UK MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

(UKMEC 2005/2006)

Adapted from the World Health Organization Medical Eligibility Criteria (WHOMEC third edition) using a formal consensus method

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SECTION A: Introduction

Contraceptive choice

Many factors determine the method of contraception a couple chooses to use. Provided a woman or man is medically eligible to use a particular method, she or he should be free to choose the method which is most acceptable. To be effective, contraception must be used correctly and consistently; and for the long acting methods (such as intrauterine devices) to be cost-effective, continuation rates must be high. Effective and continued use of a method is directly related to its acceptability to the user.

Couples should be given accurate information about all methods for which they are medically eligible and helped to decide which might best suit their needs. Health professionals who give advice about contraception should be competent to give information about the efficacy, risks and side effects, advantages and disadvantages, and non-contraceptive benefits of all available methods.

What are the Medical Eligibility Criteria?

Most contraceptive users are medically fit and can use any available contraceptive method safely. However, some medical conditions are associated with theoretical increased health risks when certain contraceptives are used, either because the method adversely affects the condition or because the condition, or its treatment, affects the contraceptive. For example the combined oral contraceptive pill may increase the risk of a woman with diabetes developing cardiovascular complications, while some anti-convulsants interfere with the efficacy of oral contraceptives. Since most trials of new contraceptive methods deliberately exclude subjects with chronic medical conditions, there is little direct evidence on which to base sound prescribing advice.

In 1994, the World Health Organization (WHO) developed a set of internationally agreed norms for providing contraception to women and men with a range of medical conditions which may contraindicate one or more contraceptive methods. These norms are the so-called WHO *Medical Eligibility Criteria for Contraceptive Use* (WHOMEC). A third edition of WHOMEC was published in 2004.[1] New evidence is regularly reviewed and available on the WHO website **(www.who.int/en/)**

Using evidence-based systematic reviews and expert opinion, the recommendations classify conditions into one of four categories (Table A). Category 1 includes conditions for which there is *no restriction for the use* of the method while category 4 includes conditions which represent an *unacceptable health risk* if the contraceptive method is used (absolutely contraindicated). Classification of a condition as category 2 indicates that the method may generally be used but that more careful follow-up is required. Category 3 conditions are those for which the risks of use generally outweighs the benefits (relatively contraindicated). Provision of a method to a woman with a category 3 condition requires expert clinical judgement since use of that method is not usually recommended unless other more appropriate methods are not available or not acceptable.[1]

Table A: WHOMEC categories for use of hormonal contraception, intrauterine devices and barrier methods.[1]

WHOMEC Category	Definition of category
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.

WHO updates and adds to the recommendations of the MEC through expert Working Group meetings every three to four years and, in between those meetings, through input from its family planning Guidelines Steering Group on an as-needed basis. The recommendations, together with the updates, are made available on the WHO web site **(www.who.int/reproductive-health)**. The web site also provides additional information determined by WHO to be relevant to these recommendations, pending the next formal consensus Working Group meeting. Such updates may be particularly warranted for issues where the evidence base may change rapidly.

WHO recognises that contraceptive provision varies greatly around the world and that it is inappropriate to set firm international guidelines on contraceptive use. Rather the WHO expects the Medical Eligibility Criteria for Contraceptive Use to be used by organisations for updating or in developing their own contraceptive guidelines in the light of their national health policies, needs, priorities and resources.

The consensus process

In 2005, a Steering Group led by the Clinical Effectiveness Unit of the Faculty of Family Planning and Reproductive Health Care (FFPRHC) began a formal process of adapting WHOMEC to reflect UK practice. A series of meetings was held culminating in a formal Consensus Meeting of a multidisciplinary group of UK experts and stakeholders. The final UK Medical Eligibility Criteria (UKMEC) is being widely disseminated in paper format and is available on the FFPRHC website **(www.ffprhc.org.uk).** The document will not be updated as living guidance. This work was supported by a grant from the Department of Health in England.

Consensus methods have been described as 'a process for making policy decisions, rather than a scientific method for creating new knowledge.'[2] The consensus process aims to make the best use of available information, be that scientific data or collective wisdom of the participants, and aims to provide authority, rationality, and scientific credibility to the UKMEC.

Using a consensus process, the extent to which group members agree (or disagree) about an issue is identified. Agreement takes two forms: the extent to which each participant agrees with an issue; and the extent to which participants agree with each other, the consensus element. The consensus method used in the process of adapting the WHOMEC for UK use is a nominal group technique (the RAND consensus method). A similar method was used by the FFPRHC in adapting another WHO document, the *Selected Practice Recommendations for Contraceptive Use*.[3;4;5] The RAND method involves a number of steps: mailed questionnaires; private decision-making and scoring; formal feedback of group choices; face-to-face discussion of evidence with structured interaction; further private decision-making and scoring; and an explicit aggregation method.

Consensus was deemed to be achieved if nine out of the eleven Consensus participants scored agreement or disagreement within a 3-point band on a 9-point Likert Scale. A change to a WHO category was only made if consensus was achieved. Where consensus was not achieved, the WHO categories were upheld.

With Consensus there may be occasions when individual participants do not agree with a UK category given. However, in order for a UK category to be changed from the existing WHO category at least nine of the eleven participants had to agree to the change.

Steering Group	Expert Consensus Group
Dr Susan Brechin (Chair)	Ms Toni Belfield
Ms Toni Belfield	Dr Alyson Elliman
Professor Anna Glasier	Professor Phil Hannaford
Dr Gillian Penney	Dr Meera Kishen
Dr Joanne Protheroe	Dr Ali Kubba
Dr Connie Smith	Dr Diana Mansour
Ms Gillian Stephen	Ms Shelley Mehigan
	Dr Gillian Penney
	Dr Anne Szarewski
	Ms Sue Ward
	Dr Anne Webb

Observers at the consensus meeting: Ms Janet Nooney and Mr Toni Isaacs (Medicines and Healthcare products Regulatory Agency); Kathy French (Sexual health adviser, Royal college of Nursing).

During the development of the UKMEC, feedback was obtained on the usability of the existing WHOMEC document from clinicians throughout the UK currently working in general practice or family planning and reproductive healthcare settings. This feedback was taken into account in developing this final UKMEC document.

How to use this document

The tables in this document (Section B) list the UK categories given for all methods of contraception currently or soon to be available in the UK. The classification system (categories 1 to 4) is used for all hormonal methods, intrauterine devices (copper IUD and levonorgestrel IUD) and barrier methods (Table B). This classification system refers to contraceptive methods being used for contraceptive purposes. The classification system does not consider the use of contraceptive methods in the management of other medical conditions where eligibility criteria may differ.

Table B: Definitions of UK categories for use of hormonal contraception, intrauterine devices and barrier methods

UK Category	Definition of category
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

UK Category 1 includes conditions for which there is no restriction for use and Category 4 includes conditions which represent an unacceptable health risk if the method is used.

UK Category 2 indicates that a method can generally be used, but more careful follow-up may be required. The provision of a method with a conditions given a UK Category 3 requires **expert clinical judgement and/or referral to a specialist contraceptive provider**, since use of the method is not usually recommended unless other methods are not available or not acceptable.

Fertility-awareness based methods (Table C) and male and female sterilisation (Table D) are classified differently. This is based on: whether it is acceptable to use the method (A); whether extra precautions, preparations or counselling are required (C); or whether use of the method should be delayed until circumstances change, for example until breastfeeding stops (D). For sterilisation a fourth category (S) denotes that special arrangements should be made for the procedure.

Table C: Definitions of UK categories for Fertility awareness based methods

UK Category		Fertility awareness based methods (FAB)
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 the method should be delayed until the condition is evaluated or changes. Alternative temporary methods of contraception should be offered.

Table D: Definitions of UK categories for Male and Female Sterilisation

UK Category		Sterilisation
A	**Accept**	There is no medical reason to deny sterilisation to a person with this condition.
C	**Caution**	The procedure is normally conducted in a routine setting, but with extra preparation, precautions and counselling.
D	**Delay**	The procedure is delayed until the condition is evaluated, treated and / or changes. 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 method is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

Section B includes individual tables (1 to 8) of UK categories for groups of contraceptives: combined hormonal methods (combined oral contraceptive pill, patch and vaginal ring); progestogen-only methods (pills, injectables and implants); intrauterine devices (copper IUD and levonorgestrel IUD); sterilisation (male and female); emergency contraception (progestogen-only and copper IUD); barrier methods (male and female condoms, diaphragms and cervical caps); and fertility awareness based methods (cervical mucus assessment method and devices for measuring hormones).

In these tables the first column indicates the **CONDITION**. Each condition is defined as representing either an individual's characteristics (e.g. age, history of pregnancy) or a known pre-existing medical condition (e.g. diabetes, hypertension). Some conditions are subdivided to differentiate between varying degrees of the condition (e.g. migraine with or without aura).

The second column classifies the condition into one of the four **CATEGORIES** (1 to 4, or A,D,C or S). In some cases **initiation** of a contraceptive method (I) and **continuation** of the method (C) are distinguished and classified differently (Table E).

Table E: Initiation and continuation of a contraceptive method by women with a medical condition

Initiation (I)	Starting a method of contraception by a woman with a specific medical condition.
Continuation (C)	Continuing with the method already being used by a woman who develops a new medical condition.

For some conditions the third column is used to provide **CLARIFICATION** or to make comment on the **EVIDENCE** for the recommendation (Table F).

At the end of each method section additional comments can be found and the references from both the **WHOMEC** and **UKMEC** used to generate the evidence are listed.

Table F: Example of Tables in UKMEC

TYPE OF CONTRACEPTIVE		
CONDITION	**CATEGORY** I =Initiation or C =Continuation	**CLARIFICATIONS / EVIDENCE**
eg Diabetes	Category 1,2 3 or 4 Category A,C,D and S NA (not applicable) denotes a condition for which a ranking was not given but for which clarifications have been provided.	Clarifications and evidence regarding the classification

The summary table (Table 9.0) at the end of the document is just that, a summary of the most common reversible methods of contraception, conditions and categories, and can be used as a quick reference in the clinic setting. In addition, Table 9 and UK Category definitions are reproduced in a pull out section which can be used for photocopying and distribution in your own clinical setting.

Commonly used abbreviations

AIDS	acquired immune deficiency syndrome
BMI	body mass index
CHC	combined hormonal contraception
Cu-IUD	copper intrauterine device
DMPA	depot medroxyprogesterone acetate
DVT	deep vein thrombosis
EE	ethinylestradiol
HAART	highly active anti-retroviral therapy
HIV	human immunodeficiency virus
IMP	implant (progestogen-only)
LNG-IUD	levonorgestrel releasing intrauterine device
NET-EN	norethisterone enanthate
PE	pulmonary embolism
PID	pelvic inflammatory disease
POC	progestogen-only contraception
POEC	progestogen-only emergency contraception
POP	progestogen-only pill
STI	sexually transmitted infection
VTE	venous thromboembolism

Summary of changes from WHOMEC

In the UKMEC some **NEW MEDICAL CONDITIONS** have been added:

Inflammatory bowel disease (Crohn's disease and Ulcerative Colitis)

Raynaud's Disease

Congenital heart disease

In the UKMEC there are **NEW SUBHEADINGS** given under existing conditions:

After smoking cessation in women aged > 35 years

BMI ≥30-34, 35-39 and ≥40

Hypertension (>140-159mmHg systolic and/or >90-94 mmHg diastolic)

Current VTE and using anticoagulants

Family history of VTE in first degree relatives aged < 45 years

Immobility unrelated to surgery

Past history of migraine with aura

Gestational trophoblastic neoplasia

Carriers of known gene mutations associated with breast cancer risk (eg BRCA1)

Some subheadings have been removed as they were felt to be inappropriate or not applicable to UK clinical practice: when BP measurement is unavailable; insertion of intrauterine contraception within 48 hours of delivery; and immediate postpartum sterilisation following vaginal delivery.

Some chapters have been altered: emergency contraception (Table 5) now includes both progestogen-only emergency contraception and Cu-IUD; fertility awareness based methods (Table 7) include either the assessment of cervical mucus or the use of devices which measure hormones; and barrier methods (Table 6) no longer includes the use of spermicide alone. The chapter on coitus interuptus has been removed.

Definitions have been added for breastfeeding; vascular disease; congenital heart disease and valvular heart disease; hyperlipidaemias; and gestational trophoblastic neoplasia. Sections on potential drug interactions (with liver enzyme inducers, including anti-retrovirals and antibiotics) have been adapted to reflect existing UK guidance.[5;6]

The specific changes to the WHO categories in the UKMEC are summarised at the end of this section. These changes included alterations to categories on use of combined hormonal contraception for women who are breastfeeding (between 6 weeks and 6 months postpartum); the use of progestogen-only contraception (POC) by women with hypertension; the use of POC and intrauterine methods by women with current venous thromboembolism (VTE); nulliparity and intrauterine methods or sterilisation; and postpartum sterilisation.

SUMMARY OF CHANGES FROM WHOMEC

Conditions for which there was a classification change for one or more methods or a major modification to the condition description are highlighted.

COMMON REVERSIBLE METHODS						
CONDITION	**CHC**	**POP**	**DMPA/ NET-EN**	**IMP**	**Cu-IUD**	**LNG-IUD**
I = Initiation, C = Continuation						
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY						
PREGNANCY	NA	NA	NA	NA	4	4
AGE	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
PARITY						
a) Nulliparous	1	1	1	1	1	1
b) Parous	1	1	1	1	1	1
BREASTFEEDING						
a) < 6 weeks postpartum	4	1	2	1		
b) 6 weeks to < 6 months (fully or almost fully breastfeeding)	3	1	1	1		
c) ≥ 6 weeks to < 6 months postpartum (partial breastfeeding medium to low)	2	1	1	1		
d) ≥ 6 months postpartum	1	1	1	1		
POSTPARTUM (non-breastfeeding women)						
a) < 21 days	3	1	1	1		
b) ≥ 21 days	1	1	1	1		
POSTPARTUM (breastfeeding or non-breastfeeding women, including post-caesarean section)						
a) 48 hours to < 4 weeks					3	3
b) ≥ 4 weeks					1	1
c) Puerperal sepsis					4	4
POST-ABORTION						
a) First trimester	1	1	1	1	1	1
b) Second trimester	1	1	1	1	2	2
c) Immediate post-septic abortion	1	1	1	1	4	4
PAST ECTOPIC PREGNANCY	1	1	1	1	1	1
HISTORY OF PELVIC SURGERY (including caesarean section) (see also postpartum section)	1	1	1	1	1	1
SMOKING						
a) Age < 35 years	2	1	1	1	1	1
b) Age ≥ 35 years						
(i) < 15 cigarettes / day	3	1	1	1	1	1
(ii) ≥ 15 cigarettes / day	4	1	1	1	1	1
(iii) Stopped smoking < 1 year ago	3	1	1	1	1	1
(iv) Stopped smoking ≥ 1 year ago	2	1	1	1	1	1
OBESITY						
a) Body mass index ≥ 30 - 34 kg/m²	2	1	1	1	1	1
b) Body mass index 35 – 39 kg/m²	3	1	1	1	1	1
c) Body mass index ≥ 40 kg/m²	4	1	1	1	1	1
CARDIOVASCULAR DISEASE						
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	2	3	2	1	2

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CATEGORY 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
CATEGORY 4	A condition which represents an unacceptable health risk if the contraceptive method is used

SUMMARY OF CHANGES FROM WHOMEC

Conditions for which there was a classification change for one or more methods or a major modification to the condition description are highlighted.

COMMON REVERSIBLE METHODS						
CONDITION	**CHC**	**POP**	**DMPA/ NET-EN**	**IMP**	**Cu-IUD**	**LNG-IUD**
		I = Initiation, C = Continuation				
HYPERTENSION						
a) Adequately controlled hypertension	3	1	2	1	1	1
b) Consistently elevated blood pressure levels (properly taken measurements)						
(i) systolic >140 to 159mmHg or diastolic > 90 to 94mmHg	3	1	1	1	1	1
(ii) systolic ≥160 or diastolic ≥ 95 mmHg	4	1	2	1	1	1
c) Vascular disease	4	2	3	2	1	2
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is normal)	2	1	1	1	1	1
VENOUS THROMBO-EMBOLISM (VTE) (includes deep vein thrombosis and pulmonary embolism)						
a) History of VTE	4	2	2	2	1	2
b) Current VTE (on anticoagulants)	4	2	3	3	3	3
c) Family history of VTE						
(i) First degree relative aged < 45 years	3	1	1	1	1	1
(ii) First degree relative aged ≥ 45 years	2	1	1	1	1	1
d) Major surgery						
(i) *With* prolonged immobilisation	4	2	2	2	1	2
(ii) *Without* prolonged immobilisation	2	1	1	1	1	1
e) Minor surgery *without* immobilisation	1	1	1	1	1	1
f) Immobility (unrelated to surgery) e.g.- wheelchair use, debilitating illness	3	1	1	1	1	1
KNOWN THROMBOGENIC MUTATIONS (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)	4	2	2	2	1	2
SUPERFICIAL VENOUS THROMBOSIS						
a) Varicose veins	1	1	1	1	1	1
b) Superficial thrombophlebitis	2	1	1	1	1	1
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	I: 2 / C: 3	3	I: 2 / C: 3	1	I: 2 / C: 3
STROKE (history of cerebrovascular accident)	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	2	2	2	1	2
VALVULAR AND CONGENITAL HEART DISEASE						
a) Uncomplicated	2	1	1	1	1	1
b) Complicated (eg. With pulmonary hypertension, atrial fibrillation, or a history of subacute bacterial endocarditis)	4	1	1	1	2	2

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CATEGORY 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
CATEGORY 4	A condition which represents an unacceptable health risk if the contraceptive method is used

SUMMARY OF CHANGES FROM WHOMEC

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COMMON REVERSIBLE METHODS						
CONDITION	**CHC**	**POP**	**DMPA/ NET-EN**	**IMP**	**Cu-IUD**	**LNG-IUD**
	I = Initiation, C = Continuation					
NEUROLOGIC CONDITIONS						
HEADACHES						
a) Non-migrainous (mild or severe)	I 1 / C 2	I 1 / C 1	I 1 / C 1	I 1 / C 1	1	I 1 / C 1
b) Migraine						
(i) Without aura, age < 35 years	I 2 / C 3	I 1 / C 2	I 2 / C 2	I 2 / C 2	1	I 2 / C 2
(ii) Without aura, age ≥ 35 years	I 3 / C 4	I 1 / C 2	I 2 / C 2	I 2 / C 2	1	I 2 / C 2
(iii) With aura, at any age	I 4 / C 4	I 2 / C 3	I 2 / C 3	I 2 / C 3	1	I 2 / C 3
c) Past history of migraine with aura at any age	3	2	2	2	1	2
EPILEPSY	1	1	1	1	1	1
DEPRESSIVE DISORDERS						
DEPRESSIVE DISORDERS	1	1	1	1	1	1
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS						
VAGINAL BLEEDING PATTERS						
a) Irregular pattern *without* heavy bleeding	1	2	2	2	1	I 1 / C 1
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1	2	2	2	2	I 1 / C 2
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition) Before evaluation	2	2	3	3	I 4 / C 2	I 4 / C 2
ENDOMETRIOSIS	1	1	1	1	2	1
BENIGN OVARIAN TUMOURS (including cysts)	1	1	1	1	1	1
SEVERE DYSMENORRHOEA	1	1	1	1	2	1
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)						
a) hCG normal	1	1	1	1	1	1
b) hCG abnormal	4	3	3	3	4	4
CERVICAL ECTROPION	1	1	1	1	1	1
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	1	2	1	1	2
CERVICAL CANCER (awaiting treatment)	2	1	2	2	I 4 / C 2	I 4 / C 2

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COMMON REVERSIBLE METHODS

I = Initiation, C = Continuation

CONDITION	CHC		POP	DMPA/ NET-EN	IMP	Cu-IUD		LNG-IUD	
	I	C				I	C	I	C
BREAST DISEASE									
a) Undiagnosed mass	3	2	2	2	2	1		2	
b) Benign breast disease	1		1	1	1	1		1	
c) Family history of cancer	1		1	1	1	1		1	
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA1)	3		2	2	2	1		2	
e) Breast cancer									
(i) Current	4		4	4	4	1		4	
(ii) Past and no evidence of current disease for 5 years	3		3	3	3	1		3	
ENDOMETRIAL CANCER	1		1	1	1	4	2	4	2
OVARIAN CANCER	1		1	1	1	3	2	3	2
UTERINE FIBROIDS									
a) Without distortion of the uterine cavity	1		1	1	1	1		1	
b) With distortion of the uterine cavity	1		1	1	1	4		4	
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	
b) Other abnormalities (including cervical stenosis or cervical lacerations) not distorting the uterine cavity or interfering with IUD insertion						2		2	
PELVIC INFLAMMATORY DISEASE									
a) Past PID (assuming no current risk factors of STIs)									
(i) With subsequent pregnancy	1		1	1	1	1	1	1	1
(ii) Without subsequent pregnancy	1		1	1	1	2	2	2	2
b) PID – current	1		1	1	1	4	2	4	2
STIs									
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1		1	1	1	4	2	4	2
b) Other STIs (excluding HIV and hepatitis)	1		1	1	1	2	2	2	2
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1		1	1	1	2	2	2	2
d) Increased risk of STIs	1		1	1	1	2/3	2	2/3	2

