Fourth edition

# Selected practice recommendations for contraceptive use

World Health Organization

human reproduction programme hrp
research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

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**Web Annex.** Development of updated recommendations and Grading of Recommendations Assessment, Development and Evaluation (GRADE) tables on interventions to ease interval placement of intrauterine devices (IUDs). In: Selected practice recommendations for contraceptive use, fourth edition. Geneva: World Health Organization; 2025. https://doi.org/10.2471/B09567.

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## Guideline Development Group (GDG)

Rachid Bezad (Université Mohammed V de Rabat, Morocco), Sharon Cameron (University of Edinburgh, United Kingdom of Great Britain and Northern Ireland), Geeta Chhibber (Jhpiego, New Delhi, India), Maria del Carmen Cravioto (Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico City, Mexico), Alison Edelman (Oregon Health & Science University, Portland, United States of America [USA]), Nasser El Kholy (Ain Shams University, Cairo, Egypt), Anna Glasier (University of Edinburgh, United Kingdom), Andy Gray (Centre for the AIDS Programme of Research in South Africa [CAPRISA], Pretoria, South Africa), Philip Hannaford (University of Aberdeen, United Kingdom), Elimase Kamanga Gama (White Ribbon Alliance, Lilongwe, Malawi), Anne-Beatrice Kihara (International Federation of Gynecology and Obstetrics [FIGO], Nairobi, Kenya), Seni Kouanda (Institute of Research in Health Sciences [IRSS], Ouagadougou, Burkina Faso), Enriquito Lu (Quezon City, Philippines), Catia Marzolini (European AIDS Clinical Society [EACS], Basel, Switzerland), Mari Nagai (National Center for Global Health and Medicine, Tokyo, Japan), Herbert Peterson (University of North Carolina at Chapel Hill, USA), Farida Shah (International Confederation of Midwives [ICM] Islamabad, Pakistan), Dirgha Raj Shrestha (Dhulikhel Municipality, Kavrepalanchok, Nepal) and Carolina Sales Vieira (University of São Paulo, São Paulo, Brazil).

## Evidence Synthesis Team (EST)

The guideline methodologist was Roger Chou (Oregon Health & Sciences University, Portland, USA), and the members of the systematic review teams for the SPR topics were: Sophia Garbarino (Emory University, Atlanta, USA), Emily M. Snyder (Noorda College of Osteopathic Medicine, Provo, USA), Tesfaye Tufa (St Paul's Hospital Millennium Medical College, Addis Ababa, Ethiopia) and Mekdes Wolderufael (St Paul's Hospital Millennium Medical College, Addis Ababa, Ethiopia).

Throughout the development of the fourth edition of the SPR guideline, until 20 January 2025, the following experts from the United States Centers for Disease Control and Prevention (CDC) supported WHO as part of the EST: Kathryn Curtis, Katherine Kortsmit, Antoinette Nguyen, Naomi Tepper and Lauren Zapata. In addition, WHO appreciates and wishes to recognize the contribution of Kathryn Curtis to all editions of the SPR since its inception as part of the GDG and the EST.

## External Review Group (ERG)

Elsie Ayeh (Network of Persons Living with HIV [NAP+], Accra, Ghana), Luis Bahamondes (State University of Campinas, Campinas, Brazil), Loshan Moonesinghe (Ministry of Health, Colombo, Sri Lanka), Chelsea Moroni (Centre for Reproductive Health, University of Edinburgh, United Kingdom), Hiromi Obara (National Center for Global Health and Medicine, Tokyo, Japan), Harshadkumar C. Sangvi (Johns Hopkins University, Baltimore, USA), Jenni Smit (University of Witwatersrand, Johannesburg, South Africa), Yahan Xu (International Federation of Medical Students Associations, Sydney, Australia) and Noreen Zafar (Girls & Women Health Initiative, Lahore, Pakistan).

## Observers

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Federation (IPPF) (Nathalie Kapp), United Nations Population Fund (UNFPA) (Agnes Chidanyika) and United States Agency for International Development (USAID) (Amanda Cordova, until 20 January 2025).

## WHO Guideline Steering Group (GSG)

WHO is also grateful for the input to this guideline from the following WHO GSG members from a range of departments at WHO headquarters in Geneva.

- Department of Sexual and Reproductive Health and Research (SRH) – James Kiarie (Unit Head, Contraception and Fertility Care [CFC]), Therese Curtin (CFC), Nancy Kidula (CFC), Petrus Steyn (CFC), Åsa Hanna Mari Nihlén (Human Rights Advisor), Caron Rahn Kim (Prevention of Unsafe Abortion [PUA])
- Department of Essential Medicines and Health Products – Matthias Mario Stahl (Prequalification) and Lorenzo Moja (Essential Medicines List)
- Global HIV, Hepatitis and Sexually Transmitted Infections Programmes – Marco Antonio De Avila Vitoria
- Director-General's Office – Anna Coates (Gender Advisor).

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- WHO Regional Office for Africa – Léopold Ouedraogo
- WHO Regional Office for the Eastern Mediterranean – Karima Gholbzouri
- WHO Regional Office for Europe – Oleg Kuzmenko
- WHO Regional Office for the Americas (Pan American Health Organization) – Rodolfo Gómez Ponce de León
- WHO Regional Office for the Western Pacific – Madeline Solitario Salva.

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- Department of SRH – Pascale Allotey (Director), Moazzam Ali (CFC), Rita Kabra (CFC), Asantesana Kamuyango (CFC), Nandita Thatte (CFC), Mercedes Bonet (Maternal and Perinatal Health), Manjulaa Narasimhan (Self-Care) and Polyphile Ntihinyurwa (PUA)
- Department of Nutrition and Food Safety – Nina Chad.

## Overall coordination and writing

Overall coordination for guideline development was provided by the WHO Secretariat Team, comprising James Kiarie (Unit Head) and Nancy Kidula (responsible technical officer) from the CFC unit at WHO's SRH Department. The first draft of the guideline was written by Maria Isabel Rodriguez, Nancy Kidula and Mary Lyn Gaffield. Drafts were reviewed and input was provided by members of the GDG, EST, ERG and the WHO GSG. The systematic reviews providing summarized evidence for this guideline were coauthored by Tesfaye Tufa and, until 20 January 2025, Kathryn Curtis, Antoinette Nguyen and Lauren Zapata. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) tables and expertise on GRADE methodology were provided by Roger Chou.

