The College of Sexual & Reproductive Healthcare

UK MEDICAL ELIGIBILITY CRITERIA

FOR CONTRACEPTIVE USE | UKMEC 2025

SUMMARY TABLES

Important information about using the UKMEC

Definition of UKMEC categories

UKMEC	DEFINITION OF CATEGORY
Category 1	A condition for which there is no restriction for the use of the 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. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable.
Category 4	A condition which represents an unacceptable health risk if the method is used.

The UKMEC relates to safety and not efficacy

The UKMEC offers guidance regarding who can use contraceptive methods safely. The recommendations do not indicate the best method for an individual, nor do they consider efficacy (including drug interactions or malabsorption).

Absence of a condition or characteristic in the UKMEC does not always mean that it is safe to use contraceptive methods

For uncommon conditions, there is rarely sufficient evidence to make clinical recommendations, and in these circumstances, clinical judgement and/or advice from a specialist may be appropriate.

Recommendations made in the UKMEC are for contraceptive purposes only

Where a method of contraception is used for a non-contraceptive indication the risk/benefit profile and eligibility criteria may differ.

UKMEC recommendations and off-label use

Recommendations made in the UKMEC are evidence-based and may fall outside of the product licence (i.e. be off-label).

Multiple UKMEC 2 categories may indicate a cumulative risk

If multiple UKMEC 2 conditions are present that all relate to the same risk, clinical judgement must be used to decide whether the risks of using the method may outweigh the benefits. Multiple risk factors are defined as more than one risk factor. Where more than one risk factor is present, clinical judgement must be applied.

Multiple UKMEC 3 categories may pose an unacceptable health risk

When an individual has multiple conditions, scoring UKMEC 3 for a method, use of this method may pose an unacceptable risk; clinical judgement should be used in each individual case.

Where multiple risk factors exist, a method may not be suitable

Multiple risk factors are included in the UKMEC for cardiovascular disease and venous thromboembolism (VTE). The Guideline Development Group (GDG) have agreed that multiple risk factors can be defined as **more than one risk factor**. Where more than one risk factor is present, clinical judgement must be applied.

Examples of VTE risk factors include previous VTE, cancer, recent major surgery, recent trauma, significant immobility, high BMI, pregnancy and the postnatal period, inflammatory disorders, antiphospholipid antibody syndrome and other thrombotic disorders. For a full list of DVT[2] and PE[3] risk factors risk please see NICE guidance.

A family history of unprovoked VTE (i.e. no precipitating factors) is a stronger risk factor for VTE that a family history of provoked VTE. Provoked VTE includes major surgery, hospital admission with acute infection or inflammatory state (e.g. sepsis), temporary significant reduction in mobility (e.g. bed or sofa bound >3 days), long-haul flight.

Drug interactions should be considered separately

Health professionals providing hormonal contraception should ask individuals about current and previous drug use including prescription, over the counter, on-line, herbal, recreational drugs, and dietary supplements.

For further guidance and resources regarding specific drug interactions, please refer to:

- CoSRH guidance on drug interactions with hormonal contraception, available on the CoSRH website.[7]
- The British National Formulary (BNF) publications and website.[8]
- Summary of product characteristics (SPC), available on electronic Medicine Compendium (eMC) website.[9]
- Stockley's Drug Interactions website (which requires a log-in).[10]
- For interactions between hormonal contraception and antiretroviral (ARV) drugs, please refer to the online human immunodeficiency virus (HIV) drugs interaction checker.[11]

UKMEC SUMMARY TABLE
HORMONAL AND INTRAUTERINE CONTRACEPTION

Cu-IUD = Copper intrauterine device; LNG-IUD = Levonorgestrel-releasing intrauterine device.
IMP = Progestogen-only implant.
DMPA = Progestogen-only injectable: depot medroxyprogesterone acetate.
POP = Progestogen-only pill; CHC = Combined hormonal contraception

CONDITION *See additional comments at end of section	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
	I = Initiation, C = Continuation					
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY						
Pregnancy	NA	NA	NA	NA	NA	NA
Age	Menarche to <20=2, ≥20=1	Menarche to <20=2, ≥20=1	After menarche =1	Menarche to <18=2, 18-45=1, >45=2	After menarche =1	Menarche to <40=1, 40 to 50=2
Parity						
a) Nulliparous	1	1	1	1	1	1
b) Parous	1	1	1	1	1	1
Postpartum						
a) 0 to <3 weeks						
(i) With other risk factors for venous thromboembolism (VTE)	**See below**		1	3	1	4
(ii) Without other risk factors			1	2	1	3
b) 3 to <6 weeks						
(i) With other risk factors for VTE	**See below**		1	3	1	3
(ii) Without other risk factors			1	1	1	2
c) ≥6 weeks			1	1	1	1
Postpartum (in breastfeeding or non-breastfeeding women, including post- caesarean section)						
a) 0 to ≤ 48 hours	1	1	**See above**			
b) 48 hours to 4 weeks	3	3				
c) ≥4 weeks	1	1				
d) Postpartum sepsis	4	4				
Breastfeeding						
a) 0 to <6 weeks postpartum	**See above**		1	2	1	4
b) ≥6 weeks to <6 months (primarily breastfeeding)			1	1	1	2
c) ≥6 months postpartum			1	1	1	1