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COMMON REVERSIBLE METHODS								
CONDITION	**CHC**	**POP**	**DMPA/ NET-EN**	**IMP**	**Cu-IUD**		**LNG-IUD**	
I = Initiation, C = Continuation								
HIV / AIDS								
HIGH RISK OF HIV	1	1	1	1	I 2	C 2	I 2	C 2
HIV INFECTED								
a) Not using anti-retroviral therapy	1	1	1	1	I 2	C 2	I 2	C 2
b) Using anti-retroviral therapy	2	2	1	2	I 2	C 2	I 2	C 2
AIDS and using HAART	2	2	2	2	I 2	C 2	I 2	C 2
OTHER INFECTIONS								
SCHISTOSOMIASIS								
a) Uncomplicated	1	1	1	1	1		1	
b) Fibrosis of the liver	1	1	1	1	1		1	
TUBERCULOSIS								
a) Non-pelvic	1	1	1	1	I 1	C 1	I 1	C 1
b) Known pelvic	1	1	1	1	I 4	C 3	I 4	C 3
MALARIA	1	1	1	1	1		1	
ENDOCRINE CONDITIONS								
DIABETES								
a) History of gestational disease	1	1	1	1	1		1	
b) Non-vascular disease								
(i) non-insulin dependent	2	2	2	2	1		2	
(ii) insulin dependent	2	2	2	2	1		2	
c) Nephropathy/ retinopathy/ neuropathy	3/4	2	3	2	1		2	
d) Other vascular disease or diabetes of >20 years' duration	3/4	2	3	2	1		2	
THYROID DISORDERS								
a) Simple goitre	1	1	1	1	1		1	
b) Hyperthyroid	1	1	1	1	1		1	
c) Hypothyroid	1	1	1	1	1		1	
GASTROINTESTINAL CONDITIONS								
GALL BLADDER DISEASE								
a) Symptomatic								
(i) treated by cholecystectomy	2	2	2	2	1		2	
(ii) medically treated	3	2	2	2	1		2	
(iii) current	3	2	2	2	1		2	
b) Asymptomatic	2	2	2	2	1		2	
HISTORY OF CHOLESTASIS								
a) Pregnancy related	2	1	1	1	1		1	
b) Past COC-related	3	2	2	2	1		2	
VIRAL HEPATITIS								
a) Active	4	3	3	3	1		3	
b) Carrier	1	1	1	1	1		1	
CIRRHOSIS								
a) Mild (compensated)	3	2	2	2	1		2	
b) Severe (decompensated)	4	3	3	3	1		3	
LIVER TUMOURS								
a) Benign (adenoma)	4	3	3	3	1		3	
b) Malignant (hepatoma)	4	3	3	3	1		3	

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SUMMARY OF CHANGES FROM WHOMEC

Conditions for which there was a classification change for one or more methods or a major modification to the condition description are highlighted.

COMMON REVERSIBLE METHODS								
CONDITION	**CHC**	**POP**	**DMPA/ NET-EN**	**IMP**	**Cu-IUD**		**LNG-IUD**	
I = Initiation, C = Continuation								
INFLAMMATORY BOWEL DISEASE (includes Crohn's disease, Ulcerative colitis)	2	2	1	1	1		1	
ANAEMIAS								
THALASSAEMIA	1	1	1	1	2		1	
SICKLE CELL DISEASE	2	1	1	1	2		1	
IRON DEFICIENCY ANAEMIA	1	1	1	1	2		1	
RAYNAUD'S DISEASE								
a) Primary	1	1	1	1	1		1	
b) Secondary								
(i) *without* lupus anticoagulant	2	1	1	1	1		1	
(ii) *with* lupus anticoagulant	4	2	2	2	1		2	
DRUG INTERACTIONS								
DRUGS WHICH AFFECT LIVER ENZYMES For example Rifampicin, Rifabutin, St John's Wort, Griseofulvin, certain anticonvulsants (phenytoin, carmazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3	3	1	3	1		1	
NON-LIVER ENZYME INDUCING ANTIBIOTICS	2	1	1	1	1		1	
HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)	2	2	2	2	I 2/3	C 2	I 2/3	C 2

References

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2. Murphy MK, Black NA, Lamping DL, McKee CM, Sanderson CFB, Askham J *et al.* Consensus Development Methods, and their use in Clinical Guideline Development. *Health Technology Assesment* 1998;**2**.

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4. Glasier A, Brechin S, Raine R, Penney G. A consensus process to adapt the World Health Organization Selected Practice Recommendations for UK use. *Contraception* 2003;**68**:327-33.

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6. Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Drug Interactions with Hormonal Contraception. *Journal of Family Planning and Reproductive Health Care* 2005;**31**:139-50.

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SECTION B: Tables of contraceptive methods

Table of contents Combined hormonal contraceptives (CHCs)

Please note: References used for the development of this UK version are numbered in **red**. The original WHO references are numbered in **black**.

COMBINED HORMONAL CONTRACEPTIVES (CHCs) *Combined oral contraception (COC); combined transdermal patch; and vaginal ring*	**These methods 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 condoms reduce the risk of STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
PREGNANCY	NA	**Clarification:** Use is not required. There is no known harm to the woman, the course of her pregnancy, or the fetus if accidentally used during pregnancy.
AGE*		**Clarification:** Guidance from the FFPRHC supports use of CHC up to age 50 years if there are no medical contraindications to use.[1]
a)Menarche to < 40 years	1	
b)≥ 40 years	2	
PARITY		
a)Nulliparous	1	
b)Parous	1	
BREASTFEEDING*		
a) < 6 weeks postpartum	4	**Clarification:** Use of combined hormonal methods < 6 weeks postpartum has a detrimental effect on breastmilk volume.[2] Evidence on the effect of combined hormonal contraception on breastmilk quality or quantity >6 weeks postpartum is poor but there appears to be no effect on infant growth. Combined hormonal methods can be used safely but are unlikely to be required if women are fully or almost fully breastfeeding, amenorrhoeic and < 6 months postpartum.[2] Women who are fully or almost fully breastfeeding, amenorrhoeic and < 6 months postpartum can rely on lactational amenorrhoea method (LAM) for contraception unless breastfeeding reduces in frequency or menstruation returns.[3] **Definition:** *Full and almost fully breastfeeding* includes *exclusive* with no other liquids or solids given; *almost exclusive*: vitamins, water or juice given infrequently in addition to breastfeeds; or *partial breastfeeding* where the vast majority of feeds are breastfeeds. *Partial or token breastfeeding*: *Medium* - about half feeds are breastfeeds; *Low* - vast majority of feeds are not breastfeeds; *Minimal* - occasional irregular breastfeeds cannot be relied upon as a contraceptive method.[3]
b) ≥ 6 weeks to < 6 months postpartum *(fully or almost fully breastfeeding)*	3	
c) ≥ 6 weeks to < 6 months postpartum *(partial breastfeeding medium to minimal)*	2	
d) ≥ 6 months postpartum	1	
POSTPARTUM* (in non-breastfeeding women)		**Clarification:** This includes any births, including stillbirths from 24 weeks gestation
a) < 21 days	3	
b) ≥ 21 days	1	

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
POST-ABORTION		**Clarification:** includes induced and spontaneous abortion at <24 weeks gestation. Combined hormonal methods may be started immediately following surgical abortion and immediately after the second part of a medical abortion.
a) First trimester	1	
b) Second trimester	1	
c) Immediate post-septic abortion	1	
PAST ECTOPIC PREGNANCY*	1	
HISTORY OF PELVIC SURGERY	1	
SMOKING		**Evidence:** COC users who smoked were at increased risk of cardiovascular diseases, especially myocardial infarction, compared with those who did not smoke. Studies also showed an increased risk of myocardial infarction (MI) with increasing number of cigarettes smoked per day.[4] Excess mortality from cigarette smoking is apparent from age 35 years. COC use had some adverse effects on ischaemic heart disease in women who smoke ≥ 15 cigarettes per day.[4] For those who stop smoking there is a rapid decrease in risk of cardiovascular disease, by as much as 50% after 1 year. However, it may take up to 10 years to reach the risk levels of those who have never smoked. A population-based case control study confirmed a three-fold reduction in the risk of MI one year after smoking cessation and the excess risk was gone 4 – 6 years after stopping.[5]
a) Age < 35 years	2	
b) Age ≥ 35 years		
(i) <15 cigarettes/day	3	
(ii) ≥15 cigarettes/day	4	
(iii) stopped smoking < 1 year ago	3	
(iv) stopped smoking ≥ 1 year ago	2	
OBESITY		**Evidence:** Obese women who used COCs were at increased risk of VTE compared with non-users. The absolute risk of VTE remained small. Data are limited regarding the impact of obesity on COC effectiveness. [6, 13, 14] Risk of VTE increases with increasing BMI and almost doubles with BMI > 30. COC use further increases VTE risk.[6,7]
a) ≥ 30 - 34 kg/m2 body mass index (BMI)	2	
b) 35 – 39 kg/m2 body mass index (BMI)	3	
c) ≥ 40 kg/m2 body mass index (BMI)	4	
CARDIOVASCULAR DISEASE		
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	**Clarification:** The addition of categories (eg. a combination of two risk factors assigned a category 2) may not necessarily warrant a higher category.

*See also additional comments at end of table

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
HYPERTENSION*		
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. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive. If elevated the BP should be re-assessed at the end of the consultation. If blood pressure is increased it should be re-assessed on at least two subsequent clinic visits at monthly intervals.[8, 9]		
a) Adequately controlled hypertension b) Consistently elevated blood pressure levels (properly taken measurements) (i) systolic >140 to 159 mmHg or diastolic > 90 to 94mmHg (ii) systolic ≥ 160 or diastolic ≥ 95 mmHg c) Vascular disease	3 3 4 4	**Clarification:** Women adequately treated for hypertension are at reduced risk of acute myocardial infarction and stroke compared to 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. Guidelines from the British Hypertension Society suggest that although estrogen-containing contraception may be used for women with adequately controlled BP other methods may be more suitable.[8] **Evidence:** Among women with hypertension, COC users were at increased risk of stroke, acute myocardial infarction, and peripheral arterial disease compared with non-users. [1, 3, 9-11, 15-31] **Clarification:** Anti-hypertensive therapy may be initiated when the BP is consistently 160/100 mmHg or greater.[9] Decisions about the initiation or continued use of combined hormonal contraception should be made at lower BP levels, and alternative contraception may be advised. **Clarification:** *Vascular disease* includes: coronary heart disease presenting with angina; peripheral vascular disease presenting with intermittent claudication; hypertensive retinopathy; and transient ischaemic attacks.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure normal)	2	**Evidence:** Women who had a history of high blood pressure in pregnancy, who also used COCs, had 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. The absolute risks of acute myocardial infarction and venous thromboembolism in this population remained small.[11, 17-19, 21, 32-37]

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
VENOUS THROMBOEMBOLISM (VTE)*		**Clarification:** VTE Includes deep vein thrombosis (DVT) and pulmonary embolism (PE)
a) History of VTE	4	
b) Current VTE (on anticoagulants)	4	***Current VTE*** refers to disease for which anti-coagulants are being used
c) Family history of VTE		***Family history*** may alert clinicians to women who may have an increased risk themselves but alone cannot identify with any certainty an underlying thrombophilia. Even when a genetic thrombophilia is identified not every woman will go on to develop a VTE. Exposure to risk factors (eg. CHC) may increase the risk for some women.[10] Young women may not yet have a first-degree relative aged 45 years. A thrombophilia screen may be considered with expert clinical judgement with family history of VTE in a first degree relative aged < 45 years. A negative screen does not alter the category given. Use of CHC is not usually recommended.[10]
(i) first-degree relative age < 45 years	3	
(ii) first-degree relative age ≥ 45 years	2	
d) Major surgery		***Major Surgery*** includes operations of > 30 minutes duration. Procedures with high risk of VTE include: general or orthopaedic surgery, trauma, neurosurgery.[11] CHC should be discontinued at least 4 weeks prior to major elective surgery and advice given on appropriate alternative methods.
(i) *with* prolonged immobilisation	4	
(ii) *without* prolonged immobilisation	2	
e) Minor surgery without immobilisation	1	***Minor surgery*** includes operations lasting < 30 minutes (eg laparoscopic sterilisation), procedures such as knee arthroscopy. Varicose vein surgery has a low risk for VTE.[11]
f) Immobility (unrelated to surgery) e.g. *wheelchair use, debilitating illness*	3	***Immobility:*** due to hospitalisation for acute trauma, acute illness, or paralysis, is associated with a high risk of VTE. Continuation of CHC should be reconsidered and alternative methods used until mobile.
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	4	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. **Evidence:** Among women with thrombogenic mutations, COC users had a two to twenty-fold higher risk of thrombosis than non-users.[38-51]
SUPERFICIAL VENOUS THROMBOSIS*		
a) Varicose veins	1	
b) Superficial thrombophlebitis	2	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE*	4	

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
STROKE* (history of cerebrovascular accident)	4	
KNOWN HYPERLIPIDAEMIAS*	2 / 3	**Clarification:** 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. Lipid levels alone are poor predictors of risk of coronary heart disease (CHD). In the UK screening and treatment is aimed towards those at greatest risk of CHD, and this may also influence hormonal contraceptive use. Risk categories will vary depending on risk of premature coronary heart disease and the presence of other risk factors.[12] *Common hypercholesterolaemia* and *Familial combined hyperlipidaemia* are associated with an increased risk of CHD but usually this occurs over the age of 60 years.[12] *Familial hypercholesterolaemia* (autosomal dominant) has a prevalence of about 1 in 500. People with this condition have a four-fold increase in the risk of premature CHD.[12]
VALVULAR AND CONGENITAL HEART DISEASE*		
a) Uncomplicated	2	**Clarification:** *Valvular heart disease* occurs when any of the four heart valves are stenotic and/or incompetent (eg. aortic stenosis, mitral regurgitation; tricuspid valve abnormalities; pulmonary stenosis).[13] *Congenital heart disease* includes Aortic stenosis; Atrial septal defects; Atrio-ventricular septal defect; Cardiomyopathy; (hypertrophic or dilated); Co-arctation of the Aorta; Complex Transposition of the Great Arteries; Ebstein's Anomaly; Eisenmenger Syndrome: Persistent Ductus Arteriosus; Pulmonary Atresia; Pulmonary Stenosis; Tetralogy of Fallot; Total Anomalous Pulmonary Venous Connection; Tricuspid Atresia ; Truncus Arteriosus; Ventricular Septal Defect.[14] Surgical correction and ongoing cardiac problems should be considered when considering contraceptive use.
b) Complicated *(eg. with pulmonary hypertension,atrial fibrillation, history of subacute bacterial endocarditis)*	4	

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
NEUROLOGIC CONDITIONS		
HEADACHES*	**I** / **C**	**Clarification:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not.
a) Non-migrainous *(mild or severe)*	1 / 2	**Definitions:** *Non-migrainous headaches* include tension-type, cluster or rebound headaches.[15] Migraine headaches are associated with *aura (focal symptoms)* which indicate ischaemia. Aura includes: homonymous hemianopia, unilateral paraesthesia and/or numbness; unilateral weakness; and aphasia or unclassifiable speech disorder. Visual symptoms progress from fortification spectra (a star shaped figure near the point of fixation with scintillating edges) to scotoma (a bright shape which gradually increases in size). Flashing lights are not classified as aura.[16] Aura occurs before the onset of headache.
b) Migraine		
(i) *without* aura *Age < 35*	2 / 3	
(ii) *without* aura *Age ≥ 35*	3 / 4	
(iii) *with* aura, at any age	4 / 4	
c) Past history of migraine with aura at any age	3	**Evidence:** Among women with migraine, those who had aura had a higher risk of stroke than those without aura.[52-54] Among women with migraine, those who used COCs had a 2 to 4-fold increased risk of stroke compared with women who did not use COCs.[52-54] Risk of stroke increases with age, hypertension and smoking. If migraine with aura develops as a *new symptom* in women using combined hormonal contraception the risks and benefits of *continuing* these methods should be discussed.
EPILEPSY	1	**Clarification:** If a woman is taking liver enzyme inducing anticonvulsants, refer to the section on drug interactions. Certain anticonvulsants lower COC effectiveness.
DEPRESSIVE DISORDERS		
DEPRESSIVE DISORDERS	1	**Clarification:** The classification is based on data for women with selected depressive disorders. No data on bipolar disorder or postpartum depression were available. There is a potential for drug interactions between certain antidepressant medications and hormonal contraceptives. **Evidence:** COC use did not increase depressive symptoms in women with depression compared to baseline or to non-users with depression.[59-61]
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS		
VAGINAL BLEEDING PATTERNS*		
a) Irregular pattern *without* heavy bleeding	1	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1	**Clarification:** Unusually heavy bleeding should raise the suspicion of a serious underlying condition.[17, 18]

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
UNEXPLAINED VAGINAL BLEEDING* (suspicious for serious condition) Before evaluation	2	**Clarification:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation.
ENDOMETRIOSIS*	1	
BENIGN OVARIAN TUMOURS (including cysts)	1	
SEVERE DYSMENORRHOEA	1	**Evidence:** There was no increased risk of side-effects with COC use among women with dysmenorrhoea compared to women not using COCs. Some COC users had a reduction in pain and bleeding.[62, 63]
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole & placental tumour)		**Clarification:** GTN includes hydatidiform mole, invasive mole and placental site trophoblastic tumour **Evidence:** Among women with GTN there was no difference in mean times to hCG normalisation or incidence of postmolar trophoblastic disease for COC users compared to non-hormonal users.[64-71] In the UK management includes assessment of serum hCG concentrations. The need for chemotherapy is based on serum hCG concentrations during follow up.[19] The safety of using hormonal contraceptives is based on measurement of serum hCG.
a) hCG normal	1	
b) hCG abnormal	4	
CERVICAL ECTROPION*	1	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	**Evidence:** Among women with persistent HPV infection, long-term COC use (≥ 5 years) may increase the risk of carcinoma in situ and invasive carcinoma.[72]
CERVICAL CANCER* (awaiting treatment)	2	
BREAST DISEASE*	**I** / **C**	
a) Undiagnosed mass	3 / 2	**Clarification:** Evaluation should be pursued as early as possible.
b) Benign breast disease	1	
c) Family history of cancer	1	**Evidence:** Among COC users with a family history of breast cancer, there was no increased risk of breast cancer compared with non-COC users with a family history of breast cancer.[73-80] Among women with BRCA1 mutations, COC users may have a small increased risk of breast cancer compared with non-users.[81-83]
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA 1)	3	
e) Breast cancer		
(i) current	4	
(ii) past and no evidence of current disease for 5 years	3	

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ENDOMETRIAL CANCER*	1	
OVARIAN CANCER*	1	
UTERINE FIBROIDS*		
a) Without distortion of the uterine cavity	1	
b) With distortion of the uterine cavity	1	
PELVIC INFLAMMATORY DISEASE (PID)*		
a) Past PID (assuming no current risk factors for STIs)		
(i) with subsequent pregnancy	1	
(ii) without subsequent pregnancy	1	
b) PID - current	1	
STIs*		
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	**Evidence:** Evidence suggests that there may be an increased risk of chlamydial cervicitis among COC users at high risk of STIs. For other STIs, there is either evidence of no association between COC use and STI acquisition or limited evidence which is insufficient to draw any conclusions.[84-160]
b) Other STIs (excluding HIV and hepatitis)	1	
c) Vaginitis (including Trichomonas vaginalis and Bacterial vaginosis)	1	
d) Increased risk of STIs	1	
HIV/AIDS		
HIGH RISK OF HIV*	1	**Evidence:** Overall, evidence is inconsistent regarding whether there is any increased risk of HIV acquisition among COC users compared with non-users.

