anaesthesia and surgery. Appropriate infection prevention procedures, including universal precautions, must be carefully observed.
b) Carrier	A	
CIRRHOSIS		
a) Mild (compensated)	C	**Comments:** Liver function and clotting might be altered. Liver function should be evaluated.
b) Severe (decompensated)	S	
LIVER TUMOURS		
a) Benign (adenoma)	C	**Comments:** Liver function and clotting might be altered. Liver function should be evaluated.
b) Malignant (hepatoma)	C	
ANAEMIAS		
THALASSAEMIA	C	
SICKLE CELL DISEASE	C	**Comments:** There is an increased risk of pulmonary, cardiac or neurologic complications and possible increased risk of wound infection.
IRON DEFICIENCY ANAEMIA		
a) Hb < 7g/dl	D	**Comments:** The underlying disease should be identified. Both preoperative Hb level and operative blood loss are important factors in women with anaemia. If peripheral perfusion is inadequate, this may decrease wound healing.
b) Hb $\geq$ 7 to < 10g/dl	C	
OTHER CONDITIONS RELEVANT ONLY FOR FEMALE SURGICAL STERILIZATION		
LOCAL INFECTION		
Abdominal skin infection	D	**Comments:** There is an increased risk of postoperative infection.
COAGULATION DISORDERS	S	**Comments:** Women with coagulation disorders are at increased risk of haematologic complications of surgery.
RESPIRATORY DISEASES		
a) Acute (bronchitis, pneumonia)	D	**Comments:** The procedure should be delayed until the condition is corrected. There are increases in anaesthesia-related and other perioperative risks.

FEMALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV, if there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**NEW EVIDENCE/COMMENTS**
RESPIRATORY DISEASES (Cont'd)		
b) Chronic (i) asthma (ii) bronchitis (iii) emphysema (iv) lung infection	 S S S S	**Comments:** For laparoscopy, the woman may experience acute exacerbation of symptoms induced by the raising of the diaphragm by pneumoperitoneum, Trendelenburg position, and decrease in venous return from gaseous compression of the large vessels.
SYSTEMIC INFECTION OR GASTROENTERITIS	D	**Comments:** There are increased risks of postoperative infection, complications from dehydration, and anaesthesia-related complications.
FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION	S	**Comments:** Decreased mobility of the uterus and bowel may make closed laparoscopy and minilaparotomy difficult and increase the risk of complications.
ABDOMINAL WALL OR UMBILICAL HERNIA	S	**Comments:** Hernia repair and tubal sterilization should be performed concurrently, if possible.
DIAPHRAGMATIC HERNIA	C	**Comments:** For laparoscopy, the woman may experience acute exacerbation of symptoms induced by raising of the diaphragm by pneumoperitoneum, Trendelenburg position, and decrease in venous return from gaseous compression of the large vessels.
KIDNEY DISEASE	C	**Comments:** Blood clotting may be impaired. There may be an increased risk of infection and hypovolemic shock. May cause baseline anaemia, electrolyte disturbances, peripheral neuropathy, and abnormalities in drug metabolism and excretion.
SEVERE NUTRITIONAL DEFICIENCIES	C	**Comments:** There may be an increased risk of wound infection and healing.
STERILIZATION CONCURRENT WITH ABDOMINAL SURGERY a) Elective b) Emergency (without previous counselling) c) Infectious condition	 C D D	
STERILIZATION CONCURRENT WITH CAESAREAN SECTION	A	**Comments:** Concurrent sterilization does not increase risk of complication in a surgically stable client.

B. Male surgical sterilization

MALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV. If there is risk of STI/HIV, the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**RATIONALE/COMMENTS**
LOCAL INFECTIONS		
(i) scrotal skin infection	D	**Comments:** There is an increased risk of postoperative infection.
(ii) active STI	D	
(iii) balanitis	D	
(iv) epididymitis or orchitis	D	
PREVIOUS SCROTAL INJURY	C	
SYSTEMIC INFECTION OR GASTROENTERITIS	D	**Comments:** There is an increased risk of postoperative infection.
LARGE VARICOCELE	C	**Comments:** The vas may be difficult or impossible to locate; a single procedure to repair varicocele and perform a vasectomy decreases the risk of complications.
LARGE HYDROCELE	C	**Comments:** The vas may be difficult or impossible to locate; a single procedure decreases the risk of complications.
FILARIASIS; ELEPHANTIASIS	D	**Comments:** The scrotum may be involved in severe elephantiasis, making it impossible to palpate the cord structure and testis.
INTRASCROTAL MASS	D	**Comments:** This may indicate an underlying disease.
CRYPTORCHIDISM	C	**Comments:** If cryptorchidism is bilateral, and fertility has been demonstrated, this will require extensive surgery to locate the vas, and this becomes category S. If unilateral, and fertility has been demonstrated, vasectomy may be performed on the normal side and the spermogram checked, as per routine. If the man continues to have a persistent presence of sperm, more extensive surgery may be required to locate the other vas, and this becomes category S.
INGUINAL HERNIA	S	**Comments:** Vasectomy can be performed concurrent with hernia repair.
SICKLE CELL DISEASE	A	
COAGULATION DISORDERS	S	**Comments:** Bleeding disorders lead to an increased risk of postoperative haematoma formation which, in turn, leads to an increased risk of infection.

