WHO's evidence-based guidelines for family planning

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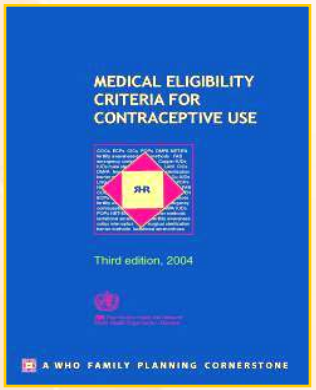
Training Course in Sexual and Reproductive Health Research

Geneva, February 2009

What option would you prefer?

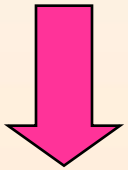
The Four Cornerstones of Evidence-Based Guidance for Family Planning

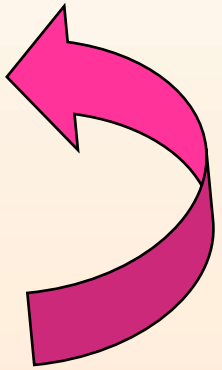
Medical Eligibility Criteria for Contraceptive Use



Selected Practice Recommendations for Contraceptive Use

Guidance for guides





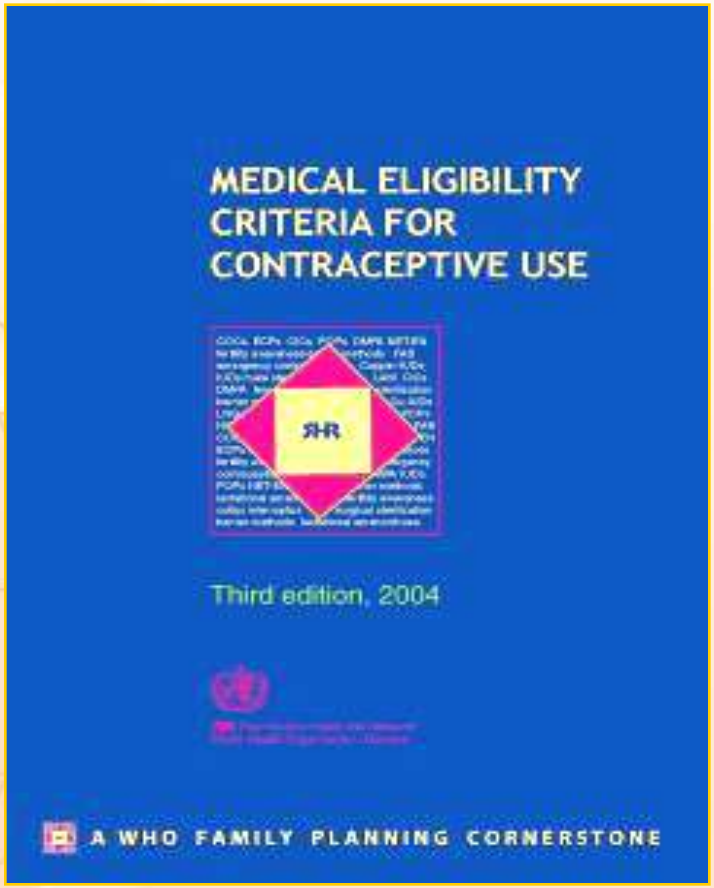
Decision-Making Tool for Family Planning Clients and Providers

Guidance for providers and clients

Family Planning: A Global Handbook for Providers

System for keeping the guidance up-to-date

Medical eligibility criteria for contraceptive use



Purpose:

Who can safely use contraceptive methods?

- First published in 1996; revised in 2000, 2004, latest 4th edition (2008) revision underway
- Provides 1800+ recommendations
- 4th edition being finalized, will be published on WHO website and bound copies.
- Layout and design will address suggestions from the field.

Methods of contraception

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

Identification of conditions

- Conditions represent either:
  - an individual's characteristics (e.g., age, parity) or
  - a known pre-existing medical condition (e.g., hypertension)
- Identify based on national/local screening practice, according to public health importance
- Client history often most appropriate approach

Classification of recommendations

- Divided into four categories:
  - 1 = a condition for which there is no restriction for the use of the contraceptive method,
  - 2 = a condition where the advantages of using the method generally outweigh the theoretical or proven risks,
  - 3 = a condition where the theoretical or proven risks usually outweigh the advantages of using the method,
  - 4 = a condition which represents an unacceptable health risk if the contraceptive method is used
- Four categories can be simplified where resources for clinical judgement are limited:
  - Woman *is* medically eligible to use the method (categories 1 & 2)
  - Woman *is not* medically eligible to use the method (categories 3 & 4)

Medical Eligibility Criteria
Smoking and Contraceptive Use

CONDITION	COC	CIC	POP	NET-EN DMPA	NOR	Cu-IUD	LNG-IUD
SMOKING							
a) Age<35	2	2	1	1	1	1	1
b) Age≥35							
(i) <15 cigarettes/day	3	2	1	1	1	1	1
(ii) ≥15 cigarettes/day	4	3	1	1	1	1	1

Case scenario 1

An 36 year old woman with three children comes to the health centre requesting oral contraceptives. She tells you she smokes 10 cigarettes per day.

A) Are oral contraceptives medically appropriate for her?

B) Does she have any other highly effective temporary contraceptive options?

Case scenario 1: the answer

A) Oral contraceptives are usually not appropriate for women who smoke over 35 unless other methods are not available or acceptable.

Women over 35 who smoke more than 15 cigarettes per day or more should not use combined oral contraceptives.

B) This client is medically eligible to use combined injectables, progestogen-only contraceptives, and IUDs.

Case Scenario 2

A 25 year old woman has just given birth and plans to breastfeed. She would like an injection for contraception prior to returning home.

Which of the following options is medically appropriate?

A) A combined injectable contraceptive provided immediately

B) A combined injectable contraceptive provided at six weeks postpartum

C) A progestogen-only injectable contraceptive provided immediately

D) A progestogen-only injectable contraceptive provided at 6 weeks postpartum

Case scenario 2: the answer

D) A progestogen-only injectable contraceptive provided at 6 weeks postpartum.

Comment

- Combined injectables are not medically appropriate in breastfeeding women prior to 6 weeks postpartum, and generally should not be used until after 6 months postpartum.
- Progestogen-only injectables are medically appropriate in breastfeeding women at 6 weeks postpartum.
- Neonate may be at risk of exposure to steroid hormones during the first six weeks postpartum.