## Funding

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# Abbreviations

| | |
|---|---|
| **CFC** | Contraception and Fertility Care (in the WHO SRH Department) |
| **CHC** | combined hormonal contraceptive |
| **CIC** | combined injectable contraceptive |
| **CIRE** | Continuous Identification of Research Evidence |
| **COC** | combined oral contraceptive |
| **CRPD** | United Nations Convention on the Rights of Persons with Disabilities |
| **Cu-IUD** | copper-bearing intrauterine device |
| **CVR** | combined contraceptive vaginal ring |
| **DMPA** | depot medroxyprogesterone acetate |
| **DMPA-IM** | DMPA, administered intramuscularly |
| **DMPA-SC** | DMPA, administered subcutaneously |
| **DOI** | declaration of interest |
| **DVT** | deep vein thrombosis |
| **EC** | emergency contraception |
| **ECP** | emergency contraceptive pill |
| **ERG** | External Review Group |
| **EST** | Evidence Synthesis Team |
| **EtD** | evidence-to-decision |
| **ETG** | etonogestrel |
| **FAB** | fertility-awareness-based (method) |
| **FIGO** | International Federation of Gynaecology and Obstetrics |
| **FP DAK** | Digital adaptation kit for family planning |
| **FPTRP** | Family planning training resource package |
| **GDG** | Guideline Development Group |
| **GRC** | Guidelines Review Committee |
| **GRADE** | Grading of Recommendations Assessment, Development and Evaluation |
| **GSG** | Guideline Steering Group |
| **HRP** | UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (also known as the Human Reproduction Programme) |
| **IBP** | Implementing Best Practices |
| **ICM** | International Confederation of Midwives |
| **ICN** | International Council of Nurses |
| **ICPD** | International Conference on Population and Development |
| **IUD** | intrauterine device |
| **LNG** | levonorgestrel |
| **LNG-IUD** | levonorgestrel-releasing intrauterine device |
| **MEC** | *Medical eligibility criteria for contraceptive use* (WHO guideline that is a companion to the SPR) |
| **NET-EN** | norethisterone enanthate |
| **NSAID** | non-steroidal anti-inflammatory drug |
| **PI** | principal investigator |
| **PICO** | population, intervention, comparator, outcome |
| **PID** | pelvic inflammatory disease |
| **POC** | progestogen-only contraceptive |
| **POI** | progestogen-only injectable |
| **POP** | progestogen-only pill |
| **PRISMA** | Preferred Reporting Items for Systematic Reviews and Meta-Analysis |
| **RCT** | randomized controlled trial |
| **SDG** | Sustainable Development Goals |
| **SDM** | Standard Days Method |
| **SPR** | *Selected practice recommendations for contraceptive use* (this publication) |
| **SRH** | sexual and reproductive health |
| **STI** | sexually transmitted infection |
| **UNDP** | United Nations Development Programme |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations Children's Fund |
| **UPA** | ulipristal acetate |
| **USAID** | United States Agency for International Development |
| **WHO** | World Health Organization |
| **WHO IRIS** | WHO institutional repository for information sharing |

# Executive summary

This document is part of the process for improving the quality of care in family planning. *Selected practice recommendations for contraceptive use* (SPR) presents current World Health Organization (WHO) recommendations on how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate. This is the fourth edition of the SPR – the latest in the series of periodic updates.

The fourth edition of the SPR has two components, published separately – this main document and a web annex. This main document contains the new, updated and reaffirmed recommendations on contraceptive provision and describes how to apply them. Meanwhile, the first part of the web annex (Development of updated recommendations) provides supplementary material that explains how the recommendations in the SPR were developed and describes the systematic reviews that informed the decision-making. The second part of the web annex contains the Grading of Recommendations Assessment, Development and Evaluation (GRADE) tables which present the relevant evidence that was reviewed relating to the topics that were prioritized for this fourth edition of the SPR.

This edition includes recommendations on initiation or continuation of use, correct use and managing problems during use of family planning methods, as well as implementation considerations, for each of the following methods: copper-bearing intrauterine devices (Cu-IUDs), levonorgestrel-releasing IUDs (LNG-IUDs), levonorgestrel (LNG) and etonogestrel (ETG) implants, depot medroxyprogesterone acetate (DMPA) administered intramuscularly or subcutaneously, norethisterone enanthate (NET-EN), progestogen-only pills (POPs), low-dose (≤ 35 µg of ethinyl estradiol) combined[1] oral contraceptive (COC) pills, the combined contraceptive transdermal patch (the patch), the combined contraceptive vaginal ring (CVR), combined injectable contraceptives (CICs), emergency contraceptive pills (ECPs), Cu-IUD for emergency contraception, Standard Days Method (SDM) (a fertility-awareness-based [FAB] method) and male sterilization (vasectomy).

## Target audience

The intended audience for this publication is policy-makers and family planning programme managers and the scientific community. The SPR is not meant to serve as the actual guidelines for national family planning and reproductive health programmes, but rather as a reference in the preparation of national- or facility-level guidelines, standards and protocols for the delivery of contraceptive services. The recommendations in this document are intended for interpretation at the country and programme levels in a manner that reflects the diversity of situations and settings in which contraceptives are provided. While it is unlikely that the recommendations in this document will change during this process, it is very likely that their application at country level will vary. In particular, the level of clinical knowledge and experience of different types of providers and the resources available at the service-delivery point will have to be taken into consideration.

## Guideline development methods

The Guideline Development Group (GDG) convened by WHO consisted of 19 individuals from 16 countries, including experts in family planning, reproductive endocrinology, midwifery, gynaecology, obstetrics, epidemiology, pharmacology, gender, policy-making, health systems, guideline methodology, evidence synthesis and user experiences. The Acknowledgements section of this document lists all the GDG members, while Annex 1 outlines their declarations of interests. The mandate of the GDG was to review the evidence and, where appropriate, revise the recommendations in the third edition of the SPR and/or derive new recommendations to develop the fourth edition. The meetings were held on 8–10 November 2022 and 23–25 July 2024.