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COMBINED HORMONAL CONTRACEPTIVES (CHCs) *Combined oral contraception (COC); combined transdermal patch; and vaginal ring*	**These methods 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 condoms reduce the risk of STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
HIV-INFECTED a) Not using anti-retroviral therapy b) Using interacting anti-retroviral therapy	1 2	**Evidence:** Limited evidence suggests no association between COC use and changes in RNA levels or CD4 counts among HIV-infected women. There is also limited evidence showing no association between COC use and female to male HIV transmission, and mixed results regarding increased risk of HIV and herpes simplex virus (HSV) shedding among HIV-infected women using hormonal contraception.[161, 199-204] Highly active anti-retroviral therapy (HAART) includes some anti-retrovirals, which can induce liver enzymes and thus potentially reduce the efficacy of combined hormonal methods. These methods may still be used safely in women using HAART, but additional contraceptive protection such as condoms should be advised.[20](see Annex 1)
AIDS and using HAART	2	**Clarification:** Highly active anti-retroviral therapy (HAART) includes some anti-retrovirals, which may induce liver enzymes and potentially reduce the efficacy of combined hormonal methods. [20] (see drug interactions)
OTHER INFECTIONS		
SCHISTOSOMIASIS a) Uncomplicated b) Fibrosis of liver (if severe, see cirrhosis)	1 1	**Evidence:** Among women with uncomplicated schistosomiasis, COC use had no adverse effects on liver function.[205-211]
TUBERCULOSIS a) Non-pelvic b) Known pelvic	1 1	**Clarification:** If a woman is taking rifampicin, refer to the section on drug interactions. Rifampicin is likely to decrease CHC effectiveness.
MALARIA	1	**Clarification:** Doxycycline is increasingly used in the treatment of malaria.[21] (see drug interactions) No changes in the pharmacokinetics of ethinylestradiol or progestogens were identified with Doxycycline use.[22] Advice is as for other non-liver enzyme inducing antibiotics.[21]

*See also additional comments at end of table

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

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
ENDOCRINE CONDITIONS		
DIABETES*		
a) History of gestational disease	1	
b) Non-vascular disease		
(i) non-insulin dependent	2	
(ii) insulin dependent	2	
c) Nephropathy/ retinopathy/ neuropathy	3/4	**Clarification:** 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 DISORDERS		
a) Simple goitre	1	
b) Hyperthyroid	1	
c) Hypothyroid	1	
GASTROINTESTINAL CONDITIONS		
GALL-BLADDER DISEASE*		
a) Symptomatic		
(i) treated by cholecystectomy	2	
(ii) medically treated	3	
(iii) current	3	
b) Asymptomatic	2	
HISTORY OF CHOLESTASIS*		
a) Pregnancy-related	2	
b) Past COC-related	3	
VIRAL HEPATITIS*		
a) Active	4	
b) Carrier	1	
CIRRHOSIS*		**Clarification**:
a) Mild (compensated)	3	*Mild (compensated) cirrhosis:* without complications
b) Severe (decompensated)	4	*Severe (decompensated) cirrhosis:* development of major complications (such as ascites, jaundice, encephalopathy, or gastrointestinal haemorrhage).[23]

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CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
LIVER TUMOURS*		
a) Benign (adenoma)	4	
b) Malignant (hepatoma)	4	
INFLAMMATORY BOWEL DISEASE (includes Crohn's disease and ulcerative colitis)	2	**Clarification:** includes Crohn's disease, Ulcerative colitis. Continuation may need to be reviewed if the woman has an acute exacerbation, acute surgery or prolonged immobilisation (see section on VTE).[24] Absorption of oral contraception may be reduced if severe malabsorption due to small bowel involvement, but is unaffected by colectomy and ileostomy.
ANAEMIAS		
THALASSAEMIA*	1	
SICKLE CELL DISEASE	2	
IRON-DEFICIENCY ANAEMIA*	1	
RAYNAUD'S DISEASE*		
a) Primary	1	**Clarification:** Primary Raynaud's is not a contraindication to use of combined hormonal contraception. Secondary Raynaud's has an underlying cause such as scleroderma, rheumatoid arthritis, systemic lupus erythematosus. Systemic lupus erythematosus causes a tendency for increased coagulation if lupus anticoagulant is present. [1; 25-29]
b) Secondary		
(i) *without* lupus anticoagulant	2	
(ii) *with* lupus anticoagulant	4	
DRUG INTERACTIONS*		
DRUGS WHICH AFFECT LIVER ENZYMES For example Rifampicin, Rifabutin, St John's Wort, Griseofulvin, certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3	**Clarification:** Although the interaction of rifampicin and rifabutin or certain anticonvulsants with COCs does not affect safety of CHC use, and is not harmful to women, it is likely to reduce the contraceptive effectiveness. Use of contraceptives which are unaffected by liver enzyme inducers should be encouraged for women who are long-term users of these drugs. For short-term use additional contraception is advised such as condoms while using the liver enzyme inducer and for 4 weeks after cessation. [21] **Evidence:** Use of rifampicin and certain anticonvulsants may decrease the contraceptive effectiveness of COCs.[212-237] St John's Wort and griseofulvin are liver enzyme inducers, but are less potent than rifampicin. [21]
NON-LIVER ENZYME INDUCING ANTIBIOTICS	2	**Evidence:** The contraceptive effectiveness of COCs may not be affected by co-administration of antibiotics.[238-290] The FFPRHC advise that women taking a short course (<3 weeks) of non-liver enzyme inducing antibiotics should be advised to use additional contraceptive protection such as condoms during the treatment and for 7 days after the antibiotic is stopped, due to the risks of unintended pregnancy. [21]

*See also additional comments at end of table

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COMBINED HORMONAL CONTRACEPTIVES (CHCs) *Combined oral contraception (COC); combined transdermal patch; and vaginal ring*	**These methods 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 condoms reduce the risk of STI/HIV.**	
CONDITION	**CATEGORY** I=Initiation C=Continuation	**CLARIFICATIONS/EVIDENCE- Most evidence available relates to COC use. However, this evidence is also applied to patch and ring use.**
HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)	2	**Clarification:** It is important to note that antiretroviral drugs (ARV) have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. The limited data available (outlined in Annex 1) suggest that potential drug interactions between many ARVs (particularly some non-nucleoside reverse transcriptase inhibitors (NNRTIs) and protease inhibitors (PIs) and hormonal contraceptives may alter safety and effectiveness of both the hormonal contraceptives and the ARVs. Thus, if a woman on ARV treatment decides to initiate or continue hormonal contraceptive use, the consistent use of condoms is recommended for preventing HIV transmission and may also compensate for any possible reduction in the effectiveness of the hormonal contraceptive. (**Evidence:** See Annex 1.)

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Additional comments

AGE

Menarche to < 40 years: Theoretical concerns about the use of combined hormonal contraceptives among young adolescents have not been substantiated.

≥ **40 years:** The risk of cardiovascular disease increases with age and may also increase with combined hormonal contraceptive use. In the absence of other adverse clinical conditions, combined hormonal contraceptives can be used until menopause. FFPRHC Guidance suggests women can use combined methods until age 50 years if they have no other medical contraindications. [28]

BREASTFEEDING

< 6 weeks postpartum: There is some theoretical concern that the neonate may be at risk due to exposure to steroid hormones during the first 6 weeks postpartum. FFPRHC Guidance suggest avoiding combined methods < 6 weeks postpartum.[1]

≥ **6 weeks to < 6 months:** Evidence that 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 is limited. FFPRHC Guidance suggests combined hormonal methods may be used from 6 weeks postpartum if other methods are unacceptable.[1]

POSTPARTUM

< 21 days: There is some theoretical concern regarding the association between combined hormonal contraceptive use up to 3 weeks postpartum and risk of thrombosis in the mother. Blood coagulation and fibrinolysis are essentially normalized by 3 weeks postpartum.

PAST ECTOPIC PREGNANCY

The risk of future ectopic pregnancy is increased among women who have had an ectopic pregnancy in the past. Combined hormonal contraceptives provide protection against pregnancy in general, including ectopic gestation.

HYPERTENSION

Vascular disease: Among women with underlying vascular disease, the increased risk of arterial thrombosis associated with combined hormonal contraceptive use should be avoided.

VENOUS THROMBOEMBOLISM (VTE)

Family history of VTE (first-degree relatives): Some conditions which increase the risk of VTE are heritable. Some women considering combined hormonal contraceptive use may not have first degree relatives yet who have reached age 45 years.

Major surgery: The degree of risk of VTE associated with major surgery varies depending on the length of time that a woman is immobilised. There is no need to stop combined hormonal contraceptives prior to female surgical sterilisation. Immobilisation due to non-surgical causes may increase risk of VTE.

SUPERFICIAL VENOUS THROMBOSIS

Varicose veins: Varicose veins are not risk factors for VTE.

CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE

Among women with underlying vascular disease, the increased risk of arterial thrombosis associated with combined hormonal contraceptive use should be avoided.

STROKE

Among women with underlying vascular disease, the increased risk of arterial thrombosis associated with combined hormonal contraceptive use should be avoided.

KNOWN HYPERLIPIDAEMIAS

Lipid levels alone are poor predictors of risk coronary heart disease (CHD).

VALVULAR HEART DISEASE

Among women with valvular heart disease, combined hormonal contraceptive use may further increase the risk of arterial thrombosis; women with complicated valvular heart disease are at greatest risk.

CONGENITAL HEART DISEASE

Surgical correction, co-existing complications, and degree of cardiac disability will vary and should be taken into account when considering contraceptive use.

HEADACHES

Aura is a specific focal neurologic symptom. For more information on this and other diagnostic criteria, see: Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders, 2nd Edition. Cephalalgia. 2004; 24 (Suppl 1): 1- 150. http://216.25.100.131/ihscommon/guidelines/pdfs/ihc_ II _main_no_print.pdf

VAGINAL BLEEDING PATTERNS

Irregular menstrual bleeding patterns are common among healthy women.

UNEXPLAINED VAGINAL BLEEDING

There are no conditions that cause vaginal bleeding that will be worsened in the short term by use of combined hormonal contraceptives.

ENDOMETRIOSIS
Combined hormonal contraceptives do not worsen, and may alleviate, the symptoms of endometriosis.

CERVICAL ECTROPION
Cervical ectropion is not a risk factor for cervical cancer, and there is no need for restriction of combined hormonal contraceptive use.

CERVICAL CANCER (awaiting treatment)
There is some theoretical concern that combined hormonal contraceptive use may affect prognosis of the existing disease. While awaiting treatment, women may use combined hormonal contraceptives. In general, treatment of this condition renders a woman sterile.

BREAST DISEASE
Family history of breast cancer: Women with BRCA1 or BRCA2 mutations have a much higher baseline risk of breast cancer than women who do not have these mutations. Most women with a family history of breast cancer do not have these mutations. Known carriers may consider use of combined hormonal contraception.

Breast cancer: Breast cancer is a hormonally sensitive tumour, and the prognosis of women with current or recent breast cancer may worsen with combined hormonal contraceptive use.

ENDOMETRIAL CANCER
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
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
COCs do not appear to cause growth of uterine fibroids.

PELVIC INFLAMMATORY DISEASE (PID)
COCs may reduce the risk of PID among women with STIs, but do not protect against HIV or lower genital tract STIs.

STIs
COCs may reduce the risk of PID among women with STIs, but do not protect against HIV or lower genital tract STIs.

HIGH RISK OF HIV
COCs may reduce the risk of PID among women with STIs, but do not protect against HIV or lower genital tract STIs.

DIABETES
Although carbohydrate tolerance may change with combined hormonal contraceptive use, the major concerns are vascular disease due to diabetes and additional risk of arterial thrombosis due to combined hormonal contraceptive use.

GALL-BLADDER DISEASE
COCs may cause a small increased risk of gall-bladder disease. There is also concern that COCs may worsen existing gall-bladder disease.

HISTORY OF CHOLESTASIS
Pregnancy-related: History of pregnancy-related cholestasis may predict an increased risk of developing COC-associated cholestasis.

Past COC-related: History of COC-related cholestasis predicts an increased risk with subsequent COC use.

VIRAL HEPATITIS
Active: COCs are metabolised by the liver, and their use may adversely affect women whose liver function is compromised.

CIRRHOSIS
COCs are metabolised by the liver and their use may adversely affect women whose liver function is compromised.

LIVER TUMOURS
COCs are metabolised 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.

INFLAMMATORY BOWEL DISEASE (IBD)
There is no evidence that women with IBD have an inherent increased risk of VTE. Risk of VTE may increase if unwell, bedbound or undergoing acute surgery or with major surgery and prolonged immobilisation. Under these circumstances the use of combined methods should be avoided and alternative methods used.

THALASSAEMIA
There is anecdotal evidence from countries where thalassaemia is prevalent that COC use does not worsen the condition.

IRON-DEFICIENCY ANAEMIA
Combined hormonal contraceptive use may decrease menstrual blood loss.

RAYNAUD'S DISEASE

Combined hormonal methods may be used in 'Primary' disease but underlying cause of secondary disease may influence safety of use.

DRUG INTERACTIONS

Generally safety of using combined hormonal methods is unaffected. Nevertheless use of liver enzyme inducers or antibiotics may reduce contraceptive efficacy, increasing risk of unintended pregnancy. Contraceptive choice may depend on the likely duration of use of concurrent medications and need for additional or alternative methods.

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Please note: References used for the development of this UK version are numbered in **red**. The original WHO references are numbered in **black**.

PROGESTOGEN-ONLY CONTRACEPTIVES (POCs) *Includes progestogen-only pills (POP); progestogen-only injectables(depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN]); and progestogen-only implants (IMP)*	**These methods 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 condoms reduce the risk of STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**CLARIFICATIONS/EVIDENCE**
	POP	**DMPA/ NET-EN**	**IMP**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY				
PREGNANCY	NA	NA	NA	**Clarification:** 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	**Evidence:** Limited evidence shows decreased bone mineral density over time among adolescent DMPA users, but not among levonorgestrel implant users. [1-10] [1-5] The FFPRHC support the use of DMPA by adolescents if after counselling about potential effects on bone density other methods are not acceptable.[11]
b) 18 to 45 years	1	1	1	**Evidence:** In general, current DMPA users had decreased bone mineral density compared with non-users; this decrease was usually within one standard deviation of normal values.[6] Results for current Norplant users were mixed.[6] One study of Implanon users showed no change in bone mineral density over two years.[7]
c) > 45 years	1	2	1	**Evidence:** Older DMPA users had decreased bone mineral density compared with non-users. However, limited evidence found that women gained bone mass following discontinuation of DMPA prior to menopause. Further, among postmenopausal women, there was no difference in bone mineral density between former DMPA users and never users. [1;4;5;12-14] [8-13]
PARITY				
a) Nulliparous	1	1	1	
b) Parous	1	1	1	

*See also additional comments at end of table

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PROGESTOGEN-ONLY CONTRACEPTIVES (POCs) *Includes progestogen-only pills (POP); progestogen-only injectables(depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN]); and progestogen-only implants (IMP)*	**These methods 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 condoms reduce the risk of STI/HIV.**			
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	POP	**DMPA/ NET-EN**	**IMP**	
BREASTFEEDING*				
a) < 6 weeks postpartum	1	2	1	**Evidence:** There is no evidence that POCs have a detrimental effect on breast milk or infant growth. FFPRHC suggest use before 6 weeks, but ideally delay until Day 21.[15]
b) ≥ 6 weeks to < 6 months postpartum (fully or almost fully breastfeeding)	1	1	1	Women who are fully or almost fully breastfeeding, amenorrhoeic and < 6 months postpartum can rely on lactational amenorrhoea method (LAM) for contraception unless breast feeding reduces or menstruation returns. **Definition:** *Fully and almost fully breastfeeding* includes exclusive with no other liquids or solids given; *almost exclusive:* vitamins, water or juice given infrequently in addition to breastfeeds; *partial* (high) where the vast majority of feeds are breastfeeds.
c) ≥ 6 weeks to < 6 months postpartum (partial breastfeeding medium to low)	1	1	1	**Definition:** *Partial or token breastfeeding: Medium* – about half feeds are breastfeeds; *Low*- vast majority of feeds are not breastfeeds; *Minimal*- occasional irregular breastfeeds.[15]
d) ≥ 6 months postpartum	1	1	1	
POSTPARTUM* (in non-breastfeeding women)				**Clarification:** This includes any births, including stillbirths from 24 weeks gestation
a) < 21 days	1	1	1	
b) ≥ 28 days	1	1	1	
POST-ABORTION				
a) First trimester	1	1	1	**Clarification:** Includes spontaneous or induced abortion < 24 weeks gestation. POCs can be commenced immediately following surgical abortion or following the second part of medical abortion.[16] **Evidence:** Limited evidence suggests that there are no adverse side effects when Norplant or NET-EN are initiated after a first trimester abortion.[39-42]
b) Second trimester	1	1	1	
c) Immediate post-septic abortion	1	1	1	

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PAST ECTOPIC PREGNANCY*	1	1	1	**Clarification:** The risk of ectopic pregnancy is lower with POC than for women not using contraception. Methods which inhibit ovulation will prevent extrauterine and intrauterine pregnancies.
HISTORY OF PELVIC SURGERY	1	1	1	
SMOKING				
a) Age < 35 years	1	1	1	**Evidence:** Myocardial infarction (MI) is rare in women of reproductive age. Smoking is an important risk factor for cardiovascular disease. Overall mortality is strongly related to smoking. Excess mortality in heavy smokers is apparent from age 35 years.[17] Risk of MI increases as the number of cigarettes smoked per day increases. Progestogen-only methods do not appear to increase the risk of cardiovascular disease. For those who stop smoking there is a rapid decrease in risk of cardiovascular disease, by as much as 50% after 1 year. However, it may take up to 10 years to reach the risk levels of those who have never smoked. A population-based case control study confirmed a three-fold reduction in the risk of MI one year after smoking cessation and the excess risk was gone 4 – 6 years after stopping.[18]
b) Age ≥ 35 years				
(i) < 15 cigarettes per day	1	1	1	
(ii) ≥ 15 cigarettes per day	1	1	1	
(iii) stopped smoking < 1 year ago	1	1	1	
(iv) stopped smoking ≥ 1 year ago	1	1	1	
OBESITY				
a) ≥ 30 – 34 kg/m² body mass index (BMI)	1	1	1	**Evidence:** Studies provide conflicting evidence regarding whether obese women are at increased risk of weight gain and bleeding problems with DMPA use relative to non-obese women with DMPA use.[43-45]
b) 35 – 39 kg/m² body mass index (BMI)	1	1	1	
c) ≥ 40 kg/m² body mass index (BMI)	1	1	1	

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	POP	**DMPA/ NET-EN**	**IMP**	
CARDIOVASCULAR DISEASE				
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	2	3	2	**Clarification:** When multiple major risk factors exist, risk of cardiovascular disease may increase substantially. The effects of DMPA and NET-EN may persist for some time after discontinuation. Evidence suggests that there are alterations in lipids with all progestogen only contraceptives with injectables and oral methods having more of an effect than intrauterine methods.
HYPERTENSION				
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. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive. If elevated, the BP should be re-assessed at the end of the consultation. If blood pressure is increased it should be re-assessed on at least two subsequent clinic visits at monthly intervals.[19;20]				
a) Adequately controlled hypertension b) Consistently elevated blood pressure levels (properly taken measurements)	1	2	1	**Clarification:** 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, POC users with adequately controlled and monitored hypertension should be at reduced risk of acute myocardial infarction and stroke compared with untreated hypertensive POC users. Anti-hypertensive therapy may be initiated when the BP is consistently of 160/100 mmHg or greater.[20] **Evidence:** Limited evidence suggests that among women with hypertension, those who used POPs or progestogen-only injectables had a small increased risk of cardiovascular events compared with women who did not use these methods.[49]
(i) systolic > 140- 159 mmHg or diastolic > 90-94 mmHg	1	1	1	
(ii) systolic > 160 or diastolic > 95 mmHg	1	2	1	
c) Vascular disease*	2	3	2	**Clarification:** *Vascular disease* includes: coronary heart disease presenting with angina; peripheral vascular disease presenting with intermittent claudication; hypertensive retinopathy; and transient ischaemic attacks.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is normal)	1	1	1	

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VENOUS THROMBO-EMBOLISM (VTE)*				**Clarification:** VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE)
a) History of VTE	2	2	2	
b) Current VTE (on anticoagulants)	2	3	3	***Current VTE*** refers to disease for which anti-coagulants are still being used. Initiating injectables or implants in women using anti-coagulants may increase the risk of haematoma, but they may be used with clinical judgement and may need appropriate specialist referal. Women using POC when VTE is diagnosed may continue use with advice, counselling and clinical judgement. Evidence is limited on the risk of VTE with POCs, however existing evidence is reassuring.[21]
c) Family history of VTE				
(i) first degree relative age < 45 years	1	1	1	
(ii) first degree relative age ≥ 45 years	1	1	1	
d) Major surgery				***Major Surgery*** includes operations of > 30 minutes duration. Procedures with high risk of VTE include: general or orthopaedic surgery, trauma, neurosurgery.[22]
(i) *with* prolonged immobilisation	2	2	2	
(ii) *without* prolonged immobilisation	1	1	1	
e) Minor surgery without immobilisation	1	1	1	***Minor surgery*** includes operations lasting < 30 minutes (eg laparoscopic sterilisation), procedures such as knee arthroscopy. Varicose vein surgery has a low risk for VTE.
f) Immobility (unrelated to surgery) e.g. *wheelchair use, debilitating illness*	1	1	1	***Immobility*** due to hospitalisation for acute trauma, acute illness, paralysis is associated with a high risk of VTE.
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	2	2	2	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
SUPERFICIAL VENOUS THROMBOSIS				
a) Varicose veins	1	1	1	
b) Superficial thrombophlebitis	1	1	1	