Global impact of the Medical Eligibility Criteria

- **Translated into 12 languages, six available on WHO website**
- **Impact on guidelines in over 50 countries**
- **Integrated into popular texts**
- **40,000+ copies disseminated**

4th edition of the *Medical eligibility criteria for contraceptive use*

- 86 new and 165 updated recommendations
- New medical condition – Systemic Lupus Erythematosus
- 12 new sub-conditions within currently existing medical conditions:
  - obesity and <18 years of age; deep venous thrombosis/pulmonary embolism (DVT/PE) and established on anticoagulant therapy; acute or flare for viral hepatitis; focal nodular hyperplasia of the liver; three classes of antiretroviral therapies; Lamotrigine (an anticonvulsant); and four classes of antimicrobials (broad-spectrum antibiotics, antifungals, antiparasitics, and rifabutin with rifampicin)

Medical eligibility criteria for contraceptive use – 2008 update

- Briefly summarizes 86 new and 165 updated recommendations across 11 contraceptive methods.
- Describes recommendation changes for female sterilization and barrier methods.
- Highlights newly defined medical conditions.
- Available on WHO website (http://www.who.int/reproductive-health/family_planning/updates.htm)
- Changes will appear in revised, 4th edition of guidance; preparation underway.

New recommendations – Systemic Lupus Erythematous (SLE)

- Divided into four sub-conditions
  - Positive (or unknown) antiphospholipid antibodies
  - Severe thrombocytopenia
  - Immunosuppressive treatment
  - None of the above

- When using these sub-conditions of SLE, it is assumed that no other risk factors for cardiovascular disease are present, otherwise categories must be modified in the presence of such risk factors.

- For severe thrombocytopenia, due to the increased risk of bleeding, assess the severity of the condition and its clinical manifestations. If thrombocytopenia is very severe, consultation with a specialist and pre-treatment may be warranted.

Systemic Lupus Erythematous (SLE) recommendations

	COC, Patch, Ring	CIC	POP	DMPA, NET-EN	LNG, ETG Implants	Cu-IUD	LNG-IUD
Positive (or unknown) anti-phospholipid antibodies	4	4	3	I=3, C=3	3	I=1, C=1	3
Severe thrombo-cytopenia	2	2	2	I=3, C=2	2	I=3, C=2	2
Immuno-suppressive treatment	2	2	2	I=2, C=2	2	I=2, C=1	2
None of the above	2	2	2	I=2, C=2	2	I=1, C=1	2

I = initiation of the method, C = continuation of the method

New recommendations - viral hepatitis

- Divided into three sub-conditions
  - Acute or flare
  - Carrier
  - Chronic
- Women who are carriers or have chronic disease are eligible to use any hormonal method or intrauterine device (category 1)
- Women with acute disease or a disease flare
  - Eligible to use any progestogen-only method or any intrauterine device (category 1)
  - For combined methods (COC, P, R, CIC)
    - ***Initiation* – the theoretical or proven risks usually outweighs the advantages of using these methods (category 3)**
      - **If the condition is severe, use of COC, P, R, or CIC becomes a category 4**
    - ***Continuation* - the advantages of these methods generally outweighs the theoretical or proven risks (category 2)**

New recommendations – liver tumours

- Divided into three sub-conditions
  - Benign
    - Focal nodular hyperplasia
    - Hepatocellular adenoma
  - Malignant (hepatoma)
- Women with focal nodular hyperplasia can use copper-bearing IUDs (category 1) and are generally eligible to use any hormonal method (category 2)
- For the hepatocellular adenoma or malignant tumour conditions,
  - Not eligible to use COCs, patch, or the ring (category 4)
  - CICs or progestogen-only methods (including LNG-IUD) are not recommended (category 3)
    - **If malignant hepatoma is severe, use of CICs becomes a category 4**
  - Can use copper-bearing IUDs (category 1)

Unchanged recommendations - age

- Expert Working Group (April 2008) re-evaluated the body of evidence
  - Recommendations should remain the same for progestogen-only and combined hormonal contraceptive methods.
  - There should be no restriction on the use of DMPA, including no restriction on duration of use, among women aged 18 to 45 who are otherwise eligible to use the method.
  - Among adolescents (menarche to <18) and women over 45, the advantages of using DMPA generally outweigh the theoretical safety concerns regarding fracture risk. Since data are insufficient to determine if this is the case with long-term use among these age groups, the overall risks and benefits for continuing use of the method should be reconsidered over time with the individual user.

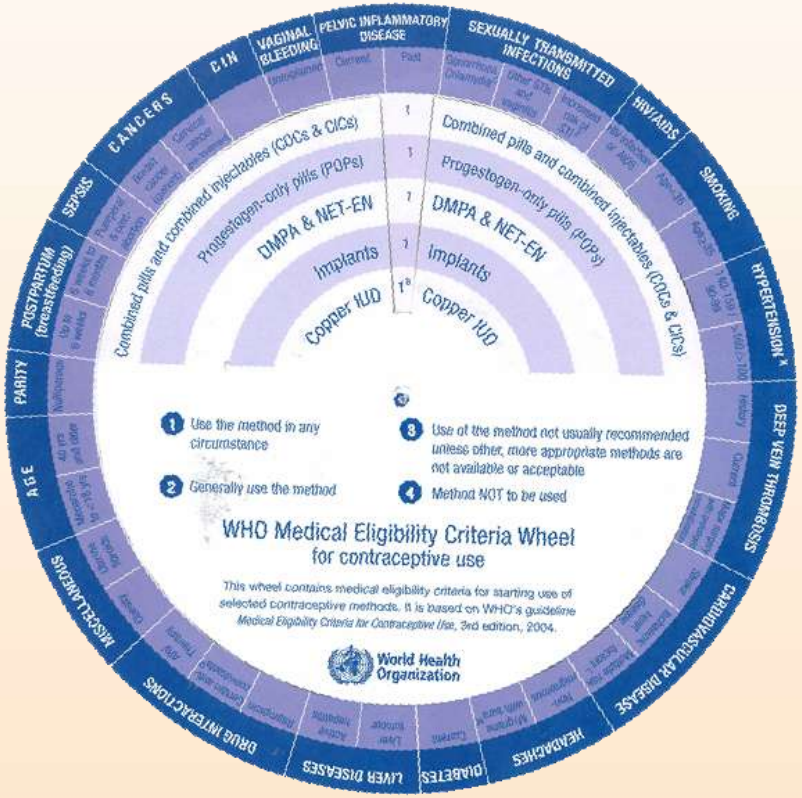
Materials derived from the guidelines
The MEC wheel

- Published in 2007

- A job aid, developed in collaboration with John Hopkins University, Communication Partnership for Family Health (Jordan), and University of Ghana Medical School.