The Continuous Identification of Research Evidence (CIRE) system was created by WHO and its partners in 2002 to identify newly published evidence that is

[1] "Combined" refers to a combination of estrogen and a progestogen.

relevant to WHO's family planning guidelines regularly and systematically *(1)*. Where applicable, systematic reviews are updated to determine whether WHO recommendations remain consistent with the overall body of evidence. In many instances, either no new evidence has been identified since the publication of the last edition or update of the SPR, or any evidence emerging since those publications simply confirms previous research findings. For this edition, the GDG prioritized the review of two new topics identified as important to the field: "Medication to ease interval IUD placement" and "Non-pharmacological interventions to ease interval IUD placement". Systematic reviews were undertaken for these topics in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, and the details are available in the web annex. The other recommendations that were published in the third edition of the SPR were reviewed and confirmed by the GDG with no changes made.

The GDG considered the overall quality of the scientific evidence available, paying particular attention to the strength and consistency of the data related to the new topics, in accordance with the GRADE approach to evidence review *(2)*. To formulate recommendations, the GDG considered the GRADE evidence profiles, any indirect evidence, and the benefits of preventing unintended pregnancy. Additionally, client values and preferences were taken into account, in order to facilitate access to contraceptive services and encourage uptake and continuation. It was clear that clients prioritized the availability of a wide range of options and the removal of unnecessary medical barriers to contraception. Through consensus, the GDG arrived at the new recommendations (see Table 1) and upheld the existing recommendations.

In this edition of the SPR, the GDG has classified the recommendations on the topics reviewed as either "strong" or "conditional". Because the target audience for the SPR is primarily policy-makers, when the GDG classifies a recommendation as strong, it is because the GDG is certain that the desirable consequences outweigh the undesirable ones, and the recommendation can thus be adopted as policy in most situations, indicating that in general, for high-quality family planning care, both health workers and clients should adhere to the recommendations. "Conditional" recommendations are issued when the benefits of adherence to a recommendation probably outweigh the undesirable effects. However, with conditional recommendations, different choices may be appropriate for some individuals or settings, the benefits may not always warrant the resource requirements in all settings, and it is possible that new evidence may result in a change to the balance of risks to benefits *(3)*.

In this fourth edition of the SPR, most of the recommendations are provided in narrative form; however, for recommendations regarding which examinations and tests should be offered for the safe provision of a contraceptive method, the recommendations are presented in tables and an A-B-C classification scale has been applied. This scale was devised by the expert group that developed the first edition of the SPR in 2001 and has been used by national programmes ever since. To avoid unnecessary confusion among users, the A-B-C classification has been retained for recommendations related to examinations and tests.

WHO will initiate a review of all the recommendations in this document in five years' time. In the interim, WHO will continue to monitor the body of evidence informing these recommendations and will convene additional consultations, as needed, should new evidence necessitate reconsideration of the existing recommendations. Such updates may be particularly warranted for issues where the evidence base may change rapidly. Any interim recommendations will be made available on WHO's web pages for sexual and reproductive health and the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) at http://www.who.int/hrp and the web page for contraception at https://www.who.int/health-topics/contraception. WHO encourages research aimed at addressing key unresolved issues related to the safe and effective use of contraceptives. WHO also invites comments and suggestions for improving this guideline.

## Summary of the topics reviewed

Two key topics encompassing 19 sub-topics were reviewed by the GDG during the revision of the SPR to develop this fourth edition, and four overarching new recommendations were made. The topics reviewed and the new recommendations are summarized in Table 1. For some types of medication, multiple outcomes of interest and/or dosages were examined, for which a range of GRADE assessments is presented.

An explanation of the process followed to select and prioritize these topics is included in Annex 2. All the other recommendations were confirmed by the GDG and did not undergo formal review for the fourth edition (these recommendations are not included in Table 1, but can all be found in section 5 of this publication).

**Table 1. Topics reviewed for the *Selected practice recommendations for contraceptive use* (SPR), fourth edition**

| Topic | SPR recommendation | GRADE assessment of quality of evidence[a] |
|---|---|---|
| **Medication to ease interval IUD placement[b]** | | |
| Misoprostol | Misoprostol is not recommended for routine use before IUD placement. Misoprostol might be helpful in select circumstances (e.g. in clients with a recent failed placement).<br>(Strength of recommendation: Conditional) | Moderate |
| *Paracervical blocks*<br>Lidocaine | Where local anaesthetics (e.g. lidocaine) and trained providers are available, paracervical blocks may be offered routinely for IUD placement. IUDs should not be withheld if local anaesthetics are not available.<br>(Strength of recommendation: Conditional) | Low |
| *Topical anaesthetics*<br>Lidocaine gel<br>Lidocaine spray<br>Lidocaine cream<br>Lidocaine-prilocaine cream | Where topical anaesthetics (e.g. lidocaine) are available, they may be offered routinely for IUD placement. IUDs should not be withheld if local anaesthetics are not available.<br>(Strength of recommendation: Conditional) | Low |
| *Nonsteroidal anti-inflammatory drugs (NSAIDs)*<br>Ibuprofen<br>Ketorolac<br>Naproxen<br>Ketoprofen<br>Etoricoxib<br>Indomethacin | NSAIDs may be offered routinely for IUD placement. IUDs should not be withheld if NSAIDs are not available.<br>(Strength of recommendation: Conditional) | Low |

| Topic | SPR recommendation | GRADE assessment of quality of evidence[a] |
|---|---|---|
| *Other medication*<br>Intrauterine instillation for IUD placement (2% lidocaine gel, 2% lidocaine, 1% mepivacaine)<br>NSAID and lidocaine[c]<br>NSAID and smooth muscle relaxant[d]<br>Tramadol<br>Paracetamol<br>Mefenamic acid<br>Smooth muscle relaxants (nitroprusside, nitroglycerin, glyceryl trinitrate, isonicotinic acid hydrazide, drotaverine)<br>Vaginal dinoprostone | The GDG reviewed evidence presented in a systematic review and GRADE tables assessing the quality of the evidence.<br>The GDG judged the body of evidence was insufficient for making any recommendation on these medicines. | Low |
| **Non-pharmacological interventions to ease interval IUD placement** | | |
| Acupuncture<br>Virtual reality headsets<br>Delayed bladder emptying<br>Valsalva (versus tenaculum)<br>Verbal analgesia (versus tramadol)<br>Placement at different points across menstrual period<br>Cold compress<br>Slow insertion (versus cough method)<br>Inhaled lavender oil (versus sesame oil)<br>Placement during or outside menstrual period | The GDG reviewed evidence presented in a systematic review and GRADE tables assessing the quality of the evidence.<br>The GDG judged the body of evidence was insufficient for making any recommendation on non-pharmacological interventions to ease IUD placement. | Very low |

[a] The categories for GRADE assessment of evidence are "very low", "low", "moderate" and "high". When a range is presented, the range reflects the GRADE quality assessment across important outcomes and/or across contraceptive methods. See the relevant GRADE table in the web annex for the outcomes explored.