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PROGESTOGEN-ONLY CONTRACEPTIVES (POCs) *Includes progestogen-only pills (POP); progestogen-only injectables(depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN]); and progestogen-only implants (IMP)*	**These methods 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 condoms reduce the risk of STI/HIV.**			
CONDITION	**CATEGORY** I=Initiation, C=Continuation			**CLARIFICATIONS/EVIDENCE**
	POP	**DMPA/ NET-EN**	**IMP**	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE*	**I** 2 / **C** 3	3	**I** 2 / **C** 3	
STROKE* (history of cerebrovascular accident)	**I** 2 / **C** 3	3	**I** 2 / **C** 3	
KNOWN HYPERLIPIDAEMIAS	2	2	2	**Clarification:** 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. Lipid levels alone are poor predictors of risk coronary heat disease (CHD). In the UK screening and treatment is aimed towards those at greatest risk of CHD, and this may also influence hormonal contraceptive use. Risk categories will vary depending on risk of premature coronary heart disease and the presence of other risk factors.[23] *Common hypercholesterolaemia* and *Familial combined hyperlipidaemia* are associated with an increased risk of CHD but usually this occurs over the age of 60 years.[23] *Familial hypercholesterolaemia* (autosomal dominant) has a prevalence of about 1 in 500. People with this condition have a four-fold increase in the risk of premature CHD.[23]

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CONDITION	**CATEGORY** I=Initiation, C=Continuation			**CLARIFICATIONS/EVIDENCE**
	POP	**DMPA/ NET-EN**	**IMP**	
VALVULAR AND CONGENITAL HEART DISEASE				
a) Uncomplicated	1	1	1	**Clarification:** *Valvular heart disease* occurs when any heart valves are stenotic and/or incompetent (eg. Aortic stenosis, mitral regurgitation; tricuspid valve abnormalities; pulmonary stenosis).[24] *Congenital heart disease:* Aortic stenosis; Atrial septal defects; Atrio-ventricular septal defect; Cardiomyopathy; (hypertrophic or dilated); Co-arctation of the Aorta; Complex Transposition of the Great Arteries; Ebstein's Anomaly; Eisenmenger Syndrome: Persistent Ductus Arteriosus; Pulmonary Atresia; Pulmonary Stenosis; Tetralogy of Fallot; Total Anomalous Pulmonary Venous Connection; Tricuspid Atresia; Truncus Arteriosus; Ventricular Septal Defect.[25] Surgical correction and ongoing cardiac problems should be considered.
b) Complicated (eg. Pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	1	1	1	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation						**CLARIFICATIONS/EVIDENCE**
	POP		**DMPA/ NET-EN**		**IMP**		
NEUROLOGIC CONDITIONS							
HEADACHES*	**I**	**C**	**I**	**C**	**I**	**C**	
a) Non-migrainous *(mild or severe)*	1	1	1	1	1	1	**Clarification:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not. *Non-migrainous headaches* include tension-type, cluster or rebound headaches.[25]
b) Migraine							
(i) *without* aura Age < 35	1	2	2	2	2	2	
(ii) *without* aura Age ≥ 35	1	2	2	2	2	2	
(iii) *with* aura, at any age	2	3	2	3	2	3	*Aura (focal symptoms)* indicates ischaemia: homonymous hemianopia, unilateral paraesthesia and /or numbness, unilateral weakness; and aphasia or unclassifiable speech disorder. Visual symptoms progress from fortification spectra (a star shaped figure near the point of fixation with scintillating edges) to scotoma (a bright shape which gradually increases in size). Flashing lights are not focal symptoms.[27] Aura occurs before the onset of headache.
c) Past history of migraine with aura at any age	2		2		2		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.
EPILEPSY	1		1		1		**Clarification:** If a woman is taking liver enzyme inducing anticonvulsants, refer to the section on drug interactions. Certain anticonvulsants lower efficacy of POP and implant.
DEPRESSIVE DISORDERS							
DEPRESSIVE DISORDERS	1		1		1		**Clarification:** The classification is based on data for women with selected depressive disorders. No data on bipolar disorder or postpartum depression were available. There is a potential for drug interactions between certain antidepressant medications and hormonal contraceptives. **Evidence:** POCs did not increase depressive symptoms in women with depression compared to baseline.[50-53]

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	POP	**DMPA/ NET-EN**	**IMP**	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS				
VAGINAL BLEEDING PATTERNS*				
a) Irregular pattern *without* heavy bleeding	2	2	2	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2	2	2	**Clarification:** Unusually heavy bleeding should raise the suspicion of a serious underlying condition. [28;29]
UNEXPLAINED VAGINAL BLEEDING* (suspicious for serious underlying condition) Before evaluation	2	3	3	**Clarification:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation.
ENDOMETRIOSIS	1	1	1	
BENIGN OVARIAN TUMOURS (including cysts)	1	1	1	
SEVERE DYSMENORRHOEA	1	1	1	
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)				**Clarification:** In the UK management depends on serum hCG concentrations and need for chemotherapy identified by measuring hCG concentrations.[30] POC can be used if hCG is abnormal, but discussion with family planning specialist and national centres, and clinical judgement is necessary.
a) hCG normal	1	1	1	
b) hCG abnormal	3	3	3	
CERVICAL ECTROPION	1	1	1	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	1	2	1	**Evidence:** Among women with persistent HPV infection, long-term DMPA use (≥ 5 years) may increase the risk of carcinoma in situ and invasive carcinoma.[54]
CERVICAL CANCER (awaiting treatment)*	1	2	2	

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	POP	**DMPA/ NET-EN**	**IMP**	
BREAST DISEASE*				
a) Undiagnosed mass	2	2	2	**Clarification:** Evaluation should be pursued as early as possible.
b) Benign breast disease	1	1	1	
c) Family history of breast cancer	1	1	1	
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA1)	2	2	2	
e) Breast cancer				
(i) current	4	4	4	
(ii) past and no evidence of current disease for 5 years	3	3	3	
ENDOMETRIAL CANCER*	1	1	1	
OVARIAN CANCER*	1	1	1	
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 for STIs)				
(i) with subsequent pregnancy	1	1	1	
(ii) without subsequent pregnancy	1	1	1	
b) PID - current	1	1	1	

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	POP	**DMPA/ NET-EN**	**IMP**	
STIs*				
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	**Evidence:** Limited evidence suggests that there may be an increased risk of chlamydial cervicitis among DMPA users at high risk of STIs. For other STIs, there is either evidence of no association between DMPA use and STI acquisition or too limited evidence to draw any conclusions. There is no evidence for other POCs.[55-61]
b) Other STIs (excluding HIV and hepatitis)	1	1	1	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	
d) Increased risk of STIs	1	1	1	
HIV/AIDS				
HIGH RISK OF HIV*	1	1	1	**Evidence:** Overall, evidence is inconsistent regarding whether there is any increased risk of HIV acquisition among POC users compared with non-users.[62-78]
HIV-INFECTED				**Evidence:** Studies are conflicting regarding whether there is an increased risk of HIV and herpes simplex virus (HSV) shedding among HIV-infected women using DMPA.[79-81]
a) Not using anti-retroviral therapy	1	1	1	
b) Using interacting anti-retroviral therapy	2	1	2	
AIDS and using HAART	2	2	2	**Clarification:** If a woman is using highly active antiretroviral therapy (HAART) there may be drug interactions (refer to section on drug interactions).
OTHER INFECTIONS				
SCHISTOSOMIASIS				**Evidence:** Among women with uncomplicated schistosomiasis, limited evidence showed that DMPA use had no adverse effects on liver function.[82]
a) Uncomplicated	1	1	1	
b) Fibrosis of liver (if severe, see cirrhosis)	1	1	1	
TUBERCULOSIS				**Clarification:** If a woman is taking rifampicin, refer to the section on drug interactions. Rifampicin is likely to decrease POC effectiveness.
a) Non-pelvic	1	1	1	
b) Known pelvic	1	1	1	
MALARIA	1	1	1	**Clarification:** Doxycycline is increasingly used in the treatment and prevention of malaria[32] There is no interaction with POC.

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	POP	**DMPA/ NET-EN**	**IMP**	
ENDOCRINE CONDITIONS				
DIABETES*				
a) History of gestational disease	1	1	1	
b) Non-vascular disease				
(i) non-insulin dependent	2	2	2	
(ii) insulin dependent	2	2	2	
c) Nephropathy/ retinopathy/ neuropathy	2	3	2	
d) Other vascular disease or diabetes of >20 years' duration	2	3	2	
THYROID DISORDERS				
a) Simple goitre	1	1	1	
b) Hyperthyroid	1	1	1	
c) Hypothyroid	1	1	1	
GASTROINTESTINAL CONDITIONS				
GALL-BLADDER DISEASE				
a) Symptomatic				
(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	
VIRAL HEPATITIS*				
a) Active	3	3	3	
b) Carrier	1	1	1	

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	POP	**DMPA/ NET-EN**	**IMP**	
CIRRHOSIS*				**Clarification:**
a) Mild (compensated)	2	2	2	*Mild (compensated) cirrhosis* without complications.
b) Severe (decompensated)	3	3	3	*Severe (decompensated) cirrhosis:* development of major complications (ascites, jaundice, encephalopathy, or gastrointestinal haemorrhage). [33]
LIVER TUMOURS*				
a) Benign (adenoma)	3	3	3	
b) Malignant (hepatoma)	3	3	3	
INFLAMMATORY BOWEL DISEASE* (Includes Crohn's disease, ulcerative colitis)	2	1	1	**Clarification:** Oral methods may be less reliable if there is significant malabsorption or small bowel resection (particularly with Crohn's disease). Oral methods are unaffected by colectomy and ileostomy.
ANAEMIAS				
THALASSAEMIA	1	1	1	
SICKLE CELL DISEASE	1	1	1	**Evidence:** Among women with sickle cell disease, POC use did not have adverse effects on haematological parameters and, in some studies, was beneficial with respect to clinical symptoms.[83-90]
IRON-DEFICIENCY ANAEMIA*	1	1	1	
RAYNAUD'S DISEASE				
a) Primary	1	1	1	**Clarification:** Secondary Raynaud's usually has an underlying disease such as scleroderma, rheumatoid arthiritis, systemic lupus erythematosis. Progesterone has little effect but no studies have suggested an association with progestogens and Raynaud's. [34-38]
b) Secondary				
(i) *without* lupus anticoagulant	1	1	1	
(ii) *with* lupus anticoagulant	2	2	2	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation			**CLARIFICATIONS/EVIDENCE**
	POP	**DMPA/ NET-EN**	**IMP**	
DRUG INTERACTIONS*				
DRUGS WHICH AFFECT LIVER ENZYMES For example Rifampicin, Rifabutin, St John's Wort, Griseofulvin, Certain anticonvulsants (phenytoin, carmazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3	1	3	**Clarification:** Although the interaction of rifampicin or certain anticonvulsants with POPs and LNG/ENG implants is not harmful to women, it is likely to reduce the effectiveness of POPs and LNG/ETG implants. 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 POPs alleviates this concern remains unclear.[31] Injectable progestogen-only contraception is unaffected by liver enzyme inducing drugs, and no reduction in injection interval is required. **Evidence:** Use of certain anticonvulsants decreased the contraceptive effectiveness of some POCs. [91-93] St John's Wort and griseofulvin are liver enzyme inducers, but are less potent than rifampicin. [32]
NON-LIVER ENZYME INDUCING ANTIBIOTICS	1	1	1	

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	POP	**DMPA/ NET-EN**	**IMP**	
HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HART)	2	2	2	**Clarification:** It is important to note that antiretroviral drugs (ARV) have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. The limited data available (outlined in Annex 1) suggest that potential drug interactions between many ARVs (particularly some non-nucleoside reverse transcriptase inhibitors (NNRTIs) and protease inhibitors (PIs)) and hormonal contraceptives may alter safety and effectiveness of both the hormonal contraceptives and the ARVs. It is not known whether the contraceptive effectiveness of progestogen-only injectable contraceptives (such as depot medroxyprogesterone acetate and norethisterone enantate) would be compromised, as these methods provide higher blood hormone levels than other progestogen-only hormonal contraceptives, as well as combined oral contraceptives. Studies are underway to evaluate potential interactions between depot medroxyprogesterone acetate and selected PI and NNRTI drugs. Thus, if a woman on ARV treatment decides to initiate or continue hormonal contraceptive use, the consistent use of condoms is recommended for preventing HIV transmission and may also compensate for any possible reduction in the effectiveness of the hormonal contraceptive.

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Additional comments

AGE

Menarche to < 18 years: For women under 18 years of age, there are theoretical concerns regarding the hypo-estrogenic effects of DMPA use, including whether these women will achieve their appropriate peak bone mass. **45 years:** DMPA can be continued to age 50 years and then stopped and a suitable alternative contraceptive used. [39]

BREASTFEEDING

< 6 weeks postpartum: There is limited theoretical concern that the neonate may be at risk due to exposure to steroid hormones during the first 6 weeks postpartum. If used < 6 weeks delay until Day 21. [16;40]

POSTPARTUM

< 21 days: POCs may be safely used by non-breastfeeding women immediately postpartum, although they are not required for contraception until Day 21.

PAST ECTOPIC PREGNANCY

All POCs reduce the risk of ectopic pregnancy. Methods which inhibit ovulation are most effective in preventing intrauterine and extrauterine pregnancies.

HYPERTENSION No evidence that POCs affect blood pressure.

Vascular disease: There is concern regarding hypo-estrogenic effects and reduced HDL levels, particularly among users of DMPA and NET-EN. However, there is little concern about these effects with regard to POPs or LNG/ETG implants. The effects of DMPA and NET-EN may persist for some time after discontinuation.

VENOUS THROMBOEMBOLISM (VTE)

No evidence that POCs increase the risk of venous thromboembolism.

CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE

There is concern regarding hypo-estrogenic effects and reduced HDL levels, particularly among users of DMPA and NET-EN. However, there is little concern about these effects with regard to POPs or LNG/ETG implants. The effects of DMPA and NET-EN may persist for some time after discontinuation.

STROKE

There is concern regarding hypo-estrogenic effects and reduced HDL levels, particularly among users of DMPA and NET-EN. However, there is little concern about these effects with regard to POPs or LNG/ETG implants. The effects of DMPA and NET-EN may persist for some time after discontinuation.

HEADACHES

Aura is a specific focal neurologic symptom. For more information on this and other diagnostic criteria, see: Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders, 2nd Edition. Cephalalgia. 2004; 24 (Suppl 1): 1- 150. http://216.25.100.131/ihscommon/guidelines/pdfs/ihc_II_main_no_print.pdf

There is concern that severe headaches may increase with use of NET-EN, DMPA and implants. The effects of NET-EN and DMPA may persist for some time after discontinuation.

VAGINAL BLEEDING PATTERNS

Irregular menstrual bleeding patterns are common among healthy women. POC use frequently induces an irregular bleeding pattern. Implant use may induce irregular bleeding patterns, especially during the first 3-6 months, but these patterns may persist longer. ETG users are more likely than LNG users to develop amenorrhoea.

UNEXPLAINED VAGINAL BLEEDING

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.

CERVICAL CANCER (awaiting treatment)

There is some theoretical concern that POC use may affect prognosis of the existing disease. While awaiting treatment, women may use POCs. In general, treatment of this condition renders a woman sterile.

BREAST DISEASE

Breast cancer: Breast cancer is a hormonally sensitive tumour, and the prognosis of women with current or recent breast cancer may worsen with POC use.

ENDOMETRIAL CANCER

While awaiting treatment, women may use POCs. In general, the treatment of this condition renders a woman sterile.

OVARIAN CANCER

While awaiting treatment, women may use POCs. In general, the treatment of this condition renders a woman sterile.

UTERINE FIBROIDS

POCs do not appear to cause growth of uterine fibroids.

PELVIC INFLAMMATORY DISEASE (PID)

Whether POCs, like COCs, reduce the risk of PID among women with STIs is unknown, but they do not protect against HIV or lower genital tract STI.

STIs
Whether POCs, like COCs, reduce the risk of PID among women with STIs is unknown, but they do not protect against HIV or lower genital tract STI.

HIGH RISK OF HIV
Whether POCs, like COCs, reduce the risk of PID among women with STIs is unknown, but they do not protect against HIV or lower genital tract STI.

DIABETES
Non-vascular disease: POCs may alter carbohydrate metabolism, but evidence limited.

Nephropathy, retinopathy, neuropathy: There is concern regarding hypo-estrogenic effects and reduced HDL levels, particularly among users of DMPA and NET-EN. The effects of DMPA and NET-EN may persist for some time after discontinuation. Some POCs may increase the risk of thrombosis, although this increase is substantially less than with COCs.

Other vascular disease or diabetes of > 20 years' duration: There is concern regarding hypo-estrogenic effects and reduced HDL levels, particularly among users of DMPA and NET-EN. The effects of DMPA and NET-EN may persist for some time after discontinuation. Some POCs may increase the risk of thrombosis, although this increase is substantially less than with COCs.

HISTORY OF CHOLESTASIS
Theoretically, a history of COC-related cholestasis may predict subsequent cholestasis with POC use. However, this has not been documented.

VIRAL HEPATITIS
Active: POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COCs.

CIRRHOSIS
POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COCs.

LIVER TUMOURS
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.

INFLAMMATORY BOWEL DISEASE
There is no evidence that women with IBD have an inherent increased risk of VTE. Risk of VTE may increase if unwell, bed bound or undergoing acute surgery or with major surgery and prolonged immobilisation. Under these circumstances the use of POC can be continued. Absorption of oral methods may be reduced with malabsorption.

IRON-DEFICIENCY ANAEMIA
Changes in the menstrual pattern associated with POC use have little effect on haemoglobin levels.

DRUG INTERACTIONS
Generally safety of using progestogen-only contraception is unaffected. Nevertheless use of liver enzyme inducers or antibiotics may reduce contraceptive efficacy, increasing risk of unintended pregnancy. Contraceptive choice may depend on the likely duration of use of concurrent medications and need for additional or alternative methods. Progestogen-only injectables are unaffected by liver enzyme inducing drugs and injection intervals need not be reduced. POCs are unaffected by use of non-liver enzyme inducing antibiotics.

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Please note: References used for the development of this UK version are numbered in **red**. The original WHO references are numbered in **black**.