- Available in English, French. Arabic translation underway.

- Available in Chinese, Mongolian, Myanmar, Pacific Island Countries.



Other materials derived from the guidelines

Developed by Johns Hopkins University

WHO statement and provider briefs

Statement

July 2005

Department of Reproductive Health and Research

Hormonal contraception and bone health

Steroid hormonal contraceptives, including oral contraceptives, injectables and implants, are highly effective and widely used. These contraceptives have important health benefits, including contraceptive and non-contraceptive benefits, and some health risks. For most women, the health benefits of use clearly exceed the health risks. Questions have been raised regarding the association between use of one particular hormonal contraceptive, depot medroxyprogesterone acetate (DMPA), and the risk of bone loss. In response, WHO convened a consultation in Geneva, on 20-21 June 2005, to assess current evidence on the relationship between the use of steroid hormonal contraceptives and bone health.

Bone health may be influenced by many factors including pregnancy, breastfeeding and use of hormonal contraceptives. The principal clinical outcome of interest with regard to bone health is the occurrence of fracture. Bone mineral density (BMD) measurements are commonly used to assess fracture risk, but the accuracy of measurements can be influenced by changes in body composition, including changes in lean body mass and fat. Furthermore, fracture risk is related to many factors, BMD being only one of them. The relationship between decrease in BMD and increase in fracture risk has been most studied in postmenopausal women, among whom the risk of any fracture increases approximately 1.3 fold for each standard deviation (SD) decrease in BMD. There is little information on the impact of BMD changes in young age groups on fracture risk later in life.

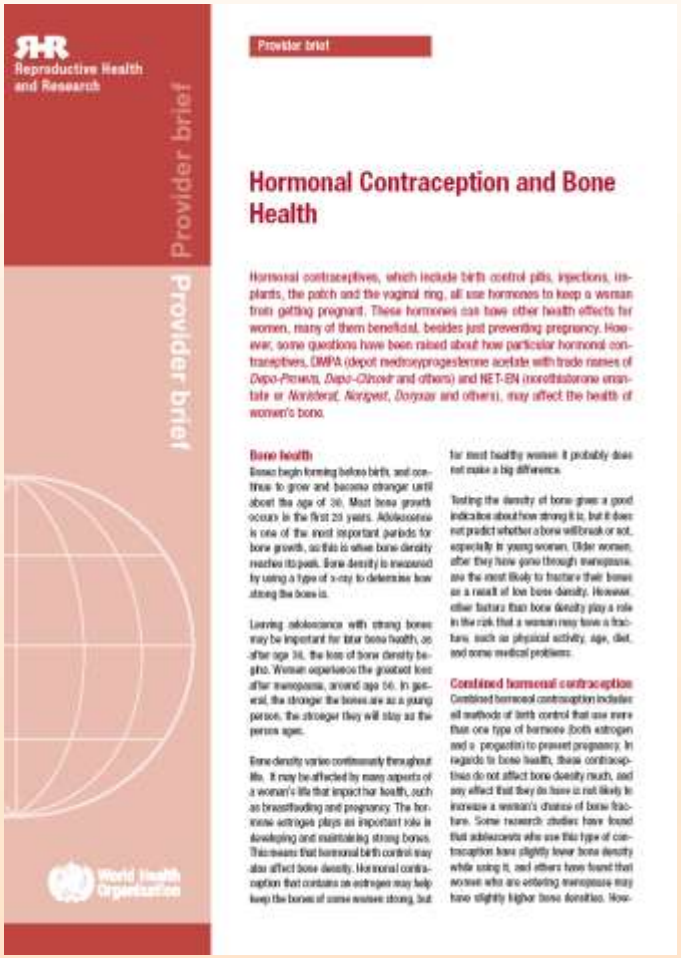
Combined methods of contraception

The use of current formulations of combined oral contraceptives (COCs) may have some small effects on BMD that are unlikely to be of clinical significance. Adolescent COC users may gain less BMD compared with adolescent non-users while perimenopausal users generally have increased BMD compared with perimenopausal non-users. A number of studies have investigated the risk of fracture among postmenopausal women in relation to past use of COCs, but the findings are inconsistent. Data for other combined hormonal contraceptives, such as combined injectables, vaginal rings and skin patches, are scarce or non-existent.

Progestogen-only methods of contraception

With regard to progestogen-only methods, data on levonorgestrel implants suggest no adverse effect on BMD. Other low-dose progestogen-only contraceptives such as pills, other implants and the levonorgestrel-releasing intrauterine device do not appear to have an effect on BMD, although data for these methods are limited.

The use of DMPA for contraception produces a hypo-estrogenic state in women; some studies have shown that this is associated with a decrease in BMD. The weight of data indicates that DMPA use reduces BMD in women who have attained peak bone mass, and impairs the acquisition of bone mineral among those who have not yet attained peak bone mass. The magnitude of effect on BMD is similar across a



Reproductive Health and Research

Provider brief

Provider brief

Provider brief

Hormonal Contraception and Bone Health

Hormonal contraceptives, which include birth control pills, injections, implants, the patch and the vaginal ring, all use hormones to keep a woman from getting pregnant. These hormones can have other health effects for women, many of them beneficial, besides just preventing pregnancy. However, some questions have been raised about how particular hormonal contraceptives, DMPA (depot medroxyprogesterone acetate with trade names of *Depo-Provera, Depo-Clinovir* and others) and NET-EN (norethisterone enanthate or *Noristerat, Norigest, Doryxas* and others), may affect the health of women's bone.

Bone health

Bones begin forming before birth, and continue to grow and become stronger until about the age of 30. Most bone growth occurs in the first 20 years. Adolescence is one of the most important periods for bone growth, as this is when bone density reaches its peak. Bone density is measured by using a type of x-ray to determine how strong the bone is.

Leaving adolescence with strong bones may be important for later bone health, as after age 30, the loss of bone density begins. Women experience the greatest loss after menopause, around age 50. In general, the stronger the bones are as a young person, the stronger they will stay as the person ages.