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CONDITION *See additional comments at end of section	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
	I = Initiation, C = Continuation					
Post-abortion						
a) First trimester	1	1	1	1	1	1
b) Second trimester	2	2	1	1	1	1
c) Post-abortion sepsis	4	4	1	1	1	1
Past ectopic pregnancy	1	1	1	1	1	1
History of pelvic surgery	1	1	1	1	1	1
Smoking	UKMEC does not include use of e-cigarettes as there is insufficient evidence to establish associated risks. However, given the unknown long term cardiovascular risks with e-cigarettes alternatives to CHC should be prioritised.					
a) Age <35 years	1	1	1	1	1	2
b) Age ≥35 years						
(i) <15 cigarettes/day	1	1	1	1	1	3
(ii) ≥15 cigarettes/day	1	1	1	1	1	4
(iii) Stopped smoking <1 year	1	1	1	1	1	3
(iv) Stopped smoking ≥1 year	1	1	1	1	1	2
Obesity						
a) BMI ≥30–34.9 kg/m^2	1	1	1	1	1	2
b) BMI ≥35 kg/m^2	1	1	1	2	1	3
History of bariatric surgery						
a) With BMI <30 kg/m^2	1	1	1	1	1	1
b) With BMI ≥30–34.9 kg/m^2	1	1	1	1	1	2
c) With BMI ≥35 kg/m^2	1	1	1	2	1	3
Organ transplant						
a) Complicated: graft failure (acute or chronic), rejection, cardiac allograft vasculopathy	I: 3 / C: 2	I: 3 / C: 2	2	2	2	3
b) Uncomplicated	2	2	2	2	2	2

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	I = Initiation, C = Continuation					
CARDIOVASCULAR DISEASE (CVD)						
Multiple risk factors for CVD (e.g., smoking, diabetes, hypertension, obesity, dyslipidemias) Where more than one risk factor is present, clinical judgement must be applied.	1	2	2	3	2	3
Hypertension						
a) Controlled hypertension	1	1	1	2	1	3
b) Consistently elevated blood pressure (BP) levels (properly taken measurements)						
(i) Stage 1 hypertension Clinic Systolic 140 – 159 and/or Diastolic 90 – 99 Home Systolic 135 – 149 and/or Diastolic 85 – 94	1	1	1	2	1	3
(ii) Stage 2 or 3 hypertension Clinic Systolic ≥ 160 and/or Diastolic ≥ 100 Home Systolic ≥ 150 and/or Diastolic ≥ 95	1	1	1	2	1	4
c) Vascular disease	1	2	2	3	2	4
History of high BP during pregnancy	1	1	1	1	1	2
Current and history of ischaemic heart disease	1	I: 2, C: 3	I: 2, C: 3	3	I: 2, C: 3	4
Stroke and transient ischemic attack* (includes arterial thrombosis, venous thrombosis and intracerebral haemorrhage)	1	2	I: 2, C: 3	3	I: 2, C: 3	4
Known dyslipidaemias	1	2	2	2	2	2

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CONDITION *See additional comments at end of section	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
	I = Initiation, C = Continuation					
Venous thromboembolism (VTE)						
History of VTE or current VTE (on anticoagulants)	1	2	2	3	2	4
Risk factors for VTE						
a) Family history of VTE (first degree relative)	1	1	1	2	1	3
b) Major surgery	1	1	2	I: 3, C: 2	2	4
c) Immobility (e.g. wheelchair use, chronic conditions)	1	1	1	2	1	3
Multiple risk factors for VTE (additional examples include cancer, high BMI, thrombotic or inflammatory disorders) Where more than one risk factor is present, clinical judgement must be applied	1	1	1	3	1	4
Superficial venous thrombosis						
a) Varicose veins	1	1	1	1	1	1
b) Superficial venous thrombosis	1	1	1	2	1	2
Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies)	1	2	2	3	2	4
Valvular and congenital heart disease						
a) Uncomplicated	1	1	1	1	1	2
b) Complicated (e.g. pulmonary hypertension, history of subacute bacterial endocarditis)	2	2	1	1	1	4
Cardiomyopathy						
a) Normal cardiac function	1	1	1	1	1	2
b) Impaired cardiac function	2	2	2	2	2	4