INTRAUTERINE DEVICES (IUDs) *Copper-bearing IUD (Cu-IUD)* *Levonorgestrel-releasing IUD (LNG-IUD)*	**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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
PREGNANCY	4	4	**Clarification:** Intrauterine methods are not indicated during pregnancy. Most pregnancies occurring in women using intrauterine contraception will be intrauterine, but ectopic pregnancy must be excluded. Women who become pregnant whilst using intrauterine contraception should be informed of increased risks of second trimester septic miscarriage, preterm delivery and infection if the IUD is left *in situ*. Women who are pregnant with intrauterine contraception *in situ*, and who wish to continue with the pregnancy, should be informed that, when possible, device removal would reduce adverse outcomes. However, removal itself carries a small risk of miscarriage. Whether or not the intrauterine method is removed, pregnant women should be advised to seek medical care if she develops heavy bleeding, cramping pain, abnormal vaginal discharge or fever.[1;2]
AGE*			
a) Menarche to < 20 years	2	2	
b) ≥ 20 years	1	1	
PARITY*			
a) Nulliparous	1	1	**Clarification:** There is no reduction in fertility associated with previous intrauterine method use. Risk of STI influences fertility and sexual history taking is important. [3;4]
b) Parous	1	1	
POSTPARTUM* (breastfeeding or non-breastfeeding, including post-caesarean section)			**Clarification:** This includes all deliveries including stillbirth from 24 weeks gestation.
a) 48 hours to < 4 weeks	3	3	Due to increased risk of perforation insertion should be delayed until 4 weeks post partum. Little LNG is absorbed systemically. No evidence was identified to suggest effects on breast milk.
b) > 4 weeks	1	1	
c) Puerperal sepsis	4	4	
POST-ABORTION*			
a) First trimester	1	1	**Clarification:** Includes all induced or spontaneous abortions <24 weeks gestation. An IUD can be inserted immediately following surgical abortion or after the second part of medical abortion < 24 weeks.[1;5]
b) Second trimester	2	2	
c) Septic abortion	4	4	
PAST ECTOPIC PREGNANCY*	1	1	

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INTRAUTERINE DEVICES (IUDs) *Copper-bearing IUD (Cu-IUD)* *Levonorgestrel-releasing IUD (LNG-IUD)*	**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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
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	
(iii) stopped smoking < 1year ago	1	1	
(iv) stopped smoking ≥ 1 year ago	1	1	
OBESITY			
a) ≥ 30 - 34 kg/m2 body mass index (BMI)	1	1	
b) 35 – 39 kg/m2 body mass index (BMI)	1	1	
c) ≥ 40 kg/m2 body mass index (BMI)	1	1	
CARDIOVASCULAR DISEASE			
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	1	2	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
HYPERTENSION*			
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. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive. If elevated the BP should be re-assessed at the end of the consultation. If blood pressure is increased it should be re-assessed on at least two subsequent clinic visits at monthly intervals.[8;9]			
a) Adequately controlled hypertension	1	1	
b) Consistently elevated blood pressure levels (properly taken measurements)			
(i) systolic > 140-159 mmHg or diastolic > 90-94 mmHg	1	1	
(ii) systolic ≥ 160 or diastolic ≥ 95 mmHg	1	1	
c) Vascular disease	1	2	**Clarification:** *Vascular disease* includes: coronary heart disease presenting with angina; peripheral vascular disease presenting with intermittent claudication; hypertensive retinopathy; and transient ischaemic attacks)
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is normal)	1	1	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
VENOUS THROMBOEMBOLISM (VTE)*			**Clarification:** VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).
a) History of VTE	1	2	***Current VTE*** refers to disease for which anti-coagulants are still being used. Systemic absorption of LNG from the LNG-IUD is low is unlikely to be associated with an increased risk of VTE. Women who have current VTE may consider use of LNG-IUD or Cu-IUD but perhaps consider delaying insertion until anti-coagulants have stopped due to potential risk of bleeding during the insertion procedure. Women who develop a VTE while using the LNG-IUD may need to consider removal but risks and benefits and lack of evidence and risks of pregnancy must be discussed. Women may wish to continue with this method.
b) Current VTE (on anticoagulants)	3	3	
c) Family history of VTE			
(i) first-degree relative aged < 45 years	1	1	
(ii) first-degree relative aged ≥ 45 years	1	1	
d) Major surgery			***Major Surgery*** includes operations of > 30 minutes duration. Procedures with high risk of VTE include: general or orthopaedic surgery, trauma, neurosurgery.[10]
(i) *with* prolonged immobilisation	1	2	
(ii) *without* prolonged immobilisation	1	1	
e) Minor surgery without immobilisation	1	1	***Minor surgery*** includes operations lasting < 30 minutes (eg laparoscopic sterilisation), procedures such as knee arthroscopy. Varicose vein surgery has a low risk for VTE.
f) Immobility (unrelated to surgery) *e.g. wheelchair use, debilitating illness*	1	1	***Immobility*** due to hospitalisation for acute trauma, acute illness, paralysis is associated with a high risk of VTE.
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	1	2	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
SUPERFICIAL VENOUS THROMBOSIS			
a) Varicose veins	1	1	
b) Superficial thrombophlebitis	1	1	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE*	1	**I** 2 / **C** 3	**Clarification:** The method may be continued if women develop IHD while using the LNG-IUD. Clinical judgement and assessment of pregnancy risk and other factors required.
STROKE* (history of cerebrovascular accident)	1	2	
KNOWN HYPERLIPIDAEMIAS	1	2	**Clarification:** 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. Lipid levels alone are poor predictors of risk of coronary heat disease (CHD). In the UK screening and treatment is aimed towards those at greatest risk of CHD. Risk categories will vary depending on risk of premature coronary heart disease and the presence of other risk factors.[11] *Common hypercholesterolaemia* and *Familial combined hyperlipidaemia* are associated with an increased risk of CHD but usually this occurs over the age of 60 years.[11] *Familial hypercholesterolaemia* (autosomal dominant) has a prevalence of about 1 in 500. People with this condition have a four-fold increase in the risk of premature CHD.[11]
VALVULAR AND CONGENTIAL HEART DISEASE a) Uncomplicated b) Complicated *(pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)*	1 2	1 2	**Clarification:** *Valvular heart* disease occurs when any of the heart valves are stenotic and/or incompetent (eg. aortic stenosis, mitral regurgitation; tricuspid valve abnormalities; pulmonary stenosis).[12] *Congenital heart disease:* Aortic stenosis; Atrial septal defects; Atrio-ventricular septal defect; Cardiomyopathy; (hypertrophic or dilated); Co-arctation of the Aorta; Complex Transposition of the Great Arteries; Ebstein's Anomaly; Eisenmenger Syndrome: Persistent Ductus Arteriosus; Pulmonary Atresia; Pulmonary Stenosis; Tetralogy of Fallot; Total Anomalous Pulmonary Venous Connection; Tricuspid Atresia ; Truncus Arteriosus; Ventricular Septal Defect.[13] Prophylaxis against bacterial endocarditis is indicated for women with artificial heart valves or previous endocarditis when inserting of removing Cu-IUD or LNG-IUD, and this may require referral to a specialist centre.[1]

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
NEUROLOGIC CONDITIONS			
HEADACHES*		I / C	**Clarification:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not. **Definition:** *Non-migrainous headaches* include tension-type, cluster or rebound headaches.[14] *Aura (focal symptoms)* indicate ischaemia: homonymous hemianopia, unilateral paraesthesia and /or numbness, unilateral weakness; and aphasia or unclassifiable speech disorder. Visual symptoms progress from fortification spectra (a star shaped figure near the point of fixation with scintillating edges to scotoma (a bright shape which gradually increases in size). Flashing lights are not focal symptoms.[15] Aura occurs before the onset of headache. 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.
a) Non-migrainous *(mild or severe)*	1	1 / 1	
b) Migraine			
(i) *without* aura Age < 35	1	2 / 2	
(ii) *without* aura Age ≥ 35	1	2 / 2	
(iii) *with* aura, at any age	1	2 / 3	
c) Past history of migraine with aura at any age	1	2	
EPILEPSY	1	1	**Clarification:** If a woman is taking liver enzyme inducing anticonvulsants, refer to the section on drug interactions.
DEPRESSIVE DISORDERS			
DEPRESSIVE DISORDERS	1	1	**Clarification:** The classification is based on data for women with selected depressive disorders. No data on bipolar disorder or postpartum depression were available. There is a potential for drug interactions between certain antidepressant medications and hormonal contraceptives.
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	**Clarification:** Unusually heavy bleeding should raise the suspicion of a serious underlying condition.[17;18] **Evidence:** Among women with heavy or prolonged bleeding, LNG-IUDs were beneficial in treating menorrhagia.[31-35, 5]

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	Cu-IUD	**LNG-IUD**	

	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	
UNEXPLAINED VAGINAL BLEEDING (suspicion for serious condition) Before evaluation	4	2	4	2	**Clarification:** 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.
ENDOMETRIOSIS*	2		1		**Evidence:** LNG-IUD use among women with endometriosis decreased dysmenorrhoea and pelvic pain.[36,37]
BENIGN OVARIAN TUMOURS (including cysts)	1		1		
SEVERE DYSMENORRHOEA*	2		1		
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN)* (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)					**Clarification:** In the UK management depends on serum hCG concentrations and need for chemotherapy identified by measuring hCG concentrations.[18]
a) hCG normal	1		1		
b) hCG abnormal	4		4		**Clarification:** Avoid use due to possible risks of perforation and irregular bleeding
CERVICAL ECTROPION	1		1		
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)*	1		2		
CERVICAL CANCER* (awaiting treatment)	4	2	4	2	
BREAST DISEASE*					
a) Undiagnosed mass	1		2		
b) Benign breast disease	1		1		
c) Family history of cancer	1		1		
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA1)	1		2		
e) Breast cancer:					
(i) current	1		4		**Clarification:** LNG-IUD is protective against endometrial hyperplasia especially for tamoxifen users.[5;19;20] Use can be considered if non-hormonal methods are unnacceptable.
(ii) past and no evidence of current disease for 5 years	1		3		
ENDOMETRIAL CANCER*	4	2	4	2	
OVARIAN CANCER*	3	2	3	2	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
UTERINE FIBROIDS*			
a) Without distortion of the uterine cavity	1	1	**Evidence:** Among women with fibroids, there were no adverse health events with LNG-IUD use and there was a decrease in symptoms and size of fibroids for some women.[38-44]
b) With distortion of the uterine cavity	4	4	
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	
b) Other abnormalities (including cervical stenosis or cervical lacerations) not distorting the uterine cavity or interfering with IUD insertion	2	2	
PELVIC INFLAMMATORY DISEASE (PID)*	**I** **C**	**I** **C**	
a) Past PID (assuming no known current risk factors for STIs)			
(i) with subsequent pregnancy	1 1	1 1	
(ii) without subsequent pregnancy	2 2	2 2	
b) PID - current	4 2	4 2	**Clarification for continuation:** Treat the PID using appropriate antibiotics. There is usually no need for removal of the IUD if the client wishes to continue its use. (See *Selected Practice Recommendations for Contraceptive Use*. WHO: Geneva, 2005).[2] Continued use of an IUD depends on the woman's informed choice and her current risk factors for STIs and PID. **Evidence:** Among IUD users treated for PID, there was no difference in clinical course if the IUD was removed or left in place.[45-47]

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CONDITION	**CATEGORY** I=Initiation, C=Continuation				**CLARIFICATIONS/EVIDENCE**
	Cu-IUD		**LNG-IUD**		
STIs*	**I**	**C**	**I**	**C**	
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	4	2	4	2	**Clarification for continuation:** Treat the STI using appropriate antibiotics. There is usually no need for removal of the IUD if the client wishes to continue its use. Continued use of an IUD depends on the woman's informed choice and her current risk factors for STIs and PID. **Evidence:** There is no evidence regarding whether IUD insertion among women with STIs increases the risk of PID compared with no IUD insertion. Among women who have an IUD inserted, the absolute risk of subsequent PID was low among women with STI at the time of insertion but greater than among women with no STI at the time of IUD insertion.[48-54]
b) Other STIs (excluding HIV and hepatitis)	2	2	2	2	
c) Vaginitis (including Trichomonas vaginalis and Bacterial vaginosis)	2	2	2	2	
d) Increased risk of STIs	2/3	2	2/3	2	**Clarification for initiation:** If a woman has a very high individual likelihood of exposure to gonorrhoea or chlamydial infection, the condition is a Category 3. **Evidence:** Using an algorithm to classify STI risk status among IUD users, one study reported that 11% of high STI-risk women experienced IUD-related complications compared with 5% of those not classified as high risk.[50]
HIV/AIDS					
HIGH RISK OF HIV*	**I**	**C**	**I**	**C**	
	2	2	2	2	**Evidence:** Among women at risk of HIV, copper IUD use did not increase risk of HIV acquisition.[55-65]
HIV-INFECTED	**I**	**C**	**I**	**C**	
a) Not using anti-retroviral therapy	2	2	2	2	**Evidence:** Among IUD users, there is limited evidence showing no increased risk of overall complications or infection-related complications when comparing HIV-infected women with non-infected women. Furthermore, IUD use among HIV-infected women was not associated with increased risk of transmission to sexual partners. [55,66-69]
b) Using interacting anti-retroviral therapy	2	2	2	2	
AIDS and using HAART	**I**	**C**	**I**	**C**	**Clarification for continuation:** IUD users with AIDS should be closely monitored for pelvic infection. **Evidence:** No good evidence that efficacy of LNG-IUD is reduced by liver enzyme inducing drugs.[5;21;22]
	2	2	2	2	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
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	
MALARIA	1	1	
ENDOCRINE CONDITIONS			
DIABETES*			
a) History of gestational disease	1	1	
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	
THYROID DISORDERS			
a) Simple goitre	1	1	
b) Hyperthyroid	1	1	
c) Hypothyroid	1	1	
GASTROINTESTINAL CONDITIONS			
GALL-BLADDER DISEASE			
a) Symptomatic			
(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	
VIRAL HEPATITIS*			
a) Active	1	3	
b) Carrier	1	1	
CIRRHOSIS*			
a) Mild (compensated)	1	2	**Clarification:** *Mild (compensated) cirrhosis:* without complications. *Severe (decompensated) cirrhosis:* development of major complications (ascites, jaundice, encephalopathy, or gastrointestinal haemorrhage).[23]
b) Severe (decompensated)	1	3	

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CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
LIVER TUMOURS*			
a) Benign (adenoma)	1	3	
b) Malignant (hepatoma)	1	3	
INFLAMMATORY BOWEL DISEASE* (includes Crohn's disease Ulcerative colitis)	1	1	
ANAEMIAS			
THALASSAEMIA*	2	1	
SICKLE CELL DISEASE*	2	1	
IRON-DEFICIENCY ANAEMIA*	2	1	
RAYNAUD'S DISEASE			
a) Primary	1	1	**Clarification:** Secondary Raynaud's usually has an underlying cause such as scleroderma, rheumatoid arthritis, systemic lupus erythematosus and other diseases. Systemic lupus erythematosus causes a tendency for increased coagulation if lupus coagulant is present.[24-28]
b) Secondary			
(i) *without* lupus anticoagulant	1	1	
(ii) *with* lupus anticoagulant	1	2	
DRUG INTERACTIONS			
DRUGS WHICH AFFECT LIVER ENZYMES For example Rifampicin, Rifabutin, St John's Wort, Griseofulvin, Certain Anticonvulsants (Phenytoin, Carmazepine, Barbiturates, Primidone, Topiramate, oxcarbazepine)	1	1	**Evidence:** One study found that rifabutin, which is in the same class of drugs as rifampicin, has no impact on the effectiveness of LNG-IUD.[70] St John's Wort and griseofulvin are liver enzyme inducers, but are less potent than rifampicin.[5;22;29]
NON-LIVER ENZYME INDUCING ANTIBIOTICS	1	1	
HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)	**I** / **C**: 2/3 / 2	**I** / **C**: 2/3 / 2	**Clarification:** There is no known drug interaction between ARV therapy and IUD use. However, AIDS as a condition is classified as Category 3 for insertion and Category 2 for continuation unless the woman is clinically well on ARV therapy in which case, both insertion and continuation are classified as Category 2. (See AIDS condition above.)

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Additional comments

AGE

Menarche to < 20 years: There is concern both about the risk of expulsion due to nulliparity and risk of STIs due to sexual behaviour in younger age groups. Although young women rarely use intrauterine methods[29] they may be suitable options for some. [30]

PARITY

Nulliparous: Nulliparity is related to an increased risk of expulsion.

POSTPARTUM

< 48 hours, 48 hours to < 4 weeks, ≥ 4 weeks: Concern that the neonate may be at risk due to exposure to steroid hormones with LNG-IUD use during the first 6 weeks postpartum is the same as for other POCs. Risk of perforation is increased between 48 hours and 4 weeks, and insertion should be delayed.
Puerperal sepsis: Insertion of an IUD may substantially worsen the condition.

POST-ABORTION

Immediate post-septic abortion: Insertion of an IUD may substantially worsen the condition.

PAST ECTOPIC PREGNANCY

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 greatly increased, and should be excluded.

HYPERTENSION

There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.

VENOUS THROMBOEMBOLISM (VTE)

Little evidence for LNG-IUD and risk of VTE. Insertion of Cu-IUD and LNG-IUD can be performed while using anticoagulants but risks and benefits should be discussed and clinical judgement is required.

CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE

There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.

STROKE

There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.

HEADACHES

Aura is a specific focal neurologic symptom. For more information on this and other diagnostic criteria, see: Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders, 2nd Edition. Cephalalgia. 2004; 24 (Suppl 1): 1- 150. http://216.25.100.131/ihscommon/guidelines/pdfs/ihc_II_main_no_print.pdf

VAGINAL BLEEDING PATTERNS

LNG-IUD use frequently causes changes in menstrual bleeding patterns. Over time, LNG-IUD users are more likely than non-users to become amenorrhoeic, thus LNG-IUDs are sometimes used as a treatment to correct heavy bleeding.

ENDOMETRIOSIS

Copper IUD use may worsen dysmenorrhoea associated with the condition.

SEVERE DYSMENORRHOEA

Dysmenorrhoea may intensify with copper IUD use. LNG-IUD use has been associated with reduction of dysmenorrhoea.

GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN)

There is an increased risk of perforation since the treatment for the condition may require multiple uterine curettages.

CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)

There is some theoretical concern that LNG-IUDs may enhance progression of CIN.

CERVICAL CANCER (awaiting treatment)

There is concern about the increased risk of infection and bleeding at insertion. 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

Breast cancer: 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. The LNG-IUS may be considered individually, and in consultation with the woman's breast surgeon.[3]

ENDOMETRIAL CANCER

There is concern about the increased risk of infection, perforation and bleeding at insertion. The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

OVARIAN CANCER

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

Without distortion of the uterine cavity: Women with heavy or prolonged bleeding should be assigned the category for that condition.

With distortion of the uterine cavity: Pre-existing uterine fibroids that distort the uterine cavity may be incompatible with insertion and proper placement of the IUD.

ANATOMICAL ABNORMALITIES

Distorted uterine cavity: In the presence of an anatomic abnormality that distorts the uterine cavity, proper IUD placement may not be possible.

PELVIC INFLAMMATORY DISEASE (PID)

IUDs do not protect against STI/HIV/PID. 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.

STIs

IUDs do not protect against STI/HIV/PID. Among women with chlamydial infection or gonorrhoea, the potential increased risk of PID with IUD insertions should be considered carefully and insertion delayed where possible until swab results are available and any treatment has been given. The concern is less for other STIs.

HIGH RISK OF HIV

IUDs do not protect against STI/HIV/PID.

TUBERCULOSIS

Known pelvic: Insertion of an IUD may substantially worsen the condition.

DIABETES

Whether the amount of LNG released by the IUD may slightly influence carbohydrate and lipid metabolism is unclear. Some progestogens may increase the risk of thrombosis, although this increase is substantially less than for COCs.

HISTORY OF CHOLESTASIS

There is concern that a history of COC-related cholestasis may predict subsequent cholestasis with LNG use. Whether there is any risk with use of an LNG-IUD is unclear.

VIRAL HEPATITIS

Active: POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COCs.

CIRRHOSIS

POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COCs.

LIVER TUMOURS

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.

INFLAMMATORY BOWEL DISEASE

There is no evidence that women with IBD have an inherent increased risk of VTE. Risk of VTE may increase if unwell, bed bound or undergoing acute surgery or with major surgery and prolonged immobilisation. Under these circumstances the use of the Cu-IUD or LNG-IUD is safe.

THALASSAEMIA

There is concern about an increased risk of blood loss with copper IUDs.

SICKLE CELL DISEASE

There is concern about an increased risk of blood loss with copper IUDs.

IRON-DEFICIENCY ANAEMIA

There is concern about an increased risk of blood loss with copper IUDs.

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SURGICAL STERILISATION PROCEDURES

Given that sterilisation is a surgical procedure that is intended to be permanent, special care must be taken to assure that every client makes a voluntary informed choice of the method. Particular attention must be given in the case of young people, nulliparous women, men who have not yet been fathers, and clients with mental health problems, including depressive conditions. All clients should be carefully counselled about the intended permanence of sterilisation 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 sterilisation procedures must be considered in the decision process.

Transcervical methods of female sterilisation are not addressed in these recommendations.

There is no medical condition that would absolutely restrict a person's eligibility for sterilisation, although some conditions and circumstances will require that certain precautions are taken, including those where the recommendation is C (Caution), D (Delay), or S (Special). For some of these conditions and circumstances, the theoretical or proven risks may outweigh the advantages of undergoing sterilisation, particularly female sterilisation. Where the risks of sterilisation outweigh the benefits, long-term, highly effective contraceptive methods are a preferable alternative. Decisions in this regard will have to be made on an individual basis, considering the risks and benefits of sterilisation versus the risks of pregnancy, and the availability and acceptability of highly effective, alternative methods.

The following classification of conditions into the four different categories is based on an in-depth review of the epidemiological and clinical evidence relevant to medical eligibility. Sterilisation procedures should only be performed by well-trained providers in appropriate clinical settings using proper equipment and supplies. Appropriate service delivery guidelines, including infection prevention protocols, should be followed to maximize client safety.

Categories in this Chapter are based on recent existing guidelines from the Royal College of Obstetricians and Gynaecologists on sterilisation.[1]

UK Category		Sterilisation
A	**Accept**	There is no medical reason to deny sterilisation to a person with this condition.
C	**Caution**	The procedure is normally conducted in a routine setting, but with extra preparation, precautions and counselling.
D	**Delay**	The procedure is delayed until the condition is evaluated, treated and / or changes. 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 method is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

Please note: References used for the development of this UK version are numbered in **red**. The original WHO references are numbered in **black**.