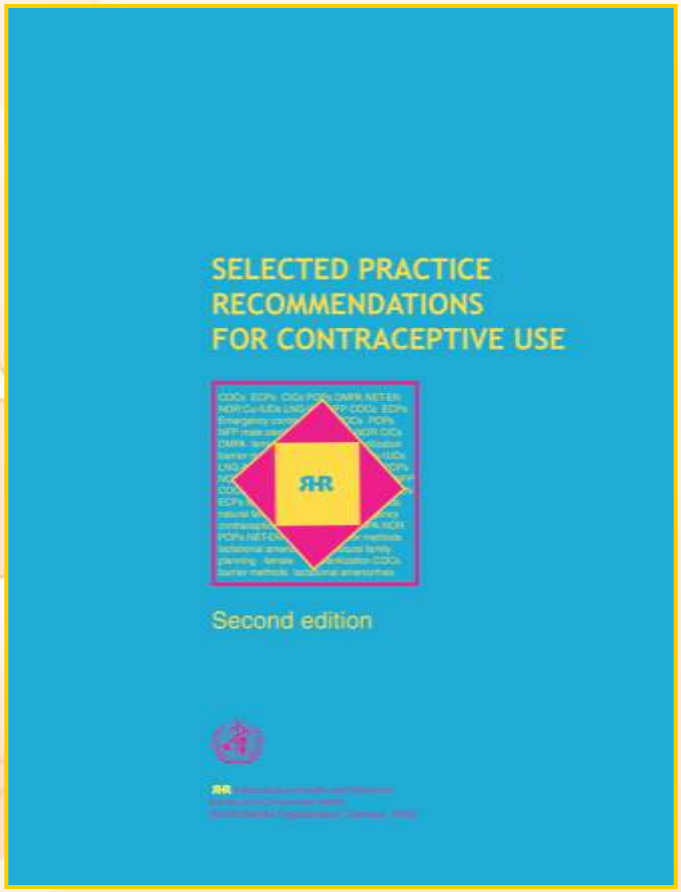
Bone density varies continuously throughout life. It may be affected by many aspects of a woman's life that impact her health, such as breastfeeding and pregnancy. The hormone estrogen plays an important role in developing and maintaining strong bones. This means that hormonal birth control may also affect bone density. Hormonal contraception that contains an estrogen may help keep the bones of some women strong, but for most healthy women it probably does not make a big difference.

Testing the density of bone gives a good indication about how strong it is, but it does not predict whether a bone will break or not, especially in young women. Older women, after they have gone through menopause, are the most likely to fracture their bones as a result of low bone density. However, other factors than bone density play a role in the risk that a woman may have a fracture, such as physical activity, age, diet, and some medical problems.

Combined hormonal contraception

Combined hormonal contraception includes all methods of birth control that use more than one type of hormone (both estrogen and a progestin) to prevent pregnancy. In regards to bone health, these contraceptives do not affect bone density much, and any effect that they do have is not likely to increase a woman's chance of bone fracture. Some research studies have found that adolescents who use this type of contraception have slightly lower bone density while using it, and others have found that women who are entering menopause may have slightly higher bone densities. How-

Selected practice recommendations for contraceptive use



Purpose:

How to use contraceptive methods

33 selected practice questions

First published in 2002, revised in 2005, 3rd edition revision underway (2008).

Updated recommendations published on the web

33 questions on contraceptive use

- When to start
- When to re-administer
- How to manage problems
  - Missed pills
  - Bleeding (progestogen-only methods and IUDs)
  - Prophylactic antibiotics and IUD insertion
- What exams or tests should be done routinely
- Follow-up
- How to be reasonably sure a woman is not pregnant

Selected Practice Recommendations

For each question:

- Working Group's recommendations for key situations
- Comments by the Working Group
- Key unresolved issues
- Information about the evidence
  - Literature search question
  - Level of evidence
  - References identified by systematic review

When can a woman start COCs?

Having menstrual cycles

- **She can start COCs within 5 days after the start of her menstrual bleeding. No additional contraceptive protection is needed.**
- **She can also start COCs at any other time, if it is reasonably certain that she is not pregnant.**
  If it has been more than 5 days since menstrual bleeding started, she will need to abstain from sex or use additional contraceptive protection for the next 7 days.

When can a woman start COCs?

Working Group comments:

- **Risk of ovulation within the first 5 days of the cycle is low.**
- **Suppression of ovulation was less reliable when starting COCs after day 5.**
- **7 days of continuous COC use was necessary to reliably prevent ovulation.**

Routine exams or tests

Class A = essential and mandatory in all circumstances for safe and effective use of the method

Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context.

Class C = does not contribute substantially to safe and effective use of the method

Routine exams or tests

Exam or screening	Hormonal methods	IUD	Condoms / Spermicide	Female sterilization
Breast exam	C	C	C	C
Pelvic exam	C	A	C	A
Cervical cancer	C	C	C	C
Routine lab tests	C	C	C	C
Haemoglobin	C	B	C	B
STI risk assessment	C	A	C*	C
STI screening	C	B	C*	C
Blood pressure	**	C	C	A

Class A: essential and mandatory in all circumstances

Class B: contributes substantially to safe and effective use

Class C: does not contribute substantially to safe and effective use

How to be reasonably sure a woman is not pregnant

No signs and symptoms of pregnancy AND

Meets any of the following criteria:

- **No intercourse since last normal menses**
- **Correctly and consistently using reliable method of contraception**
- **Within the first 7 days after normal menses**
- **Within 4 weeks postpartum for non-lactating women**
- **Within 7 days post-abortion or post-miscarriage**
- **Fully or nearly fully breastfeeding, amenorrhoeic, and less than 6 months postpartum**

Case Scenario 1

A woman comes to the clinic requesting combined oral contraceptives on day 7 of her menstrual cycle. She has not had sexual intercourse since the first day of her menstrual period.

Which of the following is medically appropriate?

A) advise her to return to clinic on the first day of her next menstrual period.

B) provide her with pills and tell her that she can start now without any further precautions.

C) provide her with pills and tell her that she can start now, but should abstain from sex or use additional contraceptive protection for the next 7 days.