[b] Interval IUD placement refers to insertion at any time during the menstrual cycle and after six weeks postpartum *(4)*.

[c] Recommendations on NSAIDs and lidocaine have been issued separately.

[d] A separate recommendation on NSAIDs only has been made.

# References for the executive summary[2]


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. Am J Prev Med. 2005;28:483–90 (https://doi.org/10.1016/j.amepre.2005.02.008).
2. Schünemann H, Brożek J, Guyatt G, Oxman A. GRADE handbook, updated October 2013 (https://gdt.gradepro.org/app/handbook/handbook.html).
3. WHO handbook for guideline development, second edition. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/145714).
4. Averbach S, Kully G, Hinz E, Dey A, Berkley H, Hildebrand M et al. Early vs interval postpartum intrauterine device placement: a randomized clinical trial. JAMA. 2023;329(11):910–7 (https://doi.org/10.1001/jama.2023.1936).


[2] All references were accessed on 18 June 2025.

# 1 Introduction

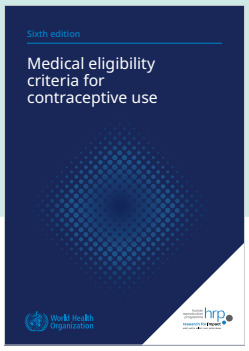
This document is part of the process for improving the quality of care in family planning. It is one of two evidence-based normative contraception guidelines which are also referred to as the "family planning cornerstones" of the World Health Organization (WHO). The first cornerstone/contraception guideline, *Medical eligibility criteria for contraceptive use* (MEC, now in its sixth edition *[1]*), provides recommendations on the safety of various contraceptive methods when used in the context of particular health conditions and physiological characteristics. This guideline document, *Selected practice recommendations for contraceptive use* (SPR, now in its fourth edition), is the second cornerstone; it provides recommendations on how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate. These cornerstone guidelines can be adapted by Member States to guide the implementation of national family planning programmes.

There are two other cornerstone documents which provide guidance to health workers on how to apply the recommendations in the MEC and SPR in clinical settings: *Decision-making tool for family planning clients and providers (2)* and *Family planning: a global handbook for providers (3)*. Figure 1.1 illustrates how each of these four WHO documents is targeted at a particular audience and addresses a unique, yet complementary aspect of family planning.

High-quality family planning services are essential to supporting the well-being and autonomy of individuals, families and communities, and for ensuring progress towards attaining high standards of health for all. As defined in the WHO publication, *Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations (4)*, high-quality care in family planning includes the following: choice among a wide range of contraceptive methods; evidence-based information on the effectiveness, risks and benefits of different methods; technically competent, well trained health workers; provider–user relationships based on respect for informed choice, privacy and confidentiality; and an appropriate combination of services available in the same locality. Informed consent is the foundation for a client's decisions on contraceptive use. The third and fourth of WHO's family planning cornerstone documents include guidance for providers on how to obtain informed consent *(2, 3)*. The SPR contributes to improving the quality of care provided by family planning services, by presenting evidence-based recommendations on the safe provision of different methods of contraception.

## Figure 1.1 The four WHO family planning cornerstones

### Target audience: Policy-makers and programme managers




**Medical eligibility criteria for contraceptive use**

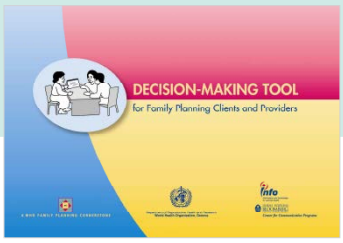
Recommendations on **who** can use contraceptive methods safely


**Selected practice recommendations for contraceptive use**

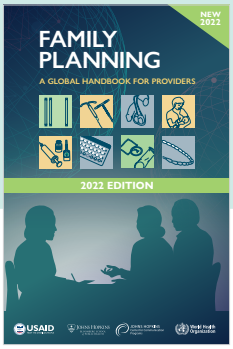
Recommendations on **how** to use contraceptive methods safely and effectively

These are evidence-based guidance and consensus-driven guidelines. They provide recommendations made by expert working groups based on an appraisal of relevant evidence. They are reviewed and updated in a timely manner.

### Target audience: Providers of contraceptive counselling and services




**Decision-making tool for family planning clients and providers**




**Family planning: a global handbook for providers**

These are tools that incorporate the *Medical eligibility criteria,* the *Selected practice recommendations* and other consensus recommendations on how to meet the needs of the family planning client. They will be updated as the guidelines are updated or as other evidence warrants.

**Process for assuring that the guidelines remain current:**

1. Identify new, relevant evidence as soon as it becomes available through an ongoing comprehensive bibliographic search.
2. Critically appraise the new evidence.
3. Evaluate the new evidence in light of prior evidence.
4. Determine whether the newly synthesized evidence is sufficient to warrant an update of existing recommendations.
5. Provide electronic updates on WHO's reproductive health website (https://www.who.int/health-topics/contraception and http://www.who.int/hrp) as appropriate and determine the need to convene an expert working group to reassess guidelines formally.

## 1.1 Purpose

The goal of the SPR is to improve access to family planning services, as well as the quality of those services, by providing recommendations that can be used for developing or revising national guidelines on the provision and safe and effective use of all hormonal contraceptives, intrauterine devices, barrier methods, fertility-awareness-based (FAB) methods, male sterilization and emergency contraception.