MALE SURGICAL STERILIZATION	**Sterilization does not protect against STI/HIV. If there is risk of STI/HIV, the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**	
CONDITION	**CATEGORY**	**RATIONALE/COMMENTS**
DIABETES	C	**Comments:** Diabetics are more likely to get postoperative wound infections. If signs of infection appear, treatment with antibiotics needs to be given.
HIV/AIDS		**Comments:** No routine screening is needed. Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures. The use of condoms is recommended following sterilization.
a) High risk of HIV	A	
b) HIV-positive	A	
c) AIDS	S	**Comments:** If the man is currently suffering an AIDS-related illness, the procedure should be delayed.

References for Sterilization Procedures

1. Hillis SD, Marchbanks PA, Tylor LR, Peterson HB, for the US Collaborative Review of Sterilization Working Group. Poststerilization regret: findings from the United States Collaborative Review of Sterilization. *Obstetrics and Gynecology* 1999,93:889-895.

2. Hardy E, Bahamondes L, Osis MJ, Costa RG, Faundes A. Risk factors for tubal sterilization regret, detectable before surgery. *Contraception* 1996,54:159-162.

SUMMARY TABLES							
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**	**LNG-IUD**
I = Initiation, **C** = Continuation							
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY							
PREGNANCY	NA	NA	NA	NA	NA	4	4
AGE	Menarche to <40=1 ≥40=2	Menarche to <40=1 ≥40=2	Menarche to <18=1 18-45=1 >45=1	Menarche to <18=2 18-45=1 >45=2	Menarche to <18=1 18-45=1 >45=1	<20=2 ≥20=1	<20=2 ≥20=1
PARITY							
a) Nulliparous	1	1	1	1	1	2	2
b) Parous	1	1	1	1	1	1	1
BREASTFEEDING							
a) < 6 weeks postpartum	4	4	3	3	3		
b) 6 weeks to < 6 months (primarily breastfeeding)	3	3	1	1	1		
c) ≥ 6 months postpartum	2	2	1	1	1		
POSTPARTUM (in non-breastfeeding women)							
a) < 21 days	3	3	1	1	1		
b) ≥ 21 days	1	1	1	1	1		
POSTPARTUM (breastfeeding or non-breastfeeding) including post-caesarean section							
a) < 48 hours						2	3
b) ≥ 48 hours to <4 weeks						3	3
c) ≥ 4 weeks						1	1[a]
d) Puerperal sepsis						4	4

[a] If the woman is breastfeeding, LNG-IUD becomes a category 3 until 6 weeks postpartum.

SUMMARY TABLES							
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**	**LNG-IUD**
I = Initiation, **C** = Continuation							
POST-ABORTION							
a) First trimester	1	1	1	1	1	1	1
b) Second trimester	1	1	1	1	1	2	2
c) Immediate post-septic abortion	1	1	1	1	1	4	4
PAST ECTOPIC PREGNANCY	1	1	2	1	1	1	1
HISTORY OF PELVIC SURGERY (see also postpartum section) (including caesarean section)	1	1	1	1	1	1	1
SMOKING							
a) Age < 35	2	2	1	1	1	1	1
b) Age ≥ 35							
(i) <15 cigarettes/day	3	2	1	1	1	1	1
(ii) ≥15 cigarettes/day	4	3	1	1	1	1	1
OBESITY ≥30 kg/m^2 body mass index (BMI)	2	2	1	2	2	1	2
ANATOMICAL ABNORMALITIES							
a) That distort the uterine cavity						4	4
b) That do not distort the uterine cavity						2	2
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	NA	NA	NA	NA	NA
CARDIOVASCULAR DISEASE							
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	3/4	2	3	2	1	2