FEMALE SURGICAL STERILISATION	Sterilisation 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 condoms reduce the risk of STI/HIV.	
CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
PREGNANCY	D	
YOUNG AGE*	C	**Clarification:** Young women, like all women, should be counselled about the permanency of sterilisation and the availability of alternative, long-term, highly effective methods. Additional care must be taken when counselling people aged <30 years.[1] **Evidence:** Studies show that up to 20% of women sterilised at a young age later regret this decision, and that young age is one of the strongest predictors of regret (including request for reversal information and obtaining reversal) that can be identified before sterilisation.[1-19]
PARITY* (specifically in relation to existing children)		
a) Nulliparous – no children	C	**Clarification:** Additional care must be taken when counselling people who have no children.[1]
b) Parous – any children	A	
BREASTFEEDING	A	
POSTPARTUM*		**Clarification:** Laprascopic sterilisation is usually performed as an interval procedure ≥ 6 weeks postpartum. Laprascopic sterilisation may be performed at the time of an elective caesarean section when there has been sufficient time (a week or more) between counselling and the procedure.[1]
a) Following vaginal delivery or emergency caesarean section	D	
b) At the time of caesarean section	C	
POST-ABORTION*	D	**Clarification:** Includes spontaneous and induced abortion < 24 weeks gestation (medical or surgical abortion). Normally sterilisation should be performed as an interval procedure following medical or surgical abortion; ≥ 6 weeks postabortion, but alternative contraception provided in the interim.[1]
PAST ECTOPIC PREGNANCY	A	
SMOKING		
a) Age < 35 years	A	
b) Age ≥ 35 years		
(i) <15 cigarettes/day	A	
(ii) ≥15 cigarettes/day	A	
(iii) stopped smoking < 1 year ago	A	
(iv) stopped smoking ≥1 year ago	A	
OBESITY		
a) ≥ 30 – 34 kg/m² body mass index (BMI)	C	**Clarification:** The procedure may be more difficult. There is an increased risk of wound infection and disruption. Obese women may have limited respiratory function and may be more likely to require general anaesthesia. Risk of laparotomy increases with obesity.[1] **Evidence:** Women who were obese were more likely to have complications when undergoing sterilisation.[20-23]
b) 35 – 39 kg/m² body mass index (BMI)	C	
c) ≥ 40 kg/m² body mass index (BMI)	C	

*See also additional comments at end of table

UKMEC		DEFINITION OF CATEGORY
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FEMALE SURGICAL STERILISATION	Sterilisation 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 condoms reduce the risk of STI/HIV.	
CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
CARDIOVASCULAR DISEASE		
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE* (such as older age, smoking, diabetes and hypertension)	S	
HYPERTENSION		
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. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive. If elevated the BP should be re-assessed at the end of the consultation. If blood pressure is increased it should be re-assessed on at least two subsequent clinic visits at monthly intervals.[4;5]		
a) Hypertension, adequately controlled	C	
b) Consistently elevated blood pressure (properly taken measurements)		**Clarification:** Elevated blood pressure should be controlled before surgery. There are increased anaesthesia-related risks and an increased risk of cardiac arrhythmia with uncontrolled hypertension. Careful monitoring of blood pressure intraoperatively is particularly necessary in this situation.
(i) systolic 140-159 or diastolic > 90 to 94mmHg	C	
(ii) systolic ≥160 or diastolic ≥95mmHg	S	
c) Vascular disease	S	*Vascular disease includes:* coronary heart disease presenting with angina; peripheral vascular disease presenting with intermittent claudication; hypertensive retinopathy; and transient ischaemic attacks)
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is normal)	A	

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
VENOUS THROMBOEMBOLISM (VTE)		**Clarification:** VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).
a) History of VTE	A	To reduce the risk of VTE, early ambulation is recommended.
b) Current VTE (on anticoagulants)	D	***Current VTE*** refers to disease for which anti-coagulants are still being used
c) Family history of VTE		***Family history*** of VTE may alert clinicians to women who may have an increased risk themselves. Nevertheless, this alone cannot identify with any certainty an underlying thrombophilia. Moreover, even when a genetic thrombophilia is identified not every woman will go on to develop a VTE.
(i) first-degree relative age < 45 years	A	
(ii) first-degree relative age ≥ 45 years	A	
d) Major surgery		***Major Surgery*** includes operations of > 30 minutes duration. Procedures with high risk of VTE include: general or orthopaedic surgery, trauma, neurosurgery.[6]
(i) *without* prolonged immobilisation	A	
(ii) *with* prolonged immobilisation	D	
e) Minor surgery without immobilisation	A	***Minor surgery*** includes operations lasting < 30 minutes (eg laparoscopic sterilisation), procedures such as knee arthroscopy. Varicose vein surgery has a low risk for VTE.
f) Immobility (unrelated to surgery) e.g. wheelchair use, debilitating illness	D	***Immobility*** due to hospitalisation for acute trauma, acute illness, paralysis is associated with a high risk of VTE.
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	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	
b) History of ischaemic heart disease	C	
STROKE (history of cerebrovascular accident)	C	
KNOWN HYPERLIPIDAEMIAS	A	

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
VALVULAR AND CONGENTIAL HEART DISEASE a) Uncomplicated b) Complicated *(e.g. pulmonary hypertension,atrial fibrillation, history of subacute bacterial endocarditis)*	 C S	**Clarification:** *Valvular heart disease* occurs when any of the valves are stenotic and/or incompetent (eg. Aortic stenosis, mitral regurgitation; tricuspid valve abnormalities; pulmonary stenosis)[8] *Congenital heart disease:* Aortic stenosis; Atrial septal defects; Atrio-ventricular septal defect; Cardiomyopathy; (hypertrophic or dilated); Co-arctation of the Aorta; Complex Transposition of the Great Arteries; Ebstein's Anomaly; Eisenmenger Syndrome: Persistent Ductus Arteriosus; Pulmonary Atresia; Pulmonary Stenosis; Tetralogy of Fallot; Total Anomalous Pulmonary Venous Connection; Tricuspid Atresia ; Truncus Arteriosus; Ventricular Septal Defect.[9] **Clarification:** The woman may require prophylactic antibiotics. **Clarification:** The woman is at high risk for complications associated with anaesthesia and surgery. If the woman has atrial fibrillation that has not been successfully managed or current subacute bacterial endocarditis, the procedure should be delayed.
NEUROLOGIC CONDITIONS		
HEADACHES a) Non-migrainous *(mild or severe)* b) Migraine (i) *without* aura Age < 35 (ii) *without* aura Age ≥ 35 (iii) *with* aura (at any age) c) Past history of migraine with aura at any age	 A A A A A	
EPILEPSY	C	Ensure epilepsy adequately controlled
DEPRESSIVE DISORDERS		
DEPRESSIVE DISORDERS	C	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS		
VAGINAL BLEEDING PATTERNS a) Irregular pattern without heavy bleeding b) Heavy or prolonged bleeding (includes regular and irregular patterns)	 A A	
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition) Before evaluation	 D	**Clarification:** The condition must be investigated before the procedure is performed.
ENDOMETRIOSIS	S	**Clarification:** The severity of endometriosis and its effects on pelvic anatomy may increase the risk of complications or the ability to gain access to both fallopian tubes.

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
BENIGN OVARIAN TUMOURS (including cysts)	A	
SEVERE DYSMENORRHOEA	A	
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)		**Clarification:** In the UK management depends on serum hCG concentrations and need for chemotherapy identified by measuring hCG concentrations.[12]
a) hCG normal	A	
b) hCG abnormal	D	
CERVICAL ECTROPION	A	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	A	
CERVICAL CANCER* (awaiting treatment)	D	
BREAST DISEASE		
a) Undiagnosed mass	A	
b) Benign breast disease	A	
c) Family history of breast cancer	A	
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA1)	A	
e) Breast cancer		
(i) current	C	
(ii) past and no evidence of current disease for 5 years	A	
ENDOMETRIAL CANCER*	D	
OVARIAN CANCER*	D	
UTERINE FIBROIDS*		**Clarification:** Depending on the size and location of the fibroids, it might be difficult to localize the tubes and mobilise the uterus.
a) Without distortion of the uterine cavity	C	
b) With distortion of the uterine cavity	C	
PELVIC INFLAMMATORY DISEASE (PID)*		**Clarification:** A careful pelvic examination must be performed to rule out recurrent or persistent infection and to determine the mobility of the uterus. Depending on degree of pelvic adhesions it may be difficult to localise the tubes.
a) Past PID (assuming no current risk factors for STIs)		
(i) with subsequent pregnancy	A	
(ii) without subsequent pregnancy	C	
b) PID – current	D	

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
STIs*		
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	D	**Clarification:** If no symptoms persist following treatment, sterilisation may be performed.
b) Other STIs (excluding HIV and hepatitis)	A	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	A	
d) Increased risk of STIs	A	
HIV/AIDS		
HIGH RISK OF HIV	A	**Clarification:** 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 sterilisation.
HIV-INFECTED	A	
AIDS and using HAART	S	**Clarification:** The presence of an AIDS-related illness may require that the procedure be delayed.
OTHER INFECTIONS		
SCHISTOSOMIASIS		
a) Uncomplicated	A	
b) Fibrosis of liver	C	**Clarification:** Liver function may need to be evaluated
TUBERCULOSIS		
a) Non-pelvic	A	**Clarification:** Depending on the degree of pelvic involvement it may be difficult to localise the tubes.
b) Known pelvic	S	
MALARIA	A	
ENDOCRINE CONDITIONS		
DIABETES*		
a) History of gestational disease	A	
b) Non-vascular disease:		**Clarification:** If blood glucose is not well controlled, referral to a higher-level facility is recommended.
(i) non-insulin dependent	C	
(ii) insulin dependent	C	**Clarification:** There is a possible decrease in healing and an increased risk of wound infection. Use of prophylactic antibiotics is recommended.
c) Nephropathy/ retinopathy/neuropathy	S	
d) Other vascular disease or diabetes of > 20 years' duration	S	**Evidence:** Diabetic women were more likely to have complications when undergoing sterilisation.[22]
THYROID DISORDERS*		
a) Simple goitre	A	**Clarification:** The woman is at high risk of complications associated with anaesthesia and surgery if thyroid disease not well controlled.
b) Hyperthyroid	S	
c) Hypothyroid	C	

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
GASTROINTESTINAL CONDITIONS		
GALL-BLADDER DISEASE a) Symptomatic (i) treated by cholecystectomy (ii) medically treated (iii) current b) Asymptomatic	 A A D A	
HISTORY OF CHOLESTASIS a) Pregnancy-related b) Past COC-related	 A A	
VIRAL HEPATITIS* a) Active b) Carrier	 D A	**Clarification:** Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures.
CIRRHOSIS a) Mild (compensated) b) Severe (decompensated)	 C S	**Clarification:** *Mild (compensated) cirrhosis:* without complications. *Severe (decompensated) cirrhosis:* development of major complications (ascites, jaundice, encephalopathy, or gastrointestinal haemorrhage).[13] Liver function and clotting might be altered. Liver function should be evaluated preoperatively.
LIVER TUMOURS a) Benign (adenoma) b) Malignant (hepatoma)	 C C	**Clarification:** Liver function and clotting might be altered. Liver function should be evaluated preoperatively.
INFLAMMATORY BOWEL DISEASE (Crohn's disease, Ulcerative colitis)	S	**Clarification:** Previous abdominal or pelvic surgery should be taken into consideration and alternative options considered.[14]
ANAEMIAS		
THALASSAEMIA	C	
SICKLE-CELL DISEASE*	C	**Clarification:** There is an increased risk of pulmonary, cardiac or neurological complications and possible increased risk of wound infection
IRON-DEFICIENCY ANAEMIA a) Hb < 7g/dl b) Hb > 7 to < 10g/dl	D C	**Clarification:** 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.
RAYNAUD'S DISEASE a) Primary b) Secondary (i) *without* lupus anticoagulant (ii) *with* lupus anti-coagulant	 A A A	**Evidence:** Secondary Raynaud's usually has an underlying cause such as scleroderma, rheumatoid arthritis, systemic lupus erythematosus and other diseases. Systemic lupus erythematosus causes a tendency for increased coagulation if lupus coagulant is present.[15-19]

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
OTHER CONDITIONS RELEVANT ONLY FOR FEMALE SURGICAL STERILISATION		
LOCAL INFECTION (Abdominal skin infection)	D	**Clarification:** There is an increased risk of postoperative infection.
COAGULATION DISORDERS*	S	**Clarification:** There may be a small risk of venous thrombosis
RESPIRATORY DISEASES*		
a) Acute (bronchitis, pneumonia)	D	**Clarification:** The procedure should be delayed until the condition is corrected. There are increases in anaesthesia-related and other perioperative risks. May require intensive anaesthesic care post-operatively.
b) Chronic		
(i) asthma	S	
(ii) bronchitis	S	
(iii) emphysema	S	
(iv) lung infection	S	
SYSTEMIC INFECTION OR GASTROENTERITIS*	D	
FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION*	S	**Clarification:** Risk of laparotomy is increased. Depending the degree of pelvic adhesions it may be difficult to localise the tubes.
ABDOMINAL WALL OR UMBILICAL HERNIA	S	**Clarification:** Hernia repair and tubal sterilisation should be performed concurrently, if possible.
DIAPHRAGMATIC HERNIA*	C	
KIDNEY DISEASE*	C	**Clarification:** Blood clotting may be impaired. There may be a risk of infection and hyporolemic shock. Condition may cause baseline anaemia, electrolyte disturbances and abnormalities in drug metabolism and excretion.
SEVERE NUTRITIONAL DEFICIENCIES*	C	**Clarification:** There may be an increased risk of wound infection and impaired healing.
PREVIOUS ABDOMINAL OR PELVIC SURGERY	S	**Evidence:** Women with previous abdominal or pelvic surgery were more likely to have complications when undergoing sterilisation.[21, 22, 24-26]
STERILISATION CONCURRENT WITH ABDOMINAL SURGERY		
a) Elective	C	
b) Emergency (without previous counselling)	D	
c) Infectious condition	D	

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MALE SURGICAL STERILISATION

MALE SURGICAL STERILISATION	Sterilisation 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 condoms reduce the risk of STI/HIV.	
CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
YOUNG AGE*	C	**Clarification:** Young men, like all men, should be counselled about the permanency of sterilisation and the availability of alternative, long-term, highly effective methods. Additional care must be taken when counselling people aged < 30 years.[1] **Evidence:** Men who underwent vasectomy at young ages were more likely to have the procedure reversed than those who underwent vasectomy at older ages.[11]
NO OFFSPRING	C	**Clarification:** Additional care must be taken when counselling people aged < 30 years.[1]
DEPRESSIVE DISORDERS		
DEPRESSIVE DISORDERS	C	
HIV/AIDS		
HIGH RISK OF HIV	A	**Clarification:** 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 sterilisation.
HIV-INFECTED	A	
AIDS	S	**Clarification:** The presence of an AIDS-related illness may require a delay in the procedure.
ENDOCRINE CONDITIONS		
DIABETES*	C	
ANAEMIAS		
SICKLE-CELL DISEASE	A	
OTHER CONDITIONS RELEVANT ONLY FOR MALE SURGICAL STERILISATION		
LOCAL INFECTIONS*		**Clarification:** There is an increased risk of postoperative infection.
a) scrotal skin infection	D	
b) active STI	D	
c) balanitis	D	
d) epididymitis or orchitis	D	
COAGULATION DISORDERS*	S	**Clarification:** Bleeding disorders lead to an increased risk of postoperative haemotoma formation which, in turn, leads to an increased risk of infection.
PREVIOUS SCROTAL INJURY	C	
SYSTEMIC INFECTION OR GASTROENTERITIS*	D	**Clarification:** There is an increased risk of postoperative infection.
LARGE VARICOCELE*	C	**Clarification:** The vas may be difficult or impossible to locate; a single procedure to repair hydrocele and perform a vasectomy decreases the risk of complications.
LARGE HYDROCELE*	C	**Clarification:** The vas may be difficult or impossible to locate; a single procedure to repair hydrocele and perform a vasectomy decreases the risk of complications.
FILARIASIS; ELEPHANTIASIS*	D	**Clarification:** If elephantiasis involves the scrotum, it may be impossible to palpate the spermatic cord and testis.
INTRASCROTAL MASS*	D	**Clarification:** This may indicate an underlying disease.

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CONDITION	**CATEGORY**	**CLARIFICATIONS/EVIDENCE**
CRYPTORCHIDISM	C	**Clarification:** If cryptorchidism is bilateral, and fertility has been demonstrated, this will require extensive surgery to locate the vas, and this becomes category S. If the cryptorchidism is unilateral, and fertility has been demonstrated, vasectomy may be performed on the normal side and semen analysis performed, 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	**Clarification:** Vasectomy can be performed with hernia repair.

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Additional comments

A. Female surgical sterilisation

PARITY

Nulliparous: Nulliparous women, like all women, should be counselled about the permanency of sterilisation and the availability of alternative, long-term, highly effective methods.

YOUNG AGE:

Additional care must be taken when counselling people aged < 30 years.

POSTPARTUM

Ideally sterilisation should be preformed after an interval, with appropriate alternative contraception while waiting surgery. Laprascopic sterilisation may be performed at the time of an elective caesarean section when there has been sufficient time (a week or more) between counselling and the procedure.[1]

POST-ABORTION

Normally sterilisation should be performed as an interval procedure following medical or surgical abortion; ≥ 6 weeks postabortion, but alternative contraception provided in the interim. [1]

MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE

When multiple risk factors are present concurrently, the woman may be at high risk for complications associated with anaesthesia and surgery.

CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE

The woman is at high risk for complications associated with anaesthesia and surgery.

CERVICAL CANCER (awaiting treatment)

In general, the treatment renders a woman sterile.

ENDOMETRIAL CANCER

In general, the treatment renders a woman sterile.

OVARIAN CANCER

In general, the treatment renders a woman sterile.

PELVIC INFLAMMATORY DISEASE (PID)

PID can lead to an increased risk of post-sterilisation infection or adhesions.

STIs

There is an increased risk of postoperative infection.

DIABETES

There is a risk of hypoglycaemia or ketoacidosis.

THYROID DISORDERS

The woman is at high risk for complications associated with anaesthesia and surgery.

VIRAL HEPATITIS

The woman is at high risk for complications associated with anaesthesia and surgery.

COAGULATION DISORDERS

Women with coagulation disorders are at increased risk of haematologic complications of surgery.

RESPIRATORY DISEASES

For laparoscopy, the woman may experience acute cardiorespiratory complications induced by pneumoperitoneum or the Trendelenburg position.

SYSTEMIC INFECTION OR GASTROENTERITIS

There are increased risks of postoperative infection, complications from dehydration, and anaesthesia-related complications.

FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION

Decreased mobility of the uterus, fallopian tubes and bowel may make laparoscopy and minilaparotomy difficult and increase the risk of complications.

DIAPHRAGMATIC HERNIA

For laparoscopy, the woman may experience acute cardiorespiratory complications induced by pneumoperitoneum or the Trendelenburg position.

STERILISATION CONCURRENT WITH CAESAREAN SECTION

Concurrent sterilisation does not increase the risk of complications in a surgically stable client.

B. Male surgical sterilisation

YOUNG AGE, CHILDREN

As for women, men should be counselled about the permanency of the procedure and variable success rates for reversal. Additional counselling for people aged < 30 years.

DIABETES

Diabetics are more likely to get postoperative wound infections. If signs of infection appear, treatment with antibiotics needs to be given.

UK REFERENCES

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2. Vessey M, Painter R, Yeates D. Mortality in relation to oral contraceptive use and cigarette smoking. *Lancet* 2003;**362**:185-91.
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Please note: References used for the development of this UK version are numbered in **red**. The original WHO references are numbered in **black**.

EC

EMERGENCY CONTRACEPTION *(Progestogen-only emergency contraception, POEC; copper intrauterine contraceptive device, Cu-IUD)*	**POEC and Cu-IUDs 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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY**		**CLARIFICATIONS/EVIDENCE**
	POEC	**Cu-IUD**	
PREGNANCY	NA	NA	**Clarification:** These methods are **not** abortifacient. Although 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 POEC is accidentally used. An IUD can be inserted up to 5 days after the *first episode* of unprotected sex or if necessary up to 5 days after the *expected date of ovulation* (day 19 in a regular 28 day cycle) thus avoiding insertion after implantation is complete.[1]
POSTPARTUM (not breastfeeding) a) <21 days b) ≥ 21 days	 NA 1	 NA 4	**Clarification:** Emergency contraception is not required if unprotected sex or barrier method failure occurs < 21 days postpartum. The risks of inserting a Cu- IUD prior to 28 days (4 weeks) postpartum outweigh the benefits. POEC is indicated between 21 and 27 days postpartum, or an IUD after day 28 (≥ 4 weeks).
BREASTFEEDING (full or partial) a) 21-27 days b) ≥ 28 days	 1 1	 4 1	Women who are fully or almost fully breastfeeding, amenorrhoeic and < 6 months postpartum can rely on lactational amenorrhoea method (LAM) for contraception and therefore emergency contraception is not indicated unless frequency of breastfeeding decreases or menstruation returns. **Definition:** *Full and almost fully breastfeeding* includes *exclusive* with no other liquids or solids given; *almost exclusive*: vitamins, water or juice given infrequently in addition to breastfeeds; or *partial breastfeeding (high):* where the vast majority of feeds are breastfeeds. **Definition:** *Partial or token breastfeeding*: *Medium* - about half feeds are breastfeeds; *Low*- vast majority of feeds are not breastfeeds; *Minimal*- occasional irregular breastfeeds.[2;3]
HISTORY OF ECTOPIC PREGNANCY	1	1	**Clarification:** Women using contraception have a lower risk of ectopic pregnancy compared to women not using contraception. There does not appear to be an increased risk of ectopic pregnancy following use of POEC or Cu-IUD.