## 1.2 Scope

This fourth edition of the SPR includes recommendations on the following family planning methods: copper-bearing intrauterine devices (Cu-IUDs), levonorgestrel-releasing IUDs (LNG-IUDs), levonorgestrel (LNG) and etonogestrel (ETG) implants, depot medroxyprogesterone acetate (DMPA) administered intramuscularly or subcutaneously, norethisterone enanthate (NET-EN), progestogen-only pills (POPs), low-dose (≤ 35 µg ethinyl estradiol) combined[3] oral contraceptive pills (COCs), the combined contraceptive transdermal patch (the patch), the combined contraceptive vaginal ring (CVR), combined injectable contraceptives (CICs), emergency contraceptive pills (ECPs), Cu-IUD for emergency contraception, Standard Days Method (SDM) (a FAB method) and male sterilization (vasectomy). It covers the following areas: initiation and continuation of the method, correct use, problems during use (vomiting and/or diarrhoea, menstrual abnormalities, pelvic inflammatory disease, pregnancy) and programmatic issues.

## 1.3 Target audience

The intended audience for this publication is mainly policy-makers and family planning programme managers and the scientific community. The SPR is not meant to serve as the actual guideline for national reproductive health programmes, but rather as a reference source for the preparation of national- or facility-level guidelines, standards and protocols for the delivery of family planning services. The recommendations in this document are intended to be interpreted at country and programme levels in a manner that reflects the diversity of situations and settings in which contraceptives are provided. While it is unlikely that the recommendations in this document will change during this process, it is very likely that their application at country level will vary. In particular, the level of clinical knowledge and experience of different types of providers and the resources available at different service-delivery points will have to be taken into consideration.

[3] "Combined" refers to a combination of ethinyl estradiol and a progestogen.

## 1.4 Reproductive and sexual health care as a human right

The Programme of Action of the International Conference on Population and Development (ICPD) in 1994 defines reproductive health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" *(5)*. The Programme of Action also states that the purpose of sexual health is "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases". Recognizing the importance of agreements made at the ICPD and other international conferences and summits, the 1995 Beijing Declaration and Platform for Action defines reproductive rights in the following way:

> Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number and spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health *(6)*.

In April 2024, in advance of the 30th Anniversary of the ICPD, at the United Nations headquarters in New York, United States of America, governments and United Nations funds, programmes and other entities, renewed their commitment and determination to accelerate the implementation of the original ICPD Programme of Action. Moreover, as part of this commitment, they reaffirmed their support for ensuring universal access to sexual and reproductive health (SRH) services and their determination to advance reproductive rights as key principles embedded within the United Nations 2030 Agenda for Sustainable Development *(7)*. Sustainable Development Goals (SDGs) 3 (Good health and well-being) and 5 (Gender equality) have targets that call for the following by 2030:

- **Target 3.7:** Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- **Target 5.6:** Ensure universal access to sexual and reproductive health and rights (SRHR).

SRH services, including family planning information and services, are recognized not only as key interventions for improving the health of all people, but also as a human right. Access to contraceptive information and services is specifically guaranteed under international and regional human rights treaties, national constitutions and laws. These include the guarantee on the part of Member States to ensure timely and affordable access to good-quality SRH information and services, including contraception, which should be delivered in a way that ensures fully informed decision-making, respects dignity, autonomy, privacy and confidentiality, and supports individuals' needs and perspectives sensitively in the context of a client–provider partnership *(4)*. A rights-based approach to the provision of contraceptives takes a holistic view of clients, which includes taking into account clients' SRH needs and considering all relevant eligibility criteria when helping clients choose and use a family planning method safely.

Evidence shows that the respect, protection and fulfilment of human rights contribute to positive health outcomes *(8)*. The provision of contraceptive information and services that respect individual privacy, confidentiality and informed choice, and which offer a wide range of safe contraceptive methods, increases people's satisfaction and supports their continued use of contraception *(9–12)*.

Delivering care in accordance with a client's human and reproductive rights is fundamental to the quality of care. The development of international norms for medical eligibility criteria and practice recommendations for contraceptive use contributes to improving the quality of reproductive health care, along with other aspects of care. Many family planning programmes have included health procedures that reflect high standards of public health and clinical practice – such as screening and treatment of cervical cancer, anaemia and sexually transmitted infections (STIs), and the promotion of breastfeeding and

cessation of smoking – but these should not be seen as eligibility requirements for specific contraceptive methods. Such procedures should be strongly encouraged if the human and material resources are available to carry them out, but they should not be seen as prerequisites for the acceptance and use of family planning methods.

## 1.5 Contraceptive choice and informed consent

While this document primarily addresses particular contraceptive practices, certain social, behavioural and other non-medical criteria – particularly client preference – must also be taken into account. **Informed consent** refers to the process of providing clients with sufficient information to enable them to make a voluntary and informed decision about whether to undergo or forego an intervention or procedure, provided that the information is given in a form that can be understood by the client. On the other hand, **informed choice** is achieved if the information provided about the benefits, risks and harms of all the options available is easy to understand and aligns to the client's goals and values, and if the health worker provides impartial assistance with decision-making.

Providing contraceptive choices to clients in a way that respects and fulfils their human rights requires both informed choice and informed consent. Clients' choices are made at a particular time, in a particular societal and cultural context. However, these choices are often taken away from them or limited by direct or indirect social, economic or cultural factors making these choices complex, multifactorial and subject to change. Decision-making for contraceptive methods usually requires making trade-offs among the advantages and disadvantages of different methods, and these vary according to individual circumstances, perceptions and interpretations. Factors to consider when helping clients to choose a particular contraceptive method include the characteristics and preferences of the user, the baseline risk of disease, the adverse-effects profile of different products, and their costs and availability.

This document does not provide recommendations about which specific product or brand to use after selecting a particular type of contraceptive method. Instead, it provides recommendations on *how* to use contraceptive methods safely and effectively. Decisions about which methods to use should take into account client eligibility to use various contraceptive methods (please refer to the sixth edition of the MEC *[1]*) as well as the provider's clinical judgement and user preferences.

## 1.6 Quality of care and access to products

While this document chiefly contains selected practice recommendations, there are many other things to take into account when providing clients with appropriate contraceptive methods. The following service-delivery criteria are universally relevant to the initiation and follow-up for all contraceptive methods.