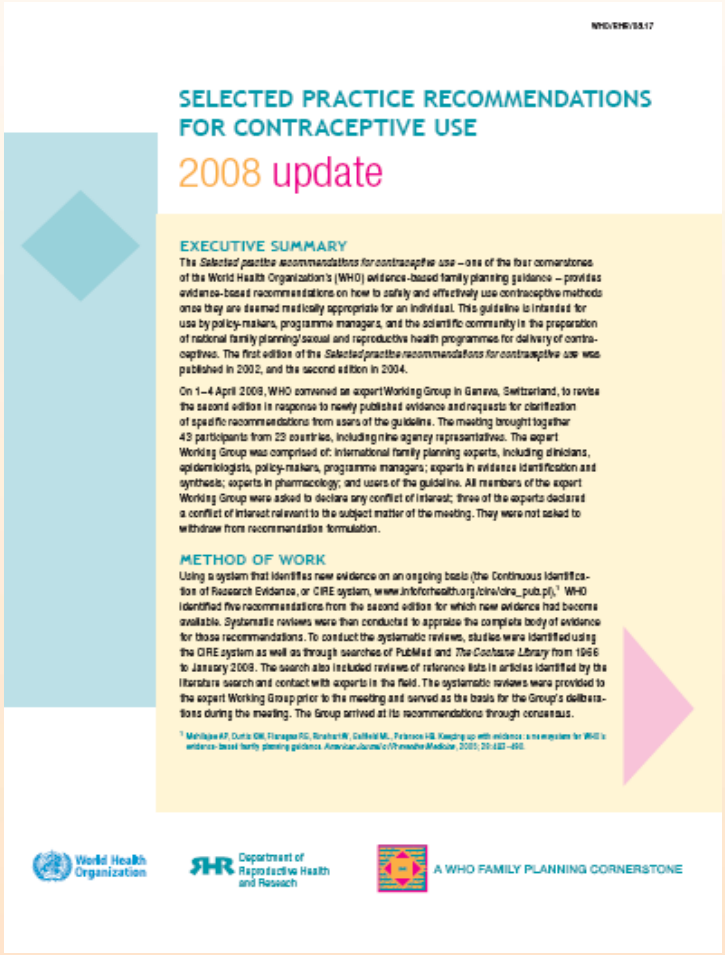
Case Scenario 1: the answer

C) provide her with pills and tell her that she can start now, but should abstain from sex or use additional contraceptive protection for the next 7 days.

Suppression of ovulation was considered to be less reliable when starting after day 5 or during amenorrhoea, seven days of continuous COC use was deemed necessary to reliably prevent ovulation.

Selected practice recommendations for contraceptive use – 2008 update

- Briefly summarizes changes for five recommendations (questions 6, 9, 11, 18, 22) and clarifies wording for question 17.
- Can be inserted into current 2nd edition.
- 2nd edition should be consulted for complete wording of each recommendation.
- Available on WHO website (http://www.who.int/reproductive-health/family_planning/updates.htm)
- Changes will appear in revised, 3rd edition of guidance; preparation underway.



2008 update – recommendation changes

- Grace period for repeat injection of DMPA extended to 4 weeks (question #6)
  - Repeat DMPA injections can be given up to 4 weeks late for women who are late for their repeat injection
  - Repeat NET-EN injections can be given up to 2 weeks late for women who are late for their repeat injection.

- Postpartum IUD insertion timing clarified (questions #9 and #11)
  - No restrictions on copper-bearing or levonorgestrel-releasing IUD insertion up to 48 hours after delivery
  - Applies to vaginal and caesarean delivery, and for breastfeeding and non-breastfeeding women

- 75 µg desogestrel-containing pills added to comments for missed progestogen-only pills (question #18)
  - The existing guidance applies when one or more pills have been missed by more than 12 hours for women taking 75 µg desogestrel-containing pills.

2008 update – recommendation changes

- Expanded treatment options for women with bleeding or spotting while using progestogen-only injectables (question #22)
  - Two nonsteroidal anti-inflammatory drugs, mefenamic acid and valdecoxib, were added to the currently available recommendation for women experiencing either spotting or light bleeding, or heavy and prolonged bleeding

- Clarification of recommendation related to missed combined oral contraceptive pills (question #17)
  - The wording of the recommendation was changed to state that where recommendation text refers to 'missed active pills', it is meant that these pills are missed on *consecutive* days, i.e., 1 or 2 days i*n a row*, or 3 or more days *in a row*.

Guidance based on evidence and kept up-to-date

Monitoring all new evidence

CIRE

Systematic review on selected issues

Expert Working Groups

Electronic Updates

www.who.int/reproductive-health/family_planning

Step 1: 

Identify new evidence pertaining to contraceptive safety and efficacy

Step 2: 

Post records on CIRE database

Step 3: 

Screen for relevance to MEC and SPR

Step 4:

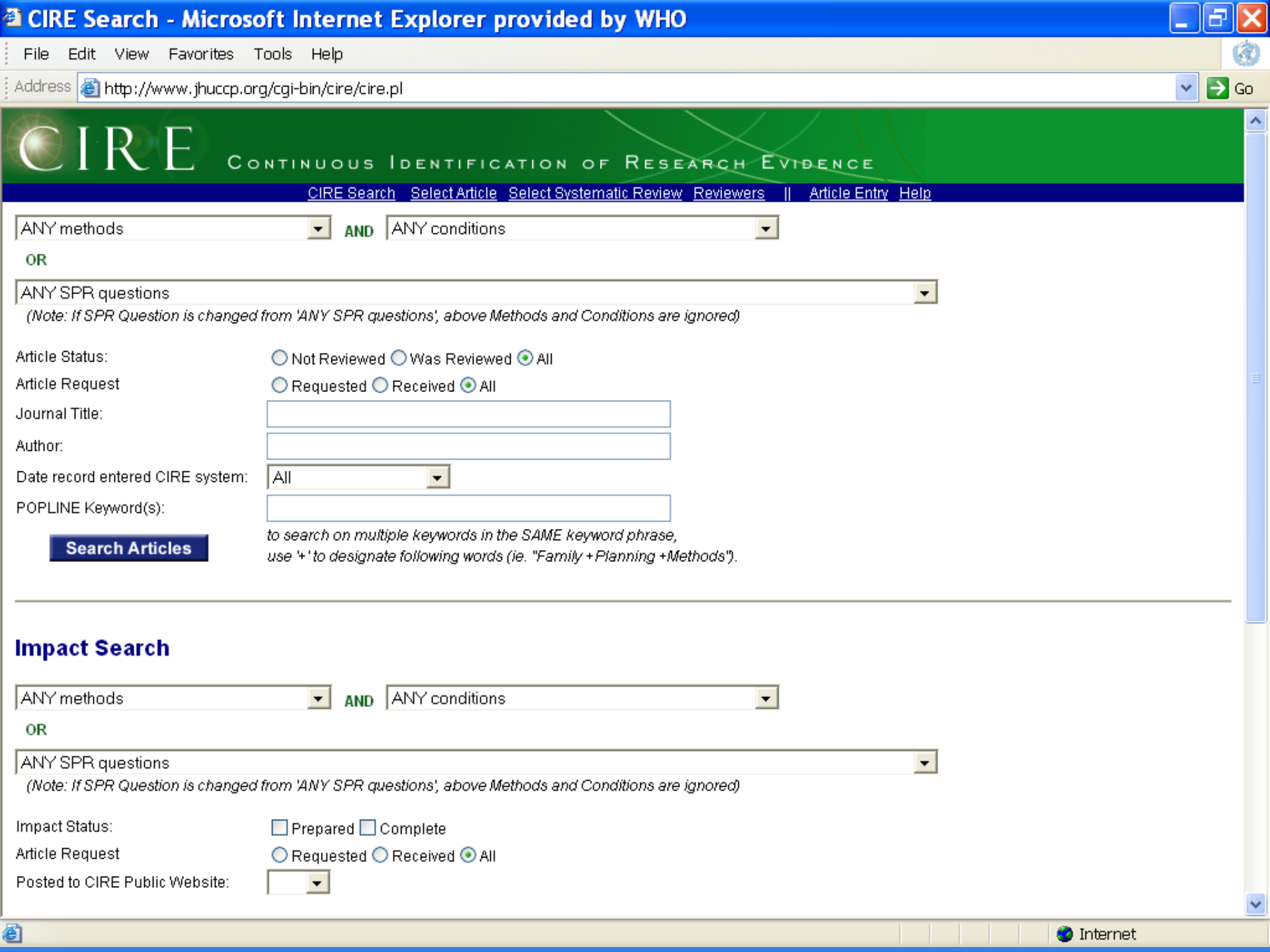
Update existing or conduct new systematic review

Step 5:

Send for peer review

Step 6:

Evaluate the need to update guidance in MEC/SPR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CIRE Search Select Article Select Systematic Review Reviewers || Article Entry Help
ANY methods
AND
ANY conditions
OR
ANY SPR questions
(Note: If SPR Question is changed from 'ANY SPR questions', above Methods and Conditions are ignored)
Article Status: Not Reviewed Was Reviewed All
Article Request Requested Received All
Journal Title:
Author:
Date record entered CIRE system: All
POPLINE Keyword(s):
Search Articles
to search on multiple keywords in the SAME keyword phrase,
use '+' to designate following words (ie. "Family +Planning +Methods").
Impact Search
ANY methods
AND
ANY conditions
OR
ANY SPR questions
(Note: If SPR Question is changed from 'ANY SPR questions', above Methods and Conditions are ignored)
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Article Request Requested Received All
Posted to CIRE Public Website:
Internet

CIRE Public System - Microsoft Internet Explorer provided by WHO

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Address http://www.jhuccp.org/cire_pub.pl Links

CIRE CONTINUOUS IDENTIFICATION OF RESEARCH EVIDENCE

NEW EVIDENCE FOR CONTRACEPTIVE USE

FOR THE WORLD HEALTH ORGANIZATION MEDICAL ELIGIBILITY CRITERIA (MEC) AND SELECTED PRACTICE RECOMMENDATIONS (SPR)

Welcome to CIRE - the Continuous Identification of Research Evidence - a collaborative effort of the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and the Johns Hopkins Bloomberg School of Public Health's Center for Communication Programs (CCP).

To ensure that its evidence-based family planning guidance remains current, the WHO collaborates on the CIRE system with the WHO Collaborating Centre in Reproductive Health at the CDC and the INFO Project at CCP. The system is supported by the United States Agency for International Development (USAID) and the National Institute of Child Health & Human Development (NICHD).

The CIRE system facilitates the updating of WHO's evidence-based family planning guidance. The system identifies articles whose study objectives concern a topic addressed by WHO's Medical Eligibility Criteria for Contraceptive Use (MEC) or the Selected Practice Recommendations for Contraceptive Use (SPR). Identification begins with screening of new articles entered into the POPLINE database since January 2002. These articles are then reviewed to determine whether the evidence they provide is relevant to WHO guidance. Any updates to current guidance based on evidence from the CIRE system will be noted on the electronic versions of the MEC or SPR. Changes to classifications of the MEC or recommendations in the SPR will ordinarily be made only following expert working group meetings.

The new articles that have been identified to date are accessible by searching the CIRE system and are also available through a regular email bulletin.

- Send this email to receive regular CIRE system postings from the email bulletin

WHO's on-line versions of the MEC and the SPR also feature the availability of new articles identified by the CIRE system. In addition, new postings to the CIRE system will be featured in CCP's weekly e-zine, The Pop Reporter. You may visit POPLINE for more information on obtaining full-text articles from CCP or view the WHO Family Planning Page for more information about family planning guidance.

SEARCH EVIDENCE

Medical Eligibility Criteria (MEC):

Choose a Method **AND/OR** Choose a Condition **Search**

Internet

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CIRE Systematic Review - Microsoft Internet Explorer provided by WHO

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↓Reviewer Information

Consensus Information

Update Status:

○ In Progress ○ Sent ○ Responses Received ◉ Complete

Disposition:

Current recommendation consistent with evidence.

Selected Peer Reviewer Information:

Reviewer Info	Date Sent	Status	See Review	Status Date	Review Reminder
CDC Appraisal Box		Sent	View / Modify		Feb 12, 2003
Dr. Polly Marchbanks, PhD		Sent	View / Modify	Jan 23, 2003	Feb 12, 2003
Dr. Bert Peterson (GSG), M.D.		Sent	View / Modify		Feb 12, 2003
Dr. Kate Curtis	Oct 06, 2004	Sent	View / Modify	Oct 06, 2004	Oct 27, 2004

Article Notes:

Peer Reviewers Summary:

CDC: No, Poor
Reviewer 1
Yes: No statistical difference between the Sunday Start and Quick Start groups for side effects; suggestion of better compliance / continuation amongst QS group (especially since there was a selection bias against compliance in the QS group.