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	I = Initiation, C = Continuation					
Cardiac arrhythmias						
a) Atrial fibrillation	1	2	2	2	2	4
b) Known long QT syndrome	I: 3, C: 1	I: 3, C: 1	1	2	1	2
NEUROLOGICAL CONDITIONS						
Headaches						
a) Non-migrainous (mild or severe)	1	1	1	1	1	I: 1, C: 2
b) Migraine without aura, at any age	1	2	2	2	I: 1, C: 2	I: 2, C: 3
c) Migraine with aura, at any age	1	2	2	2	2	4
d) History (≥5 years ago) of migraine with aura, any age	1	2	2	2	2	3
Idiopathic intracranial hypertension (IIH)	1	1	1	1	1	2
Epilepsy	1	1	1	1	1	1
Taking anti-epileptic drugs	Certain anti-epileptic drugs have the potential to affect the bioavailability of steroid hormones in hormonal contraception. For up-to-date information on the potential drug interactions between hormonal contraception and anti-epileptic drugs, please refer to the online drug interaction checker available on Stockley's Interaction Checker website.[10]					
Multiple sclerosis (MS)						
a) MS with prolonged immobility	1	1	1	2	1	3
b) MS without prolonged immobility	1	1	1	2	1	1
MENTAL HEALTH CONDITIONS						
Anxiety and mood disorders	There is not consistent evidence that hormonal contraceptives (HCs) worsen or improve anxiety or mood (affective) disorders in those with pre-existing conditions. When starting hormonal contraception, clinicians should provide individualised counselling and advise patients to monitor their mood, seeking follow-up with their healthcare provider if they notice a deterioration. See CoSRH statement.[15]					

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	I = Initiation, C = Continuation					
BREAST AND REPRODUCTIVE TRACT CONDITIONS						
Vaginal bleeding patterns						
a) Irregular pattern without heavy bleeding	1	1	2	2	2	1
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2	I: 1 / C: 2	2	2	2	1
Unexplained vaginal bleeding (suspicious for serious condition) before evaluation	I: 4 / C: 2	I: 4 / C: 2	3	3	2	2
Endometriosis	2	1	1	1	1	1
Benign ovarian tumours (including cysts)	1	1	1	1	1	1
Severe dysmenorrhoea	2	1	1	1	1	1
Gestational trophoblastic disease (GTD)						
a) Undetectable human chorionic gonadotropin (hCG) levels	1	1	1	1	1	1
b) Decreasing hCG levels	3	3	1	1	1	1
c) Persistently elevated hCG levels or malignant disease	4	4	1	1	1	1
Cervical ectropion	1	1	1	1	1	1
Cervical intraepithelial neoplasia (CIN) Includes individuals with high-risk human papillomavirus (HR-HPV)	1	2	1	2	1	2
Cervical cancer						
a) Awaiting treatment	I: 4 / C: 2	I: 4 / C: 2	2	2	1	2
b) Radical trachelectomy	3	3	2	2	1	2
Breast conditions						
a) Undiagnosed mass/breast symptoms	1	2	2	2	2	I: 3 / C: 2
b) Benign breast conditions	1	1	1	1	1	1

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	I = Initiation, C = Continuation					
c) Family history of breast cancer	1	1	1	1	1	1
d) Carriers of high-risk gene mutations associated with breast cancer (e.g. BRCA1/BRCA2)	1	2	2	2	2	3
e) Breast cancer						
(i) Currently being treated for breast cancer	1	4	4	4	4	4
(ii) Completed treatment for breast cancer	1	3	3	3	3	3
Ovarian cancer (epithelial) BRCA carriers – see above	1	1	1	2	1	2
Endometrial cancer	I: 4 / C: 2	I: 4 / C: 2	1	2	1	2
Uterine fibroids						
a) Without distortion of the uterine cavity	1	1	1	1	1	1
b) With distortion of the uterine cavity	3	3	1	1	1	1
Anatomical abnormalities						
a) Distorted uterine cavity	3	3				
b) Other abnormalities	2	2				
Pelvic inflammatory disease (PID)						
a) Past PID (assuming no current risk factor for STIs)	1	1	1	1	1	1
b) Current PID	I: 4 / C: 2	I: 4 / C: 2	1	1	1	1
Sexually transmitted infections (STIs)						
a) Chlamydia, gonorrhoea or mycoplasma genitalium* (current infection)	I	C	I	C		
(i) Clinical symptoms/signs of infection**	4	2	4	2	1	1	1	1
(ii) No clinical symptoms/signs of	3	2	3	2	1	1	1	1