SUMMARY TABLES							
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**	**LNG-IUD**
I = Initiation, **C** = Continuation							
HYPERTENSION							
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3	3	2	2	2	1	2
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3	3	1	2	1	1	1
c) Elevated blood pressure levels (properly taken measurements)							
(i) systolic 140-159 or diastolic 90-99	3	3	1	2	1	1	1
(ii) systolic ≥160 or diastolic ≥100	4	4	2	3	2	1	2
d) Vascular disease	4	4	2	3	2	1	2
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	2	1	1	1	1	1
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)							
a) History of DVT/PE	4	4	2	2	2	1	2
b) Current DVT/PE	4	4	3	3	3	1	3
c) Family history (first-degree relatives)	2	2	1	1	1	1	1

SUMMARY TABLES							
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**	**LNG-IUD**
I = Initiation, **C** = Continuation							
DVT/PE (Cont'd)							
d) Major surgery							
(i) with prolonged immobilization	4	4	2	2	2	1	2
(ii) without prolonged immobilization	2	2	1	1	1	1	1
e) Minor surgery without immobilization	1	1	1	1	1	1	1
SUPERFICIAL VENOUS THROMBOSIS							
a) Varicose veins	1	1	1	1	1	1	1
b) Superficial thrombophlebitis	2	2	1	1	1	1	1
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	4	**I** 2 / **C** 3	3	**I** 2 / **C** 3	1	**I** 2 / **C** 3
STROKE (history of cerebrovascular accident)	4	4	**I** 2 / **C** 3	3	**I** 2 / **C** 3	1	2
KNOWN HYPERLIPIDAEMIAS (screening is NOT necessary for safe use of contraceptive methods)	2/3[b]	2/3[b]	2	2	2	1	2
VALVULAR HEART DISEASE							
a) Uncomplicated	2	2	1	1	1	1	1
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	4	4	1	1	1	2	2

[b] Depending on severity of condition.

SUMMARY TABLES														
CONDITION	**COC**		**CIC**		**POP**		**DMPA NET-EN**		**NOR**		**Cu-IUD**		**LNG-IUD**	
I = Initiation, **C** = Continuation														
NEUROLOGIC CONDITIONS														
HEADACHES	**I**	**C**	**I**	**C**	**I**	**C**	**I**	**C**	**I**	**C**			**I**	**C**
a) Non migrainous (mild or severe)	1	2	1	2	1	1	1	1	1	1	1		1	1
b) Migraine														
(i) without focal neurologic symptoms														
Age <35	2	3	2	3	1	2	2	2	2	2	1		2	2
Age ≥35	3	4	3	4	1	2	2	2	2	2	1		2	2
(ii) with focal neurologic symptoms (at any age)	4	4	4	4	2	3	2	3	2	3	1		2	3
EPILEPSY	1		1		1		1		1		1		1	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS														
VAGINAL BLEEDING PATTERNS													**I**	**C**
a) Irregular pattern *without* heavy bleeding	1		1		2		2		2		1		1	1
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1		1		2		2		2		2		1	2
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)											**I**	**C**	**I**	**C**
Before evaluation	2		2		2		3		3		4	2	4	2
ENDOMETRIOSIS	1		1		1		1		1		2		1	
BENIGN OVARIAN TUMOURS (including cysts)	1		1		1		1		1		1		1	
SEVERE DYSMENORRHOEA	1		1		1		1		1		2		1	

SUMMARY TABLES									
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**		**LNG-IUD**	
I = Initiation, **C** = Continuation									
TROPHOBLAST DISEASE									
a) Benign gestational trophoblastic disease	1	1	1	1	1	3		3	
b) Malignant gestational trophoblastic disease	1	1	1	1	1	4		4	
CERVICAL ECTROPION	1	1	1	1	1	1		1	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	2	1	2	2	1		2	
CERVICAL CANCER (awaiting treatment)						**I**	**C**	**I**	**C**
	2	2	1	2	2	4	2	4	2
BREAST DISEASE									
a) Undiagnosed mass	2	2	2	2	2	1		2	
b) Benign breast disease	1	1	1	1	1	1		1	
c) Family history of cancer	1	1	1	1	1	1		1	
d) Cancer									
(i) current	4	4	4	4	4	1		4	
(ii) past and no evidence of current disease for 5 years	3	3	3	3	3	1		3	
ENDOMETRIAL CANCER						**I**	**C**	**I**	**C**
	1	1	1	1	1	4	2	4	2
OVARIAN CANCER						**I**	**C**	**I**	**C**
	1	1	1	1	1	3	2	3	2
UTERINE FIBROIDS									
a) Without distortion of the uterine cavity	1	1	1	1	1	2		2	
b) With distortion of the uterine cavity	1	1	1	1	1	4		4	