Update Info | Print Consensus

Internet

Evaluating the need to update the guidance

If consistent with current guidance or not urgent:

→ **Review at next Expert Working Group Meeting**

If inconsistent and urgent:

→ **Consult Guideline Steering Group and post guidance updates on web**

Family planning - Guidance updates - Microsoft Internet Explorer provided by WHO

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Address http://www.who.int/reproductive-health/family_planning/updates.html Go

World Health Organization

Family Planning

Family planning home
Evidence-based guidance
Guidance updates
Documents & publications

Research:
Safety & effectiveness of methods
New & improved methods
Social & behavioural

What's new:
Hormonal Contraception and HIV: Science and Policy
Decision-making tool for family planning clients & providers
WHO Statement on carcinogenicity of combined hormonal contraceptives and combined menopausal treatment
WHO Statement on hormonal contraception and bone health
Levonorgestrel for emergency contraception
Levonorgestrel para Anticoncepción de Emergencia
Lévonorgestrel et contraception d'urgence

Related link:
Reproductive Health Library

Guidance updates

To ensure that its evidence-based family planning guidance remains current, the WHO collaborates on the CIRE system (Continuous Identification of Research Evidence) with the WHO Collaborating Centre in Reproductive Health at the CDC and the INFO Project at CCP. In this way, WHO monitors the publication of new research evidence that may affect the recommendations contained in the Medical Eligibility Criteria for Contraceptive Use.

Since the latest publications of the Medical Eligibility Criteria in 2004, and the Selected Practice Recommendations in 2005, new evidence or new recommendations by other WHO bodies have been identified to warrant comments on or changes to the original guidelines. The new updates are shown below.

New information is available on the following:

WHO Statement on hormonal contraception and risk of STI acquisition
(July 2005)

Statement (PDF - 31 KB)

This statement does not affect current guidance.

WHO Statement on hormonal contraception and bone health
(July 2005)

Statement (PDF - 2 pages - 103 KB)

This statement does not affect current guidance.

The CIRE system identifies articles whose study objectives concern a topic addressed by WHO's Medical Eligibility Criteria for Contraceptive Use (MEC) or the Selected Practice Recommendations for Contraceptive Use (SPR). Identification begins with screening of new articles entered into the POPLINE database since January 2002. These articles are then reviewed to determine whether the evidence they provide is relevant to WHO guidance. Any updates to current guidance based on evidence from the CIRE system will be noted on the electronic versions of the MEC or SPR. Changes to classifications of the MEC or recommendations in the SPR will ordinarily be made only following expert working group meetings.

The new articles that have been identified to date are accessible by searching the CIRE system and are also available through a regular email bulletin. The system is supported by the United States Agency for International Development (USAID) and the National Institute of Child Health & Human Development (NICHD).

Local intranet

Family planning - WHO - Microsoft Internet Explorer provided by WHO

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Address http://www.who.int/reproductive-health/family_planning/index.html Go

World Health Organization

Family Planning

Family planning home
Evidence-based guidance
Guidance updates
Documents & publications
Research:
Safety & effectiveness of methods
New & improved methods
Social & behavioural

What's new:
Hormonal Contraception and HIV: Science and Policy
Decision-making tool for family planning clients & providers
WHO Statement on carcinogenicity of combined hormonal contraceptives and combined menopausal treatment
WHO Statement on hormonal contraception and bone health
Levonorgestrel for emergency contraception
Levonorgestrel para Anticoncepción de Emergencia
Lévonorgestrel et contraception d'urgence

Related link:
Reproductive Health Library

Unmet needs

There are still some 123 million women around the world, mostly in developing countries, who are not using contraception in spite of an expressed desire to space or limit the numbers of their births.[1]

An estimated 38% of all pregnancies occuring around the world every year are unintended, and around 6 out of 10 such unplanned pregnancies result in an induced abortion.[2]

A woman's ability to space or limit the number of her pregnancies has a direct impact on her health and well-being as well as the outcome of her pregnancy. In enabling women to exercise their reproductive rights, family planning programmes can also improve the social and economic circumstances of women and their families.

WHO's role in promoting FP

The reasons why family planning needs are often not met are varied, but include: poor access to quality services, a limited choice of methods, lack of information, concerns about safety or side-effects and partner disapproval.

WHO is currently addressing some of these needs in working to help

- improve the safety and effectiveness of contraceptives methods;
- widen the range of family planning methods available to women and men.

Progress newsletter
Issue 68 (June 2005)
Contraceptive methods—better information for a wider choice
Who is eligible to use the different types of contraceptives?
Safe and effective use of contraceptives
Some recommendations for the use of oral contraceptives
Some recommendations for the use of emergency contraception
Some recommendations for the use of levonorgestrel releasing intrauterine devices (LNG IUDs)
How to be reasonably certain a woman is not pregnant
8 pages (PDF 285 KB)

Evidence-based guidance on contraceptive use

Decision-Making Tool for Family Planning Clients and Providers

An evidence-based tool to promote high-quality family planning counselling. More info/full text

Third edition of the Medical Eligibility Criteria for Contraceptive Use

More information/full text
Français - Español - русский - Português

Second edition of the Selected Practice Recommendations for Contraceptive Use

More information/full text
Español - Français - русский

Photo credits

Local intranet

Decision-making Tool for Family Planning Clients and Providers

- A tool for primary and secondary level FP providers and their clients
- Facilitates the interaction between the client and the provider
- Promotes informed choice of a contraceptive method
- Adaptable to local contexts