- Clients must be given adequate information to help them make an informed, voluntary choice about which contraceptive method to use, and should not be subjected to coercion, violence or discrimination of any kind. Informed consent must also be obtained, for all methods of contraception.
- To obtain informed consent, the following information should be provided about each contraceptive method:
  - the relative effectiveness of the method;
  - how to correctly use the method;
  - how the method works and any common side-effects;
  - potential health risks and benefits of the method;
  - signs and symptoms that would necessitate a return to the clinic;

  - information on return to fertility after discontinuing method use; and
  - information on protection against STIs.

  The above information should be presented using language and formats that can be easily understood and accessed by the client. There should be an opportunity for clients to ask questions and they should be answered completely.

- Obtaining a client's informed consent for any contraceptive method is of paramount importance. A person may consult their partner and/or others about the decision to use contraception, and may consider their views, but the decision cannot be made for that person by a partner, another family member, a health worker, a community leader or anyone else. Family planning service providers have a duty to make sure that the decision for or against the use of contraception (or the use of a particular method) is made by the client and that the client is not pressured or coerced by anyone else.
- In order for a facility to offer contraceptive methods that require surgical approaches, insertion/placement, fitting and/or removal by a trained health worker (i.e. sterilization, implants, IUDs, diaphragms, cervical caps), the facility must have appropriately trained personnel and must be adequately equipped, accessible and able to ensure visual and auditory privacy to clients during the procedure. Appropriate infection-prevention procedures must be followed.
- Adequate and appropriate equipment and supplies need to be maintained and held in stock (e.g. contraceptive commodities and supplies for infection-prevention procedures).
- Health workers should be given guidelines, job aids, client cards and the other tools necessary to facilitate the provision of family planning information and services to clients.

## 1.7 Effectiveness of methods

Contraceptive choice is in part dependent on the effectiveness of the contraceptive method in preventing unplanned pregnancy, which is, in turn (for some methods), dependent not only on the protection afforded by the method itself, but also on how consistently and correctly the client uses it. Table 1.1 compares the percentage of women experiencing an unintended pregnancy during the first year of contraceptive method use when the method is used perfectly (consistently and correctly) and when it is used typically (assuming occasional non-use and/or incorrect use). Consistent usage and correct usage can both vary greatly based on client characteristics such as age, income, desire to prevent or delay pregnancy, and culture. The effectiveness of methods that depend on consistent and correct usage by clients (e.g. condoms and pills) can vary widely for different individuals or couples. Most people tend to be more effective users as they become more experienced with a method. However, programmatic features, such as the availability and cost of services and the quality of counselling, also have a profound effect on how effectively (consistently and correctly) the client will use the method.

## Table 1.1 Percentage of users becoming pregnant during the first year of contraceptive use in the United States of America (USA) (perfect use and typical use) and internationally (typical use)

| | % of users experiencing an unintended pregnancy within the first year of contraceptive use | | | |
|---|---|---|---|---|
| **Method** | **Perfect use[a]** | **Typical use, USA[b] (bold indicates population-based estimate)** | **Typical use, international population-based survey estimates[c]** | **Effectiveness category** |
| **Implant** | 0.1 | 0.1 | **0.3** | Category 1<br>< 1 pregnancy per 100 women in 1 year with either perfect or typical use |
| **Vas surgery** | 0.1 | 0.15 | | |
| **Fallopian tube surgery** | 0.5 | 0.5 | | |
| **Intrauterine contraceptives** | | | | |
| LNG-releasing IUDs[d] | 0.3 | 0.4 | | |
| Copper-bearing IUD | 0.6 | 0.8 | **1** | |
| **Depot medroxyprogesterone acetate (DMPA, Depo-Provera) injectable** | 0.2 | **4** | **2** | Category 2<br>1–7 pregnancies per 100 women in 1 year with typical use |
| **Oral contraceptive pills** (combined or progestin-only) | 0.3 | **7** | **6** | |
| **Transdermal patches** | 0.3 | 7 | | |
| **Contraceptive vaginal rings (CVRs)** | 0.3 | 7 | | |
| **Fertility-awareness-based (FAB) methods[e]** | | | | This group of methods spans Effectiveness Categories 2 and 3 |
| Sensiplan | 0.4 | 2 | | |
| Natural Cycles | | 7 | | |
| Clue | 3 | 8 | | |
| Standard Days | 5 | 13 | | |
| Billings | 3 | 23 | | |
| Calendar rhythm | N/A | **15** | **19** | |
| **External (male) condom** | 2 | **13** | **9** | Category 3<br>More than 8 pregnancies per 100 women in 1 year with typical use |
| **Sponge** (both parous and nulliparous)[f] | 12 | 17 | | |
| **Diaphragm**[g] | 16 | 17 | | |
| **Withdrawal** | 4 | **20** | **17** | |
| **Internal (female) condom** | 5 | 21 | | |
| **Vaginal pH regulator** (Phexxi) | 12 | 21 | | |
| **Spermicides** | 16 | 21 | | |
| **Cervical cap** (FemCap) | 22 | 22 | | |

| Method | % of users experiencing an unintended pregnancy within the first year of contraceptive use | | | Effectiveness category |
|---|---|---|---|---|
| | Perfect use[a] | Typical use, USA[b] (bold indicates population-based estimate) | Typical use, international population-based survey estimates[c] | |
| **No method**[h] | 85 | 85 | | |
| **Emergency contraceptives:** Use of emergency contraceptive pills or placement of an IUD after unprotected intercourse substantially reduces the risk of pregnancy. | | | | |
| **Lactational amenorrhea method:** LAM is a highly effective, temporary method of contraception. [i] | | | | |

*IUD:* intrauterine device; LNG: levonorgestrel.

[a] Among couples who initiate use of a method (not necessarily for the first time) and who use it perfectly (both consistently and correctly) for the first year, the percentage who experience an accidental pregnancy if they do not stop use for any other reason. Most estimates in this column come from clinical data; see text of the source document for the derivation of the estimate for each method.

[b] Among couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year of typical use if they do not stop use for any reason other than pregnancy. Estimates of the probability of pregnancy during the first year of typical use for withdrawal, the male condom, the pill, and Depo-Provera are taken from the 2006–2010 National Survey of Family Growth (NSFG) corrected for under-reporting of abortion. See text of the source document for the derivation of estimates for the other methods.