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CATEGORY 1	A condition for which there is no restriction for the use of the contraceptive method
CATEGORY 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks but more careful follow up is required
CATEGORY 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. Provision of a method requires expert clinical judgement and/or referral ot a specialist contraceptive provider, since use of the method is not usually recommended unless other methods are not available or not acceptable
CATEGORY 4	A condition which represents an unacceptable health risk if the contraceptive method is used

EMERGENCY CONTRACEPTION *(Progestogen-only emergency contraception, POEC; copper intrauterine contraceptive device, Cu-IUD)*	**POEC and Cu-IUDs 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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY**		**CLARIFICATIONS/EVIDENCE**
	POEC	**Cu-IUD**	
SMOKING			
a) Age < 35 years	1	1	**Evidence:** Myocardial infarction (MI) is rare in women of reproductive age. Smoking is an important risk factor for cardiovascular disease. Overall mortality is strongly related to smoking. Excess mortality in heavy smokers is apparent from age 35 years.[4] MI increases as the number of cigarettes smoked per day increases. For those who stop smoking there is a rapid decrease in risk of cardiovascular disease, by as much as 50% after 1 year. However, it may take longer, up to 10 years to reach the risk levels of those who have never smoked. A population-based case control study confirmed a three-fold reduction in the risk of MI one year after smoking cessation and the excess risk was gone 4 – 6 years after stopping.[5]
b) Age ≥ 35 years			
(i) <15 cigarettes/day	1	1	
(ii) ≥15 cigarettes/day	1	1	
(iii) stopped smoking < 1 year ago	1	1	
(iv) stopped smoking ≥ 1 year ago	1	1	
HYPERTENSION			
a) Adequately controlled hypertension	1	1	
b) Consistently elevated blood pressure levels (properly taken measurements)			
(i) systolic >140 to 159 mmHg or diastolic > 90 to 94mmHg	1	1	
(ii) systolic ≥160 or diastolic ≥95 mmHg	1	1	
c) Vascular disease	1	1	

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

EMERGENCY CONTRACEPTION *(Progestogen-only emergency contraception, POEC; copper intrauterine contraceptive device, Cu-IUD)*	**POEC and Cu-IUDs 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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY**		**CLARIFICATIONS/EVIDENCE**
	POEC	**Cu-IUD**	
VENOUS THROMBOEMBOLISM (VTE)			**Clarification:** VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE)
a) History of VTE	1	1	***Current VTE*** refers to disease for which anti-coagulants are still being used. Evidence is limited on the risk of VTE with progestogen-only oral contraceptives, however existing evidence is reassuring.[6]
b) Current VTE (on anticoagulants)	2	3	
c) Family history of VTE			
(i) first-degree relative age < 45 years	1	1	
(ii) first-degree relative ≥ 45 years	1	1	
d) Major surgery			***Major Surgery*** includes operations of > 30 minutes duration. Procedures with high risk of VTE include: general or orthopaedic surgery, trauma, neurosurgery.[7]
(i) *with* prolonged immobilisation	1	1	
(ii) *without* prolonged immobilisation	1	1	
e) Minor surgery without immobilisation	1	1	***Minor surgery*** includes operations lasting < 30 minutes (eg laparoscopic sterilisation), procedures such as knee arthroscopy. Varicose vein surgery has a low risk for VTE.
f) Immobility (unrelated to surgery) e.g. *wheelchair bound, debilitating illness*	1	1	***Immobility*** due to hospitalisation for acute trauma, acute illness, paralysis is associated with a high risk of VTE.
KNOWN HYPERLIPIDAEMIAS	1	1	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.

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EMERGENCY CONTRACEPTION *(Progestogen-only emergency contraception, POEC; copper intrauterine contraceptive device, Cu-IUD)*	**POEC and Cu-IUDs 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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY**		**CLARIFICATIONS/EVIDENCE**
	POEC	**Cu-IUD**	
HEADACHES			**Clarification:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not.
a) Non-migrainous (mild or severe)	1	1	**Definition:** *Non-migrainous headaches* include tension-type, cluster or rebound headaches.[8]
b) Migraine			
i) *without* aura Age < 35	1	1	
ii) *without* aura Age ≥ 35	1	1	
iii) *with* aura, at any age	1	1	*Aura (focal symptoms)* indicate ischaemia: homonymous hemianopia, unilateral paraesthesia and /or numbness, unilateral weakness; and aphasia or unclassifiable speech disorder. Visual symptoms progress from fortification spectra (a star shaped figure near the point of fixation with scintillating edges to scotoma (a bright shape which gradually increases in size). Flashing lights are not focal symptoms.[9] Aura occurs before the onset of headache.
c) Past history of migraine with aura at any age	1	1	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.
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)			**Clarification:** In the UK management depends on serum hCG concentrations and need for chemotherapy identified by measuring hCG concentrations.[10]
a) hCG normal	1	1	POEC may be considered but needs discussion with a family planning specialist anal centres, and clinical judgement is necessary.
b) hCG abnormal	3	4	
BREAST DISEASE			
a) Undiagnosed mass	1	1	
b) Benign breast disease	1	1	
c) Family history of cancer	1	1	
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA)	1	1	
e) Breast cancer			
(i) current	2	1	
(ii) past and no evidence of current disease for 5 years	2	1	

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

EMERGENCY CONTRACEPTION *(Progestogen-only emergency contraception, POEC; copper intrauterine contraceptive device, Cu-IUD)*	**POEC and Cu-IUDs 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 condoms reduce the risk of STI/HIV.**		
CONDITION	**CATEGORY**		**CLARIFICATIONS/EVIDENCE**
	POEC	**Cu-IUD**	
INFLAMMATORY BOWEL DISEASE (includes Crohn's disease, ulcerative colitis)	2	1	**Clarification:** Oral methods may be less reliable if there is significant malabsorption or small bowel resection (particularly with Crohn's disease). Oral methods are unaffected by colectomy.
HISTORY OF SEVERE CARDIOVASCULAR COMPLICATIONS* (ischaemic heart disease, cerebrovascular attack, or other thromboembolic conditions)	1	1	**Clarification:** There is no evidence that POEC increases the risk of cardiovascular disease.
ANGINA PECTORIS*	1	1	
SEVERE LIVER DISEASE (including jaundice)*	1	1	
ACUTE INTERMITTENT PORPHYRIA	2	1	**Evidence:** Acute intermittent porphyria is a rare disorder characterised by acute attacks often precipitated by drugs. Estrogen and progestogens have been implicated. Around 1% of acute attacks are fatal. A third of female patients have cyclical symptoms in relation to the menstrual cycle but seldom proceed to an acute attack. In a population study almost half of women with porphyria had used hormonal contraception but only 4.5% had associated acute attacks. Combined hormonal contraception has been shown to reduce attacks for some women. Natural fluctuations in estrogen and progesterone appear to be associated with acute attacks more often than exogenous hormones. Women may use hormonal contraception following discussion of the risks and benefits and with clinical judgement.[11-15]
REPEATED USE OF POEC (in the same cycle)	1	NA	**Clarification:** Recurrent use of emergency contraception is an indication that the woman requires further counselling on other contraceptive options. POEC can be used more than once in a cycle if clinically indicated.[16] Alternatively a Cu-IUD can be inserted if repeated unprotected sex occurs up to 5 days after the first episode of unprotected sex **or** up to five days after expected date of ovulation.
RISK OF STI	1	1	**Clarification:** Women thought to be at higher risk of STI from their sexual history (aged < 25 years, or with a change in sexual partner or two or more partners in the last year) should be offered testing for STI.[1] A Cu-IUD can be inserted as emergency contraception, pending swab results. If deemed higher risk prophylactic antibiotics (such as azithromycin or doxycycline) can be given to protect against Chlamydia trachomatis at the time of Cu-IUD insertion.[1]

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

Additional comments

POSTPARTUM

The earliest ovulation postpartum s thought to be day 21 and therefore unprotected sex prior to day 21 is not an indication for emergency contraception. If unprotected sex occurs after day 21 emergency contraception can be considered. A Cu-IUD should not be inserted < 4 weeks postpartum.

BREASTFEEDING

Although women who are fully or nearly fully breastfeeding, amenorrhoeic and < 6 months postpartum can rely on this as an effective method of contraception, if breastfeeding frequency decreases or menstruation recurs emergency contraception may be indicted. POEC can be used from day 21 postpartum even if breastfeeding and a Cu-IUD from 28 days postpartum.

HISTORY OF SEVERE CARDIOVASCULAR COMPLICATIONS, ANGINA PECTORIS

Use of POEC are not thought to increase the risk of cardiovascular complications

MIGRAINE

Use of POEC is safe for women with a history of migraine with aura

SEVERE LIVER DISEASE (including jaundice)

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.

ACUTE INTERMITTENT PORPHYRIA

Cyclical symptoms have been found in relation to the menstrual cycle but seldom lead to acute attacks. Natural fluctuations in estrogen and progesterone appear to be associated with acute attacks more often than exogenous hormones. Women may use POEC following discussion of the risks and benefits and with clinical judgement.

REPEAT USE OF EMERGENCY CONTRACEPTION

POEC can be used more than once in a cycle if clinically indicated.

RISK OF STI

Women who are thought to be a higher risk for STI based on a sexual history (age < 25 years or age >25 years with a change in sexual partner or two or more partners in the last year) can be offered testing for STI and should be given prophylactic antibiotics to prevent *Chlamydia trachomatis* at the time of Cu-IUD insertion pending swab results.

INTERACTIONS WITH DRUGS WHICH AFFECT LIVER ENZYMES

No category was scored by the Concensus Group on use of progestogen-only contraception by women using liver enzyme inducers. Current guidance from the FFPRHC recommends that women using liver enzyme inducers should be advised to use a Cu-IUD.[18] If progestogen-only emergency contraception is to be used it should be given as soon as possible and within 72 hours of unprotected sex: levonorgestrel when using 0.75 milligram tablets take 3 tablets (2.25 milligrams) as a single dose; or if using 1.5 milligram levonorgestrel tablets take 2 tablets (3 milligrams) as a single dose.

References for Emergency Contraception

UK REFERENCES

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BARRIER METHODS *Male latex condoms, male & female polyurethane condoms, spermicide-free condoms (C) Diaphragm (with spermicide) and cervical caps (D)*	**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 condoms reduce the risk of 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		CLARIFICATIONS/EVIDENCE
	C	D	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
PREGNANCY	NA	NA	**Clarification:** 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	
b) ≥ 40 years	1	1	
PARITY			
a) Nulliparous	1	1	
b) Parous	1	2	**Clarification:** Possible higher risk of cervical cap failure in parous women than in nulliparous women, but may be due to less caution with use than true increased failure.
POSTPARTUM			
a) < 6 weeks postpartum	NA	NA	**Clarification:** This includes any births, including stillbirths from 24 weeks gestation Diaphragm and cap are unsuitable < 6 weeks postpartum until uterine involution is complete.
b) ≥ 6 weeks postpartum	1	1	
POST-ABORTION			**Clarification:** Includes spontaneous and induced abortion < 24 weeks gestation
a) First trimester	1	1	
b) Second trimester	NA	NA	Diaphragm and cap are unsuitable until 6 weeks after second-trimester abortion.
c) Immediate post-septic abortion	1	1	
PAST ECTOPIC PREGNANCY	1	1	
HISTORY OF PELVIC SURGERY	1	1	
SMOKING			
a) Age < 35	1	1	**Evidence:** Myocardial infarction (MI) is rare in women of reproductive age. Smoking is an important risk factor for cardiovascular disease. Overall mortality is strongly related to smoking. Excess mortality in heavy smokers is apparent from age 35 years.[1] MI increases as the number of cigarettes smoked per day increases.
b) Age ≥ 35			
(i) <15 cigarettes/day	1	1	
(ii) ≥15 cigarettes/day	1	1	
OBESITY* > 30 kg/m^2 body mass index (BMI)	1	1	**Clarification:** Weigh increase or decrease of > 3 kg should prompt women to seek advice regarding diaphragm fitting.
CARDIOVASCULAR DISEASE			
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	1	1	

*See also additional comments at end of table

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CATEGORY 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
CATEGORY 4	A condition which represents an unacceptable health risk if the contraceptive method is used

BARRIER METHODS *Male latex condoms, male & female polyurethane condoms, spermicide-free condoms (C) Diaphragm (with spermicide) and cervical caps (D)*	**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 condoms reduce the risk of 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		CLARIFICATIONS/EVIDENCE
	C	D	
HYPERTENSION			
a) Adequately controlled hypertension	1	1	**Clarification:** 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. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive. If elevated the BP should be re-assessed at the end of the consultation. If blood pressure is increased it should be re-assessed on at least two subsequent clinic visits at monthly intervals.[2;3] *Vascular disease includes*: coronary heart disease presenting with angina; peripheral vascular disease presenting with intermittent claudication; hypertensive retinopathy; and transient ischaemic attacks)
b) Consistently elevated blood pressure levels (properly taken measurements)			
(i) systolic 140-159 or diastolic > 90 to 94mmHg	1	1	
(ii) systolic ≥160 or diastolic ≥95 mmHg	1	1	
c) Vascular disease	1	1	
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is normal)	1	1	
VENOUS THROMBOEMBOLISM (VTE)			**Clarification:** VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).
a) History of VTE	1	1	
b) Current VTE (on anticoagulants)	1	1	***Current VTE*** refers to disease for which anti-coagulants are still being used
c) Family history of VTE			***Family history*** of VTE may alert clinicians to women who may have an increased risk themselves. Nevertheless, this alone cannot identify with any certainty an underlying thrombophilia. Moreover, even when a genetic thrombophilia is identified not every woman will go on to develop a VTE.
(i) first-degree relative aged < 45 years	1	1	
(ii) first-degree relative age ≥ 45 years	1	1	
d) Major surgery			***Major Surgery*** includes operations of > 30 minutes duration. Procedures with high risk of VTE include: general or orthopaedic surgery, trauma, neurosurgery.[4]
(i) *without* prolonged immobilisation	1	1	
(ii) *with* prolonged immobilisation	1	1	
e) Minor surgery without immobilisation	1	1	***Minor surgery*** includes operations lasting < 30 minutes (eg laparoscopic sterilisation), procedures such as knee arthroscopy. Varicose vein surgery has a low risk for VTE.
f) Immobility (unrelated to surgery) *e.g. wheelchair use, debilitating illness*	1	1	***Immobility*** due to hospitalisation for acute trauma, acute illness, paralysis is associated with a high risk of VTE.

*See also additional comments at end of table

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CONDITION	CATEGORY		CLARIFICATIONS/EVIDENCE
	C	D	
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	1	1	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
SUPERFICIAL VENOUS THROMBOSIS			
a) Varicose veins	1	1	
b) Superficial thrombophlebitis	1	1	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	1	1	
STROKE (history of cerebrovascular accident)	1	1	
KNOWN HYPERLIPIDAEMIAS	1	1	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening. Lipid levels alone are poor predictors of risk coronary heat disease (CHD). In the UK screening and treatment is aimed towards those at greatest risk of CHD. Risk categories will vary depending on risk of premature coronary heart disease and the presence of other risk factors.[5] *Common hypercholestrolaemia* and *Familial combined hyperlipidaemia* are associated with an increased risk of CHD but usually this occurs over the age of 60 years. *Familial hypercholesterolaemia* (autosomal dominant) has a prevalence of about 1 in 500. People with this condition have a four-fold increase in the risk of premature CHD.[5]
VALVULAR AND CONGENITAL HEART DISEASE*			
a) Uncomplicated	1	1	**Clarification:** *Valvular heart disease* occurs when any of the heart valves are stenotic and/or incompetent (eg. aortic stenosis, mitral regurgitation; tricuspid valve abnormalities; pulmonary stenosis).[6] *Congenital heart disease:* Aortic stenosis; Atrial septal defects; Atrio-ventricular septal defect; Cardiomyopathy; (hypertrophic or dilated); Co-arctation of the Aorta; Complex Transposition of the Great Arteries; Congenitally corrected Transposition of the Great Arteries; Ebstein's Anomaly; Eisenmenger Syndrome: Persistent Ductus Arteriosus; Pulmonary Atresia; Pulmonary Stenosis; Tetralogy of Fallot; Total Anomalous Pulmonary Venous Connection; Tricuspid Atresia ; Truncus Arteriosus; Ventricular Septal Defect.[7]
b) Complicated (e.g. with pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	1	2	

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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		CLARIFICATIONS/EVIDENCE
	C	D	
NEUROLOGIC CONDITIONS			
HEADACHES			**Clarification:** Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not.
a) Non-migrainous *(mild or severe)*	1	1	**Definition:** *Non-migrainous headaches* include tension-type, cluster or rebound headaches.[8]
b) Migraine			
(i) *without* aura Age < 35 years	1	1	
(ii) *without* aura Age ≥ 35	1	1	
(iii) *with* aura, at any age	1	1	*Aura (focal symptoms)* indicate ischaemia: homonymous hemianopia, unilateral paraesthesia and /or numbness, unilateral weakness; and aphasia or unclassifiable speech disorder. Visual symptoms progress from fortification spectra (a star shaped figure near the point of fixation with scintillating edges to scotoma (a bright shape which gradually increases in size). Flashing lights are not focal symptoms.[9] Aura occurs before the onset of headache. Any new headaches or marked changes in headaches should be evaluated.
c) Past history of migraine with aura at any age	1	1	
EPILEPSY	1	1	
DEPRESSIVE DISORDERS			
DEPRESSIVE DISORDERS	1	1	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS			
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition before evaluation)	1	1	**Clarification:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation.
ENDOMETRIOSIS	1	1	
BENIGN OVARIAN TUMOURS (including cysts)	1	1	
SEVERE DYSMENORRHOEA	1	1	
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)			**Clarification:** In the UK management depends on serum hCG concentrations and need for chemotherapy identified by measuring hCG concentrations.[10]
a) hCG normal	1	1	
b) hCG abnormal	1	1	
CERVICAL ECTROPION	1	1	
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	1	1	**Clarification: The cap should not be used.** There is no restriction for diaphragm use.
CERVICAL CANCER* (awaiting treatment)	1	1	**Clarification: The cap should not be used**. There is no restriction for diaphragm use.

*See also additional comments at end of table

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CONDITION	CATEGORY		CLARIFICATIONS/EVIDENCE
	C	D	
BREAST DISEASE			
a) Undiagnosed mass	1	1	
b) Benign breast disease	1	1	
c) Family history of cancer	1	1	
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA1)	1	1	
e) Breast cancer			
(i) current	1	1	
(ii) past and no evidence of disease for 5 years	1	1	
ENDOMETRIAL CANCER	1	1	
OVARIAN CANCER	1	1	
UTERINE FIBROIDS			
a) Without distortion of the uterine cavity	1	1	
b) With distortion of the uterine cavity	1	1	
ANATOMICAL ABNORMALITIES	1	NA	**Clarification:** The diaphragm cannot be used in certain cases of prolapse. Cap use is not appropriate for a client with a markedly distorted cervical anatomy.
PELVIC INFLAMMATORY DISEASE (PID)			
a) Past PID (assuming no current risk factors of STIs)			
(i) with subsequent pregnancy	1	1	
(ii) without subsequent pregnancy	1	1	
b) PID current	1	1	
STIs			
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	
b) Other STIs (excluding HIV and hepatitis)	1	1	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	
d) Increased risk of STIs	1	1	
HIV/AIDS			
HIGH RISK OF HIV*	1	3	**Evidence:** Repeated and high-dose use of the spermicide nonoxynol-9 was associated with increased risk of genital lesions, which may increase the risk of acquiring HIV infection.[1]

*See also additional comments at end of table

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CONDITION	CATEGORY		CLARIFICATIONS/EVIDENCE
	C	D	
HIV-INFECTED			**Evidence:** Repeated and high-dose use of the spermicide nonoxynol-9 was associated with increased risk of genital lesions, which may increase the risk of acquiring HIV infection.[1]
a) Not using anti-retroviral therapy	1	3	
b) Using interacting anti-retroviral therapy	1	3	
AIDS and using HAART	1	3	**Clarification:** Diaphragm and caps can be used but condoms required in addition to reduce the risk of HIV and other STI transmission.
OTHER INFECTIONS			
SCHISTOSOMIASIS			**Clarification:** Diaphragm and caps can be used but condoms required in addition to reduce the risk of HIV and other STI transmission.
a) Uncomplicated	1	1	
b) Fibrosis of liver	1	1	
TUBERCULOSIS			
a) Non-pelvic	1	1	
b) Known pelvic	1	1	
MALARIA	1	1	
HISTORY OF TOXIC SHOCK SYNDROME (TSS)*	1	3	**Evidence:** A case-control study suggested diaphragm (and sponge) are associated with increased risk of non-menstrual TSS.[11;12]
URINARY TRACT INFECTION*	1	2	
ENDOCRINE CONDITIONS			
DIABETES			
a) History of gestationaldisease	1	1	
b) Non-vascular disease			
(i) non-insulin dependent	1	1	
(ii) insulin dependent	1	1	
c) Nephropathy/ retinopathy/neuropathy	1	1	
d) Other vascular disease or diabetes of > 20 years' duration	1	1	
THYROID DISORDERS			
a) Simple goitre	1	1	
b) Hyperthyroid	1	1	
c) Hypothyroid	1	1	
GASTROINTESTINAL CONDITIONS			
GALL-BLADDER DISEASE			
a) Symptomatic			
(i) treated by cholecystectomy	1	1	
(ii) medically treated	1	1	
(iii) current	1	1	
b) Asymptomatic	1	1	
HISTORY OF CHOLESTASIS			
a) Pregnancy-related	1	1	
b) Past COC-related	1	1	

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CONDITION	CATEGORY		CLARIFICATIONS/EVIDENCE
	C	D	
VIRAL HEPATITIS			
a) Active	1	1	
b) Carrier	1	1	
CIRRHOSIS			**Clarification:**
a) Mild (compensated)	1	1	*Mild (compensated) cirrhosis:* without complications.
b) Severe (decompensated)	1	1	*Severe (decompensated) cirrhosis:* development of major complications (ascites, jaundice, encephalopathy, or gastrointestinal haemorrhage).[13]
LIVER TUMOURS			
a) Benign (adenoma)	1	1	
b) Malignant (hepatoma)	1	1	
INFLAMMATORY BOWEL DISEASE (includes Crohn's disease, Ulcerative colitis)	1	1	
ANAEMIAS			
THALASSAEMIA	1	1	
SICKLE CELL DISEASE	1	1	
IRON-DEFICIENCY ANAEMIA	1	1	
RAYNAUD'S DISEASE	1	1	
DRUG INTERACTIONS			
DRUGS WHICH AFFECT LIVER ENZYMES For example Rifampicin, Rifabutin, St John's Wort, Griseofulvin, Certain anticonvulsants (phenytoin, carmazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1	1	**Clarification:** St John's Wort and griseofulvin are liver enzyme inducers, but are less potent than rifampicin.[14]
NON-LIVER ENZYME INDUCING ANTIBIOTICS	1	1	
HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)	1	1	
SENSITIVITY TO LATEX PROTEINS	3	3	**Clarification:** This does not apply to non-latex condoms/diaphragms.

