

SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE

2008 update

EXECUTIVE SUMMARY

The *Selected practice recommendations for contraceptive use* – one of the four cornerstones of the World Health Organization's (WHO) evidence-based family planning guidance – provides evidence-based recommendations on how to safely and effectively use contraceptive methods once they are deemed medically appropriate for an individual. This guideline is intended for use by policy-makers, programme managers, and the scientific community in the preparation of national family planning/sexual and reproductive health programmes for delivery of contraceptives. The first edition of the *Selected practice recommendations for contraceptive use* was published in 2002, and the second edition in 2004.

On 1–4 April 2008, WHO convened an expert Working Group in Geneva, Switzerland, to revise the second edition in response to newly published evidence and requests for clarification of specific recommendations from users of the guideline. The meeting brought together 43 participants from 23 countries, including nine agency representatives. The expert Working Group was comprised of: international family planning experts, including clinicians, epidemiologists, policy-makers, programme managers; experts in evidence identification and synthesis; experts in pharmacology; and users of the guideline. All members of the expert Working Group were asked to declare any conflict of interest; three of the experts declared a conflict of interest relevant to the subject matter of the meeting. They were not asked to withdraw from recommendation formulation.

METHOD OF WORK

Using a system that identifies new evidence on an ongoing basis (the Continuous Identification of Research Evidence, or CIRE system, www.infoforhealth.org/cire/cire_pub.pl),¹ WHO identified five recommendations from the second edition for which new evidence had become available. Systematic reviews were then conducted to appraise the complete body of evidence for those recommendations. To conduct the systematic reviews, studies were identified using the CIRE system as well as through searches of PubMed and *The Cochrane Library* from 1966 to January 2008. The search also included reviews of reference lists in articles identified by the literature search and contact with experts in the field. The systematic reviews were provided to the expert Working Group prior to the meeting and served as the basis for the Group's deliberations during the meeting. The Group arrived at its recommendations through consensus.

¹ Mohllajee AP, Curtis KM, Flanagan RG, Rinehart W, Gaffield ML, Peterson HB. Keeping up with evidence: a new system for WHO's evidence-based family planning guidance. *American Journal of Preventive Medicine*, 2005; 28:483–490.

HOW TO USE THIS SUMMARY

This document summarizes the changes made to recommendations related to questions 6, 9, 11, 18 and 22 in the second edition of the *Selected practice recommendations for contraceptive use*. The revised recommendations will appear in the 3rd edition of the guideline when it is published. In addition, this document includes a clarification of the recommendation related to question 17.

Only recommendations that have changed are included here. The changes are highlighted in **bold** lettering. For the complete text of each of the questions refer to the 2nd edition of the guideline (available at <http://www.who.int/reproductive-health/publications/spr/index.htm>).

It is expected that the recommendations in the 3rd edition of the *Selected practice recommendations for contraceptive use* will remain valid until 2011. The Department of Reproductive Health and Research at WHO Headquarters in Geneva will be responsible for initiating a review of the guideline at that time.

Grace period for a repeat injection of DMPA extended to 4 weeks

The following changes were made to address situations where a woman comes late for her repeat DMPA injection.

Question 6. When can a woman have repeat progestogen-only injectables (POIs) – depot-medroxyprogesterone acetate (DMPA) or norethisterone enantate (NET-EN)?

Late for an injection

- The repeat injection of **DMPA can be given up to 4 weeks late** without requiring additional contraceptive protection. For NET-EN, the repeat injection can be given up to 2 weeks late without requiring additional contraceptive protection.
- If she is more than **4 weeks late for a DMPA repeat injection**, or more than 2 weeks late for a NET-EN repeat injection, she can have the injection if it is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days. She may wish to consider the use of emergency contraception if appropriate.

Comments

The expert Working Group considered the risk of ovulation to be minimal within **4 weeks** following the time for a repeat injection for DMPA (3 months) and 2 weeks following the time for a repeat injection for NET-EN (2 months).

DMPA injections should be administered every 3 months. While the repeat DMPA injection can be given up to 4 weeks late without requiring additional contraceptive protection, this does not mean that the regular DMPA injection interval can be extended by 4 weeks.