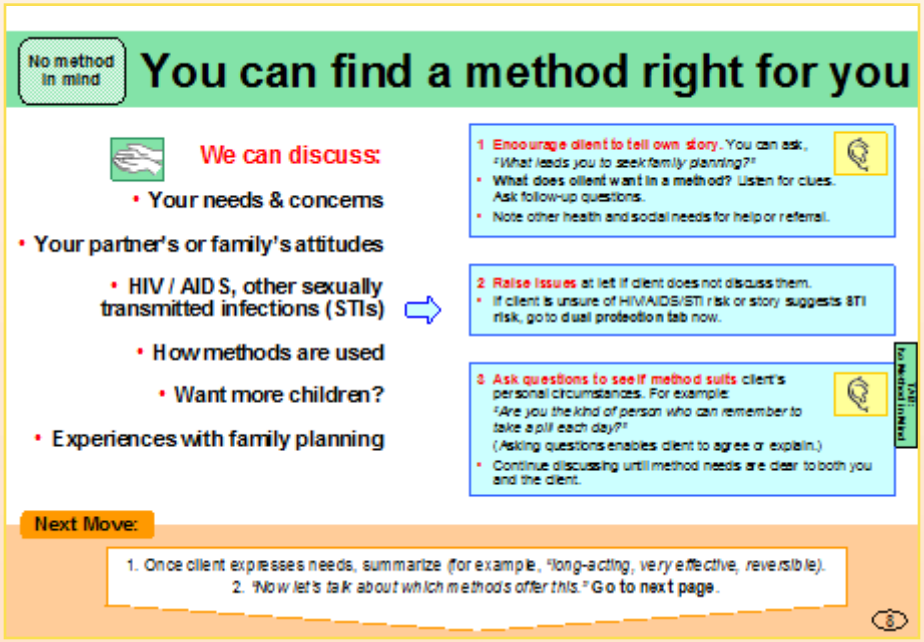
Decision-Making Tool for Clients...

You can find a method right for you

We can discuss:

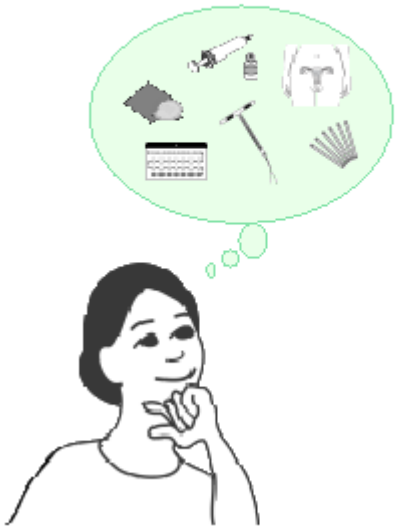
- Your needs & concerns
- Your partner's or family's attitudes
- HIV / AIDS, other sexually transmitted infections (STIs)
- How methods are used
- Want more children?
- Experiences with family planning

...and Providers



Best Practices in Client-Provider Interaction

Do you have a method in mind?



If you do, let's talk about how well it suits your needs

- What have you heard about it?
- What do you like about it?

If not, we can find a method right for you

Important for choosing a method:

*Do you need protection from pregnancy **AND** sexually transmitted infections?*

Evidence-Based Technical Information

If you miss pills

ALWAYS:

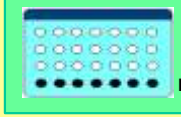
1. Take a pill as soon as you remember
2. Take the next pill at the usual time
3. Continue to take your pill as usual, one each day

4. If you miss 2 or more pills, or start pack 2 or more days late, you ALSO need to:

USE BACK-UP:
Avoid sex or use condoms for 7 days

AND

SKIP WEEK 4:
(inactive pills or pill-free week)
and go straight to next pack

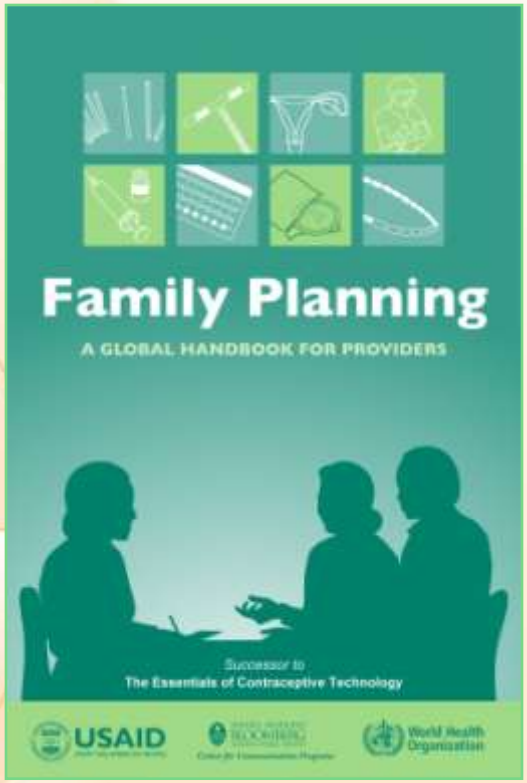


Inactive Pills

Special rule for Inactive Pills
(28 day packs only!)

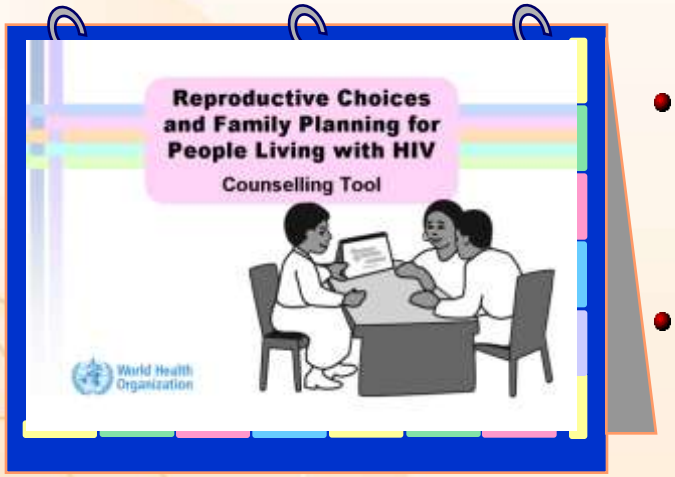
Inactive Pills

Family Planning: A Global Handbook for Providers



- Launched in October 2007
- Over 100,000 copies distributed
- Printed in English, French, and Spanish
- Translations underway in Arabic, Chinese, Farsi, Hindi, Lithuanian, Portuguese, Romanian, Russian, Swahili, Urdu
- Accompanying curriculum under development
- Endorsed by close to 50 organizations

Reproductive Choices and Family Planning For People with HIV



- Two-day training and job aid – an adaptation of the Decision-Making Tool for Family Planning Clients and Providers
- Developed as part of Integrated Management of Adolescent and Adult Illness (IMAI) series
- Field tested in Uganda and Lesotho
- Developed in collaboration with the INFO Project at Johns Hopkins Bloomberg School of Public Health
- First edition published in 2006 and available on WHO website

Adaptation of Reproductive Health (RH) guidelines

- Generic adaptation guideline for all RH Guidelines and Tools
- Published in 2007
- Available from WHO website or publication centre

For more information

- Contact: reproductivehealth@who.int