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Additional comments

OBESITY
Severe obesity may make diaphragm and cap placement difficult.

VALVULAR HEART DISEASE
Risk of urinary tract infection with the diaphragm may increase risk in a client with sub-acute bacterial endocarditis.

CERVICAL CANCER (awaiting treatment)
Repeated and high-dose use of nonoxynol-9 can cause vaginal and cervical irritation or abrasions.

HIGH RISK OF HIV
Category 3 for diaphragm use is assigned due to concerns about the spermicide, not the diaphragm.

HISTORY OF TOXIC SHOCK SYNDROME
Toxic shock syndrome has been reported in association with contraceptive sponge and diaphragm use.

URINARY TRACT INFECTION
There is a potential increase of urinary tract infection with diaphragms and spermicides.

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WHO REFERENCES

1. Wilkinson D et al. Nonoxynol-9 for preventing vaginal acquisition of HIV infection by women from men. Cochrane Database of Systematic Reviews, 2002, 4:CD003936.

Please note: References used for the development of this UK version are numbered in **red**. The original WHO references are numbered in **black**.

FAB

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.

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

MUCUS	Cervical Secretion and cycle length	FAB methods are based on observation of the signs of fertility, cervical secretions and menstrual cycle length (such as Billing's method). **These methods must be taught by a trained FAB method teacher.**
DEVICE	Devices which measure hormones	FAB method based on devices which measure hormonal changes (e.g. Persona). The main device available in the UK is Persona, which uses a computerised monitor and a series of urine test sticks to measure hormonal changes.

UK Category		Fertility awareness based methods (FAB)
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 the method should be delayed until the condition is evaluated or changes. Alternative temporary methods of contraception 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 condoms reduce the risk of 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		CLARIFICATIONS/EVIDENCE
	MUCUS	DEVICE	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
PREGNANCY	NA		**Comments:** FAB methods are not relevant during pregnancy.
LIFE STAGE			
a) In the first 2 years post-menarche	C	C	**Clarification:** Menstrual irregularities are common in post-menarche and peri-menopause and may complicate the learning and use of FAB methods. Methods may be more difficult to learn at these times but can be used with caution.
b) Peri-menopause	C	C	
BREASTFEEDING*			
a) < 6 weeks postpartum	D	D	
b) ≥ 6 weeks	C	C	
c) After menses begin	C	C	
POSTPARTUM* (in non-breastfeeding women)			**Clarification:** This includes any births, including stillbirths from 24 weeks gestation
a) < 4 weeks	D	D	
b) ≥ 4 weeks	A	A	
POST-ABORTION*	C	D	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS			
IRREGULAR VAGINAL BLEEDING*	D	D	
VAGINAL DISCHARGE*	D	A	
OTHER			
USE OF DRUGS WHICH AFFECT CYCLE REGULARITY, HORMONES AND/OR FERTILITY SIGNS*	D	D	Devices should not be relied upon during the use of these drugs or until two menstrual cycles have occurred. Users will just notice that the mucus symptoms will not be accurate, so it cannot be relied upon for preventing pregnancy.

UKMEC		DEFINITION OF CATEGORY
A	ACCEPT	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C	CAUTION	The procedure is normally conducted 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 the method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.

Additional comments

BREASTFEEDING

FAB methods during breastfeeding may be more difficult to learn than when not breastfeeding.

< 6 weeks postpartum: 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.

After menses begin: 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.

POSTPARTUM

< 4 weeks: 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.

≥ 4 weeks: 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

Post-abortion women are likely to have sufficient ovarian function to produce detectable fertility signs and/or hormonal changes; likelihood increases with time post-abortion. Women can start using calendar based methods after they have had at least one post-abortion menses (e.g. women who before this pregnancy had most cycles between 26 and 32 days can use the Standard Days Method then). Methods appropriate for the post-abortion period should be offered prior to that time.

IRREGULAR VAGINAL BLEEDING

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

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.

USE OF DRUGS WHICH AFFECT CYCLE REGULARITY, HORMONES AND/OR FERTILITY SIGNS

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.

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Lactational amenorrhoea method

LAM

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**. Table 8 includes definitions of full and partial or token breastfeeding.

Table 8.0 Definition Of Full / Exclusive Breastfeeding – Adapted From Knight and Pyper [1, 2]

DEFINITION OF BREASTFEEDING		CONTRACEPTIVE EFFICACY
Full breastfeeding		Over 98% effective if also -
Exclusive –	*No other liquids or solids given*	Amenorrhoeic Less than 6 months postpartum No long intervals between feeds day or night
Almost exclusive –	*Vitamins, water or juice given infrequently in addition to breastfeeds*	
Partial or token breastfeeding		Little impact on fertility
High –	*Vast majority of feeds are breastfeeds*	
Medium –	*About half of feeds are breastfeeds*	
Low –	*Vast majority are not*	
Minimal –	*Occasional irregular breastfeeds*	

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. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life, and should then be discontinued as soon as it is feasible. Women who are HIV-positive should receive counselling that includes information about both the risks and benefits of various infant feeding options based on local assessments, guidance in selecting the most suitable option for their situation, and be supported in their choice. They should also have access to follow-up care and support, including family planning and nutritonal support.

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.

References for lactational amenorrhoea method

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SECTION C: Summary table

Pull out copy of common reversible contraceptive methods

SUMMARY

COMMON REVERSIBLE METHODS SUMMARY TABLE						
CONDITION	**CHC**	**POP**	**DMPA / NET-EN**	**IMP**	**Cu-IUD**	**LNG-IUD**
I = Initiation, C = Continuation						
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY						
PREGNANCY	NA	NA	NA	NA	4	4
AGE	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
PARITY						
a) Nulliparous	1	1	1	1	1	1
b) Parous	1	1	1	1	1	1
BREASTFEEDING						
a) < 6 weeks postpartum	4	1	2	1		
b) 6 weeks to < 6 months *(fully or almost fully breastfeeding)*	3	1	1	1		
c) ≥ 6 weeks to < 6 months postpartum *(partial breastfeeding medium to low)*	2	1	1	1		
d) ≥ 6 months postpartum	1	1	1	1		
POSTPARTUM (non-breastfeeding women)						
a) < 21 days	3	1	1	1		
b) ≥ 21 days	1	1	1	1		
POSTPARTUM (breastfeeding or non-breastfeeding, including post-caesarean section)						
a) 48 hours to < 4 weeks					3	3
b) > 4 weeks					1	1
c) Puerperal sepsis					4	4
POST-ABORTION						
a) First trimester	1	1	1	1	1	1
b) Second trimester	1	1	1	1	2	2
c) Immediate post-septic abortion	1	1	1	1	4	4
PAST ECTOPIC PREGNANCY	1	1	1	1	1	1
HISTORY OF PELVIC SURGERY (including caesarean section) (see also postpartum section)	1	1	1	1	1	1
SMOKING						
a) Age < 35 years	2	1	1	1	1	1
b) Age ≥ 35 years						
(i) < 15 cigarettes / day	3	1	1	1	1	1
(ii) ≥ 15 cigarettes / day	4	1	1	1	1	1
(iii) Stopped smoking < 1 year ago	3	1	1	1	1	1
(iv) Stopped smoking ≥ 1 year ago	2	1	1	1	1	1
OBESITY						
a) ≥ 30 - 34 kg/m² body mass index(BMI)	2	1	1	1	1	1
b) 35 – 39 kg/m² body mass index (BMI)	3	1	1	1	1	1
c) ≥ 40 kg/m² body mass index (BMI)	4	1	1	1	1	1
CARDIOVASCULAR DISEASE						
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4	2	3	2	1	2

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

COMMON REVERSIBLE METHODS SUMMARY TABLE						
CONDITION	**CHC**	**POP**	**DMPA / NET-EN**	**IMP**	**Cu-IUD**	**LNG-IUD**
I = Initiation, C = Continuation						
HYPERTENSION						
a) Adequately controlled hypertension	3	1	2	1	1	1
b) Consistently elevated blood pressure levels (properly taken measurements)						
(i) systolic >140 to 159 mmHg or diastolic > 90 to 94mmHg	3	1	1	1	1	1
(ii) systolic >160 or diastolic ≥ 95mmHg	4	1	2	1	1	1
c) Vascular disease	4	2	3	2	1	2
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is normal)	2	1	1	1	1	1
VENOUS THROMBO-EMBOLISM (VTE) (includes deep vein thrombosis and pulmonary embolism)						
a) History of VTE	4	2	2	2	1	2
b) Current VTE (on anticoagulants)	4	2	3	3	3	3
c) Family history of VTE						
(i) First degree relative aged < 45 years	3	1	1	1	1	1
(ii) First degree relative aged ≥ 45 years	2	1	1	1	1	1
d) Major surgery						
(i) *With* prolonged immobilisation	4	2	2	2	1	2
(ii) *Without* prolonged immobilisation	2	1	1	1	1	1
e) Minor surgery without immobilisation	1	1	1	1	1	1
f) Immobility (unrelated to surgery) *e.g.- wheelchair use, debilitating illness*	3	1	1	1	1	1
KNOWN THROMBOGENIC MUTATIONS (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)	4	2	2	2	1	2
SUPERFICIAL VENOUS THROMBOSIS						
a) Varicose veins	1	1	1	1	1	1
b) Superficial thrombophlebitis	2	1	1	1	1	1
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE	4	I: 2 / C: 3	3	I: 2 / C: 3	1	I: 2 / C: 3
STROKE (history of cerebrovascular accident)	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	2	2	2	1	2
VALVULAR AND CONGENITAL HEART DISEASE						
a) Uncomplicated	2	1	1	1	1	1
b) Complicated *(eg. With pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)*	4	1	1	1	2	2

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

COMMON REVERSIBLE METHODS SUMMARY TABLE						
CONDITION	**CHC**	**POP**	**DMPA / NET-EN**	**IMP**	**Cu-IUD**	**LNG-IUD**
I = Initiation, C = Continuation						
NEUROLOGIC CONDITIONS						
HEADACHES						
a) Non-migrainous (mild or severe)	I: 1, C: 2	I: 1, C: 1	I: 1, C: 1	I: 1, C: 1	1	I: 1, C: 1
b) Migraine						
(i) Without aura, age < 35 years	I: 2, C: 3	I: 1, C: 2	I: 2, C: 2	I: 2, C: 2	1	I: 2, C: 2
(ii) Without aura, age ≥ 35 years	I: 3, C: 4	I: 1, C: 2	I: 2, C: 2	I: 2, C: 2	1	I: 2, C: 2
(iii) With aura, at any age	I: 4, C: 4	I: 2, C: 3	I: 2, C: 3	I: 2, C: 3	1	I: 2, C: 3
c) Past history of migraine with aura at any age	3	2	2	2	1	2
EPILEPSY	1	1	1	1	1	1
DEPRESSIVE DISORDERS						
DEPRESSIVE DISORDERS	1	1	1	1	1	1
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS						
VAGINAL BLEEDING PATTERS						
a) Irregular pattern *without* heavy bleeding	1	2	2	2	1	I: 1, C: 1
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1	2	2	2	2	I: 1, C: 2
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition) Before evaluation	2	2	3	3	I: 4, C: 2	I: 4, C: 2
ENDOMETRIOSIS	1	1	1	1	2	1
BENIGN OVARIAN TUMOURS (including cysts)	1	1	1	1	1	1
SEVERE DYSMENORRHOEA	1	1	1	1	2	1
GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)						
a) hCG normal	1	1	1	1	1	1
b) hCG abnormal	4	3	3	3	4	4
CERVICAL ECTROPION	1	1	1	1	1	1
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	1	2	1	1	2
CERVICAL CANCER (awaiting treatment)	2	1	2	2	I: 4, C: 2	I: 4, C: 2
BREAST DISEASE						
a) Undiagnosed mass	I: 3, C: 2	2	2	2	1	2
b) Benign breast disease	1	1	1	1	1	1
c) Family history of cancer	1	1	1	1	1	1
d) Carriers of known gene mutations associated with breast cancer (eg. BRCA1)	3	2	2	2	1	2
e) Breast cancer						
(i) Current	4	4	4	4	1	4
(ii) Past and no evidence of current disease for 5 years	3	3	3	3	1	3

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

COMMON REVERSIBLE METHODS SUMMARY TABLE								
CONDITION	**CHC**	**POP**	**DMPA / NET-EN**	**IMP**	**Cu-IUD**		**LNG-IUD**	
I = Initiation, C = Continuation								
ENDOMETRIAL CANCER	1	1	1	1	**I** 4	**C** 2	**I** 4	**C** 2
OVARIAN CANCER	1	1	1	1	**I** 3	**C** 2	**I** 3	**C** 2
UTERINE FIBROIDS								
a) Without distortion of the uterine cavity	1	1	1	1	1		1	
b) With distortion of the uterine cavity	1	1	1	1	4		4	
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	
b) Other abnormalities (including cervical stenosis or cervical lacerations) not distorting the uterine cavity or interfering with IUD insertion					2		2	
PELVIC INFLAMMATORY DISEASE (PID)								
a) Past PID (assuming no current risk factors of STIs)								
(i) With subsequent pregnancy	1	1	1	1	**I** 1	**C** 1	**I** 1	**C** 1
(ii) Without subsequent pregnancy	1	1	1	1	**I** 2	**C** 2	**I** 2	**C** 2
b) PID – current	1	1	1	1	**I** 4	**C** 2	**I** 4	**C** 2
STIs								
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	1	**I** 4	**C** 2	**I** 4	**C** 2
b) Other STIs (excluding HIV and hepatitis)	1	1	1	1	**I** 2	**C** 2	**I** 2	**C** 2
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	**I** 2	**C** 2	**I** 2	**C** 2
d) Increased risk of STIs	1	1	1	1	**I** 2/3	**C** 2	**I** 2/3	**C** 2
HIV / AIDS								
HIGH RISK OF HIV	1	1	1	1	**I** 2	**C** 2	**I** 2	**C** 2
HIV INFECTED								
a) Not using anti-retroviral therapy	1	1	1	1	**I** 2	**C** 2	**I** 2	**C** 2
b) Using anti-retroviral therapy	2	2	1	2	**I** 2	**C** 2	**I** 2	**C** 2
AIDS and using HAART	2	2	2	2	**I** 2	**C** 2	**I** 2	**C** 2
OTHER INFECTIONS								
SCHISTOSOMIASIS								
a) Uncomplicated	1	1	1	1	1		1	
b) Fibrosis of the liver	1	1	1	1	1		1	

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COMMON REVERSIBLE METHODS SUMMARY TABLE								
CONDITION	**CHC**	**POP**	**DMPA / NET-EN**	**IMP**	**Cu-IUD**		**LNG-IUD**	
I = Initiation, C = Continuation								
TUBERCULOSIS					**I**	**C**	**I**	**C**
a) Non-pelvic	1	1	1	1	1	1	1	1
					I	**C**	**I**	**C**
b) Known pelvic	1	1	1	1	4	3	4	3
MALARIA	1	1	1	1	1		1	
ENDOCRINE CONDITIONS								
DIABETES								
a) History of gestational disease	1	1	1	1	1		1	
b) Non-vascular disease								
(i) non-insulin dependent	2	2	2	2	1		2	
(ii) insulin dependent	2	2	2	2	1		2	
c) Nephropathy/ retinopathy/ neuropathy	3/4	2	3	2	1		2	
d) Other vascular disease or diabetes of >20 years' duration	3/4	2	3	2	1		2	
THYROID DISORDERS								
a) Simple goitre	1	1	1	1	1		1	
b) Hyperthyroid	1	1	1	1	1		1	
c) Hypothyroid	1	1	1	1	1		1	
GASTROINTESTINAL CONDITIONS								
GALL BLADDER DISEASE								
a) Symptomatic								
(i) treated by cholecystectomy	2	2	2	2	1		2	
(ii) medically treated	3	2	2	2	1		2	
(iii) current	3	2	2	2	1		2	
b) Asymptomatic	2	2	2	2	1		2	
HISTORY OF CHOLESTASIS								
a) Pregnancy related	2	1	1	1	1		1	
b) Past COC-related	3	2	2	2	1		2	
VIRAL HEPATITIS								
a) Active	4	3	3	3	1		3	
b) Carrier	1	1	1	1	1		1	
CIRRHOSIS								
a) Mild (compensated)	3	2	2	2	1		2	
b) Severe (decompensated)	4	3	3	3	1		3	
LIVER TUMOURS								
a) Benign (adenoma)	4	3	3	3	1		3	
b) Malignant (hepatoma)	4	3	3	3	1		3	
INFLAMMATORY BOWEL DISEASE (includes Crohn's disease, Ulcerative colitis)	2	2	1	1	1		1	
ANAEMIAS								
THALASSAEMIA	1	1	1	1	2		1	
SICKLE CELL DISEASE	2	1	1	1	2		1	
IRON DEFICIENCY ANAEMIA	1	1	1	1	2		1	
RAYNAUD'S DISEASE								
a) Primary	1	1	1	1	1		1	
b) Secondary								
(i) without lupus anticoagulant	2	1	1	1	1		1	
(ii) with lupus anticoagulant	4	2	2	2	1		2	
DRUG INTERACTIONS								
DRUGS WHICH AFFECT LIVER ENZYMES For example Rifampicin, Rifabutin, St John's Wort, Griseofulvin, certain anticonvulsants (phenytoin, carmazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3	3	1	3	1		1	

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COMMON REVERSIBLE METHODS SUMMARY TABLE								
CONDITION	CHC	POP	DMPA / NET-EN	IMP	Cu-IUD		LNG-IUD	
I = Initiation, C = Continuation								
NON LIVER ENZYME INDUCING ANTIBIOTICS	2	1	1	1	1		1	
HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)	2	2	2	2	I 2/3	C 2	I 2/3	C 2

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SECTION D: Annex

Annex 1. COCs and antiretroviral therapies

This section is unchanged from WHOMEC. Few data from small, mostly unpublished studies suggest that the pharmacokinetics of a single dose of COCs may be altered by various antiretroviral (ARV) therapies. However, no clinical outcome studies have been conducted and the clinical significance of such changes, especially when the COCs have not been allowed to reach steady-state, is unknown. The following table summarizes the evidence to date regarding the effects of ARVs on contraceptive steroid levels and the effects of hormonal contraceptives on ARV levels. (This annex is unchanged from WHOMEC).

Table 1. Pharmacokinetic COC-ARV drug interactions.

ARV	Contraceptive steroid levels	ARV levels
Protease inhibitors		
Nelfinavir	↓	No data
Ritonavir	↓	No data
Lopinavir/ritonavir	↓	No data
Atazanavir	↑	No data
Amprenavir	↑	↓
Indinavir	↑	No data
Saquinavir	No data	No change
Non-nucleoside reverse transcriptase inhibitors		
Nevirapine		No change
Efavirenz	↓	No change
Delavirdine	? ↑	No data

(Reproduced directly from WHOMEC)

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