[c] Among couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any reason other than pregnancy. Estimates in this column are based on population-based Demographic and Health Survey data from 15 countries, not adjusted for under-reporting of abortion. All estimates in this column are calculated using life tables. See text of the source document for details.

[d] For details rates for specific LNG-releasing IUDs, see text of the source document.

[e] Multiple FABMs exist with varying features; a subset are shown here. See Chapter 15 of the source document for additional detail.

[f] Estimates are for all sponge users. For nulliparous women, the typical-use pregnancy rate is 14% and the perfect use pregnancy rate is 9%. For parous women the typical use pregnancy rate is 27% and the perfect use pregnancy rate is 20%.

[g] With spermicidal cream or jelly.

[h] This estimate represents the percentage who would become pregnant within 1 year without using contraception. See text of the source document.

[i] However, to maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches 6 months of age.

Note: Estimates in **bold** are from population-based surveys.

*Source:* Reproduced with permission from Bradley et al., 2023 *(13)*.

## 1.8 Return to fertility

Among contraceptive methods, only male and female sterilization are regarded as permanent (i.e. ending the possibility of natural conception). All individuals and couples considering these methods should be counselled accordingly. No other methods result in permanent infertility.

All other contraceptive methods are reversible, usually with prompt return to fertility upon discontinuation, with the exception of injectable depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN). Women should be informed that there can be a delay of up to one year in the return to ovulation after discontinuation of DMPA (given intramuscularly or subcutaneously) and NET-EN *(14–18)*.

## 1.9 STIs and contraception: dual protection

In addition to the imperative of international norms to ensure quality of care in the provision of contraceptive services, the social, cultural and behavioural context of each client must also be considered. Given that sexually transmitted infections (STIs) and HIV are among the most common communicable conditions affecting health and well-being, preventing the transmission of these infections among sexually active clients of reproductive age – including those using contraception services – warrants special consideration. When there is a risk of transmission, such as in the context of high prevalence rates of HIV and other STIs in the geographical area, or individual risk behaviour (e.g. multiple sexual partners without use of condoms), it is important that health workers offer information on safer sexual practices that will help prevent transmission as well as pregnancy. Health workers should strongly recommend dual protection to all persons at significant risk, either through the simultaneous use of condoms with another contraceptive methods or through the consistent and correct use of condoms alone. Women and men seeking contraceptive advice must always be reminded of the importance of using condoms to prevent the transmission of HIV and other STIs, and such use should be encouraged and facilitated where appropriate. When used correctly and consistently, condoms offer one of the most effective methods of protection against STIs, including HIV.

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# 2 Methods: summary of the development of the SPR

This document builds upon a process initiated in 2000 that culminated in the publication of the first edition of the *Selected practice recommendations for contraceptive use* (SPR) in 2002 *(1)*. Since then the SPR was revised in 2004 (second edition *[2]*), five recommendations were updated in 2008 *(3)*, and the third edition was released in 2016 with 75 new recommendations *(4)*. For each revision, a multidisciplinary Guideline Development Group (GDG) of experts is assembled to review newly published evidence pertaining to the topics addressed in the guideline. In addition, with each revision, the GDG used the opportunity to consider inclusion of new practice recommendations.

To ensure that the recommendations remain current between guideline meetings and between editions, new evidence is identified through an ongoing comprehensive bibliographic search, using the Continuous Identification of Research Evidence (CIRE) system *(5)*. For interested readers, Annex 2 of this document presents a summary of the methods used to develop the recommendations in the SPR, starting with the first edition, a summary of the changes to the recommendations over the last 22 years, as well as a detailed description of the methods used to develop the recommendations issued in this fourth edition. This section presents only a summary of the methods for developing this updated fourth edition of the SPR.

The groups responsible for the development of this fourth edition of the SPR included: a WHO Secretariat Team, a Guideline Steering Group (GSG), an Evidence Synthesis Team (EST) (including a guideline methodologist), a Guideline Development Group (GDG) and an External Review Group (ERG). For the names of the members of these groups, see the Acknowledgements at the beginning of this publication, and refer to Annex 1 for details of declared academic interests.

In preparation for reviewing and updating the SPR, the WHO Secretariat Team disseminated an online survey to a broad group of experts and stakeholders in January–February 2022; completed surveys were received from 335 individuals from across all six WHO regions. The findings were compiled and presented at the first GDG meeting, which was held on 8–10 November 2022. At this scoping meeting, the GDG was tasked with prioritizing the SPR topics to be reviewed and updated based on the stakeholder survey and reports from the CIRE process. The two topics prioritized for review by the GDG for the fourth edition of the SPR are presented in Box 2.1. These topics were new to the SPR. Among existing topics, no new evidence was identified requiring an update.

### Box 2.1 Prioritized topics reviewed by the GDG for the fourth edition of the SPR

These questions relate to the two overarching topics identified as being of particular importance to the field:

- What medication can be offered to ease interval intrauterine device (IUD) placement?[a]
- What non-pharmacological interventions can be offered to ease interval IUD placement?

All other existing recommendations from the SPR third edition were reaffirmed by the GDG in November 2022 and thus not reviewed for this fourth edition.[b]

[a] Interval IUD placement refers to insertion at any time during the menstrual cycle and after six weeks postpartum *(6)*.

[b] Evidence is continuously monitored using the Continuous Identification of Research Evidence (CIRE) system *(5)*.

For the prioritized topics, the GDG proposed questions using the "PICO" format (i.e. questions with specified populations, interventions, comparators and outcomes) to guide the systematic reviews and the preparation of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) evidence tables *(7)* (refer to the web annex for the PICO questions and the GRADE tables). The systematic review findings, including the GRADE and evidence-to-decision tables, were prepared and presented by the EST, including the methodologist, and discussed during the second GDG meeting 23–25 July 2024. On

the basis of these findings, recommendations were made to WHO. For existing recommendations in the third edition of the SPR, either no new evidence was identified or any new evidence confirmed prior findings, such that prior recommendations were simply reaffirmed.