SUMMARY TABLES									
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**		**LNG-IUD**	
I = Initiation, **C** = Continuation									
PELVIC INFLAMMATORY DISEASE (PID)									
a) Past PID (assuming no current risk factors of STIs)						**I**	**C**	**I**	**C**
(i) with subsequent pregnancy	1	1	1	1	1	1	1	1	1
(ii) without subsequent pregnancy	1	1	1	1	1	2	2	2	2
b) PID - current or within the last 3 months	1	1	1	1	1	4	3	4	3
STIs[c]									
a) Current or within 3 months (including purulent cervicitis)	1	1	1	1	1	4		4	
b) Vaginitis without purulent cervicitis	1	1	1	1	1	2		2	
c) Increased risk of STIs (e.g. multiple partners or partner who has multiple partners)	1	1	1	1	1	3		3	
HIV/AIDS[c]									
HIGH RISK OF HIV	1	1	1	1	1	3		3	
HIV-POSITIVE	1	1	1	1	1	3		3	
AIDS	1	1	1	1	1	3		3	
OTHER INFECTIONS									
SCHISTOSOMIASIS									
a) Uncomplicated	1	1	1	1	1	1		1	
b) Fibrosis of the liver	1	1	1	1	1	1		1	
TUBERCULOSIS						**I**	**C**	**I**	**C**
a) Non-pelvic	1	1	1	1	1	1	1	1	1
b) Known pelvic	1	1	1	1	1	4	3	4	3

[c] Barrier methods, especially condoms, are always recommended for prevention of STI/HIV/PID.

SUMMARY TABLES							
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**	**LNG-IUD**
I = Initiation, **C** = Continuation							
MALARIA	1	1	1	1	1	1	1
ENDOCRINE CONDITIONS							
DIABETES							
a) History of gestational disease	1	1	1	1	1	1	1
b) Non-vascular disease							
(i) non-insulin dependent	2	2	2	2	2	1	2
(ii) insulin dependent	2	2	2	2	2	1	2
c) Nephropathy/ retinopathy/ neuropathy	3/4	3/4	2	3	2	1	2
d) Other vascular disease or diabetes of >20 years' duration	3/4	3/4	2	3	2	1	2
THYROID							
a) Simple goitre	1	1	1	1	1	1	1
b) Hyperthyroid	1	1	1	1	1	1	1
c) Hypothyroid	1	1	1	1	1	1	1
GASTROINTESTINAL CONDITIONS							
GALL-BLADDER DISEASE							
a) Symptomatic							
(i) treated by cholecystectomy	2	2	2	2	2	1	2
(ii) medically treated	3	2	2	2	2	1	2
(iii) current	3	2	2	2	2	1	2
b) Asymptomatic	2	2	2	2	2	1	2
HISTORY OF CHOLESTASIS							
a) Pregnancy-related	2	2	1	1	1	1	1
b) Past COC-related	3	2	2	2	2	1	2

SUMMARY TABLES							
CONDITION	**COC**	**CIC**	**POP**	**DMPA NET-EN**	**NOR**	**Cu-IUD**	**LNG-IUD**
I = Initiation, **C** = Continuation							
VIRAL HEPATITIS							
a) Active	4	3/4	3	3	3	1	3
c) Carrier	1	1	1	1	1	1	1
CIRRHOSIS							
a) Mild (compensated)	3	2	2	2	2	1	2
b) Severe (decompensated)	4	3	3	3	3	1	3
LIVER TUMOURS							
a) Benign (adenoma)	4	3	3	3	3	1	3
b) Malignant (hepatoma)	4	3/4	3	3	3	1	3
ANAEMIAS							
THALASSAEMIA	1	1	1	1	1	2	1
SICKLE CELL DISEASE	2	2	1	1	1	2	1
IRON DEFICIENCY ANAEMIA	1	1	1	1	1	2	1
DRUG INTERACTIONS							
COMMONLY USED DRUGS WHICH AFFECT LIVER ENZYMES							
a) Certain antibiotics (rifampicin and griseofulvin)	3	3	3	2	3	1	1
b) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone)	3	3	3	2	3	1	1
OTHER ANTIBIOTICS (excluding rifampicin and griseofulvin)	1	1	1	1	1	1	1

MEETING ON
IMPROVING ACCESS AND
QUALITY OF CARE IN FAMILY PLANNING:
MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

Salle A, World Health Organization, Geneva
8-10 March 2000

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