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	I = Initiation, C = Continuation					
infection						
b) Other current STIs (excluding HIV & hepatitis)	2	2	1	1	1	1
c) Current vaginitis, including trichomonas vaginalis (TV) and bacterial vaginosis (BV)	2	2	1	1	1	1
*M Gen testing is only recommended in certain circumstances, see BASHH guidelines.[16] **Clinical symptoms and signs of infection include cervicitis, purulent discharge, lower abdominal pain, post-coital bleeding and/or systemic manifestations. PID is covered above.						
Human Immunodeficiency Virus (HIV)						
a) High risk for HIV	1	1	1	1	1	1
b) Living with HIV						
(i) Living with HIV Clinically well, on treatment	2	2	1	1	1	1
(ii) Living with HIV Clinically unwell and not on treatment	I: 3 / C: 2	I: 3 / C: 2	1	1	1	1
c) Taking HIV medications (for treatment or prophylaxis)	Certain HIV drugs have the potential to affect the bioavailability of steroid hormones in hormonal contraception. Drug interactions are not presented in the UKMEC as MEC categories relate to safety of contraceptive use, not effectiveness. For current recommendations, clinicians should refer to the FSRH Clinical Effectiveness Unit (CEU) Guidance: Drug Interactions Between HIV Antiretroviral Therapy and Contraception[17] and the University of Liverpool HIV Drug Interactions Checker.[11] Note, there may be specific bone mineral density considerations around coadministration of tenofovir disoproxil (TDF) when used for HIV pre-exposure prophylaxis (PrEP) or treatment and DMPA.						
OTHER INFECTIONS						
Tuberculosis						
a) Non-pelvic	1	1	1	1	1	1
b) Pelvic	I: 4 / C: 3	I: 4 / C: 3	1	1	1	1
ENDOCRINE CONDITIONS						
Diabetes						
a) History of gestational disease	1	1	1	1	1	1

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	I = Initiation, C = Continuation					
b) Non-vascular disease						
(i) Non-insulin dependent	1	2	2	2	2	2
(ii) Insulin dependent	1	2	2	2	2	2
c) Nephropathy/retinopathy/ neuropathy	1	2	2	2	2	3
d) Other vascular disease	1	2	2	2	2	3
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
Chronic kidney disease						
a) Current nephrotic syndrome	2	2	2	3	2*	4
b) Haemodialysis	2	2	2	3	2*	4
c) Peritoneal dialysis	2	2	2	3	2*	4
*POP: excluding drospirenone (DRSP), which should not be used in individuals with severe renal insufficiency or acute renal failure and should be used with caution in individuals at risk of hyperkalaemia.[18] See FSRH Clinical Guideline: Progestogen-only pills.[19]						
GASTROINTESTINAL CONDITIONS						
Gallbladder disease						
a) Symptomatic						
(i) Treated by cholecystectomy	1	2	2	2	2	2
(ii) Medically treated	1	2	2	2	2	3
(iii) Current	1	2	2	2	2	3
b) Asymptomatic	1	2	2	2	2	2
History of cholestasis						
a) Pregnancy related	1	1	1	1	1	2
b) Past combined oral contraception (COC) related	1	2	2	2	2	3
Viral hepatitis						
a) Acute or flare	1	1	1	1	1	I: 3 / C: 2
b) Carrier	1	1	1	1	1	1

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	I = Initiation, C = Continuation					
c) Chronic	1	1	1	1	1	1
Cirrhosis						
a) Mild (compensated without complications)	1	1	1	1	1	1
b) Severe (decompensated)	1	3	3	3	3	4
Liver tumours						
a) Benign						
(i) Focal nodular hyperplasia	1	2	2	2	2	2
(ii) Hepatocellular adenoma	1	3	3	3	3	4
b) Malignant (hepatocellular carcinoma)	1	3	3	3	3	4
Inflammatory bowel disease (including Crohn's disease and ulcerative colitis)	1	1	1	2	2	2
ANAEMIAS						
Thalassaemia	2	1	1	1	1	1
Sickle cell disease	2	1	1	2	1	2
Sickle cell trait (SCT)	There is insufficient evidence to give MEC ratings for SCT. There is a small increase in the risk of VTE with SCT, therefore alternatives to CHC should be prioritised.					
Iron deficiency anaemia	2	1	1	1	1	1
RHEUMATIC DISEASES						
Rheumatoid arthritis	1	2	2	2	2	2
Systemic lupus erythematosus (SLE) No antiphospholipid antibodies	1	2	2	2	2	2
Positive antiphospholipid antibodies	1	2	2	3	2	4
DRUG INTERACTIONS						
Taking medication	Refer to FSRH guideline Drug Interactions with Hormonal Contraception.[7] See Drug interactions with hormonal contraception in Section A: Introduction (full UKMEC only) for further resources including drug interaction checkers.					

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