Postpartum IUD insertion timing clarified

Guidance for postpartum IUD insertion was revised in the *Medical eligibility criteria for contraceptive use* (4th edition, in press). The recommendations below reflect those changes.

Question 9. When can a woman have a copper-bearing IUD inserted?

Postpartum and breastfeeding or non-breastfeeding (including after caesarean delivery)

- **She can have a copper-bearing IUD inserted up to 48 hours after delivery, including immediately after delivery of the placenta.**
- **If the delivery is by caesarean section, a copper-bearing IUD can be placed after delivery of the placenta, before closing the uterus.**

Question 11. When can a woman have a levonorgestrel-releasing IUD (LNG-IUD) inserted?

Postpartum and non-breastfeeding (including after caesarean delivery)

- **She can have an LNG-IUD inserted up to 48 hours after delivery, including immediately after delivery of the placenta.**
- **If the delivery is by caesarean section, the LNG-IUD can be placed after delivery of the placenta, before closing the uterus.**

Clarification of recommendations related to question 17 on missed combined oral contraceptive pills

Question 17. What can a woman do if she misses combined oral contraceptives (COCs)?

The expert Working Group addressed this issue in response to requests from the field to clarify the language of the recommendations related to missed pills. The clarification is not based on any new data, rather it relates to the wording of the recommendations. In the recommendations for Question 17, each time the text refers to missing active pills, the text now states that the pills are missed on **consecutive days, i.e. 1 or 2 days in a row, or 3 or more days in a row.**

Comments on 75 µg desogestrel-containing pills added to the recommendation on missed progestogen-only pills

Question 18. What can a woman do if she misses progestogen-only pills (POPs)?

Comments

Existing guidance is provided for situations when a user misses one or more pills by more than 3 hours. For women taking the 75 µg desogestrel-containing pill, the existing guidance for both women having menstrual cycles and those breastfeeding and amenorrhoeic applies when one or more pills have been missed by more than 12 hours.



Expanded treatment options for women with bleeding or spotting while using progestogen-only injectables

Two nonsteroidal anti-inflammatory drugs, mefenamic acid and valdecoxib, were added to the currently available recommendations for women experiencing either spotting or light bleeding, or heavy or prolonged bleeding related to the use of progestogen-only injectables.

Question 22. What can be done if a woman has menstrual abnormalities when using progestogen-only injectables (POIs) – depot medroxyprogesterone acetate (DMPA) or norethisterone enantate (NET-EN)?

Spotting or light bleeding

- **If no gynaecologic problems are found and she finds the bleeding unacceptable, short-term treatment with nonsteroidal anti-inflammatory drugs may be helpful.** If she decides to discontinue the injectable, help her choose another method.

Heavy or prolonged bleeding (more than 8 days or twice as much as her usual menstrual period)

- If the bleeding becomes a threat to the health of the woman or it is not acceptable to her, discontinue the injectable. Help her choose another method. **In the interim, short-term treatment with either ethinylestradiol or nonsteroidal anti-inflammatory drugs may be helpful.**

Comments

The expert Working Group reviewed the limited available data on treatment options for light or heavy bleeding and determined that the following drugs may be helpful for short-term treatment (i.e. 5–7 days):

Spotting or light bleeding

- **Nonsteroidal anti-inflammatory drugs**
Mefenamic acid
Valdecoxib

Heavy or prolonged bleeding

- **Nonsteroidal anti-inflammatory drugs**
Mefenamic acid
Valdecoxib
- **Hormonal drugs**
Ethinylestradiol

update OF REFERENCE LIST IN THE 2ND EDITION

Question 6:

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Conflicts of interest: Dr A. Glasier works at a clinic that receives research funding support from four companies that manufacture various contraceptive products. Dr J. Shelton has shareholdings in a pharmaceutical company that manufactures antiretroviral therapies. Dr E. Weisberg receives funding for contraceptive research from four contraceptive manufacturers. She also serves on the advisory board of a manufacturer of the vaccine against human papillomavirus and on an advisory board for contraceptive education funded by a contraceptive manufacturer.