In this fourth edition of the SPR, the GRADE approach was used to classify recommendations on the topics reviewed as either "strong" or "conditional". Because the target audience for the SPR is primarily policy-makers, when the GDG classifies a recommendation as "strong" it is because the GDG is very certain that the desirable consequences outweigh the undesirable consequences and the recommendation can thus be adopted as policy in most situations, indicating that in general, for high-quality family planning care, both health workers and clients should adhere to the recommendations. "Conditional" recommendations are issued when the benefits of adherence to a recommendation probably outweigh the undesirable effects. However, with conditional recommendations, different choices may be appropriate for some individuals or settings, the benefits may not always warrant the resource requirements in all settings, and it is possible that new evidence may result in a change to the balance of risks to benefits *(8)*.

### Box 2.2 Definitions of strong and conditional recommendations

**Strong recommendation:**

- The GDG is certain that the desirable consequences outweigh the undesirable ones.
- The recommendation can be adopted as policy in most situations.
- Users should adhere to the recommendations for high-quality family planning care.

**Conditional recommendation:**

- The benefits of adherence to the recommendation probably outweigh the undesirable effects.
- Different choices may be appropriate for some individuals or settings.
- The benefits may not always warrant the resource requirements in all settings.
- New evidence may result in a change to the balance of risks to benefits.

In this document, most recommendations are presented in narrative form for the benefit of readers accustomed to the format of previous SPR editions. However, the recommendation categories for examinations and tests employs the A-B-C classification which was defined by the expert group that developed the first edition of the SPR in 2001. They serve to alert programme managers and policy-makers as to whether or not a particular test or examination is mandatory before a contraceptive method is provided. In developing the recommendations for these examinations and tests, the GDG followed the same rigorous process of evidence review as was used for other recommendations in this edition.

The GDG endorsed an approach to client values and preferences that prioritized the availability of a wide range of contraceptive options and the removal of unnecessary medical barriers *(9)*. Because the focus of these recommendations is on the safe provision of contraceptive methods, once counselling and shared decision-making regarding a contraceptive method has taken place, and since costs vary widely in different regions and settings, opportunity costs were not formally assessed during the formulation process.

The GDG arrived at new recommendations and upheld existing recommendations through consensus. Consensus was achieved through discussion, debate and consultation with experts to reconcile any disagreements. For each recommendation, the Chair asked the other GDG members whether they agreed with the recommendation; any disagreement was documented. All the GDG members agreed with all of the recommendations in the guideline. A draft version of the guideline was reviewed by an ERG, comprising nine experts who did not participate in

the GDG meeting (a list of ERG members is provided in the Acknowledgements and a summary of their declarations of interests is presented in Annex 1).

The final version of this document was approved by the Guidelines Review Committee on 10 February 2025.

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[5] All references were accessed on 18 June 2025.

# 3 How to use this document

This *Selected practice recommendations for contraceptive use* (SPR) document is not meant to serve as the actual guidelines for national family planning and reproductive health programmes, but rather as a reference in the preparation of national or facility-level guidelines for the delivery of contraceptive services. The recommendations in this document are intended for interpretation at country and programme levels in a manner that reflects the diversity of the situations and settings in which contraceptives are provided. While it is unlikely that the recommendations in this document will change during this process, it is very likely that their application at country level will vary. In particular, the level of clinical knowledge and experience of different types of providers, and the resources available at the service-delivery point will have to be taken into consideration.

The recommendations are presented in section 5 in sub-sections by type of contraceptive method: intrauterine devices (IUDs), progestogen-only contraceptives (POCs), combined hormonal contraceptives (CHCs), emergency contraception (EC), Standard Days Method (SDM) and male sterilization. In these sub-sections, recommendations are presented for the following: timing of initiation; examinations and tests needed before initiation; method continuation, discontinuation and switching; management of problems during use, such as side-effects or dosing errors; and appropriate follow-up. In addition, remarks and information on the underlying principles are provided when needed, as are lists of all the relevant references. This fourth edition contains information on the recommendations, which are based upon a review of the summarized epidemiological and clinical data, considerations of benefits and harms, client values and preferences, and the quality of the evidence. Details on this process are presented in Annex 2 and in the web annex for this document.

## 3.1 Classification of examinations and tests before initiation of different contraceptive methods

The following classification system is used to indicate the applicability of the various examinations and tests before the initiation of different contraceptive methods.

**Class A:** The examination or test is essential and mandatory in all circumstances for the safe and effective use of the contraceptive method.

**Class B:** The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available.

**Class C:** The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

The examinations or tests considered for each type of contraceptive in section 5 apply to persons who are presumed to be healthy. Those with known medical problems or other special conditions may need additional examinations or tests before being confirmed as appropriate candidates for a particular contraceptive method. The SPR's partner document, *Medical eligibility criteria for contraceptive use, sixth edition* (MEC, published in 2025) may be used in such circumstances *(1)*.

These classifications focus on the relationship of the examinations or tests to safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some of the examinations or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

## 3.2 Contraceptive eligibility

The MEC categories for contraceptive eligibility (categories 1–4) are often referred to in this edition of the SPR. Box 3.1 lists these categories and their basic definitions.

**Box 3.1 MEC categories for contraceptive eligibility**

| | |
|---|---|
| **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 |

*Source:* WHO, 2025 *(1)*. For further information, please refer to this source.

# Reference for section 3

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# 4 Summary of changes within the fourth edition of the SPR

Two new topics were considered in this edition:

- Medication to ease interval intrauterine device (IUD) placement
- Non-pharmacological interventions to ease interval IUD placement

## Table 4.1 Summary of new recommendations in the *Selected practice recommendations for contraceptive use*, fourth edition (SPR)

| Topic | SPR recommendation | GRADE assessment of quality of evidence[a] |
|---|---|---|
| **Medication to ease interval IUD placement** | | |
| Misoprostol | Misoprostol is not recommended for routine use before IUD placement. Misoprostol might be helpful in select circumstances (e.g. in clients with a recent failed placement).<br>(Strength of recommendation: Conditional) | Moderate |
| *Paracervical blocks*<br>Lidocaine | Where local anaesthetics (e.g. lidocaine) and trained providers are available, paracervical blocks may be offered routinely for IUD placement. IUDs should not be withheld if local anaesthetics are not available.<br>(Strength of recommendation: Conditional) | Low |
| *Topical anaesthetics*<br>Lidocaine gel<br>Lidocaine spray<br>Lidocaine cream<br>Lidocaine-prilocaine cream | Where topical anaesthetics are available (e.g. lidocaine), they may be offered routinely for IUD placement. IUDs should not be withheld if topical anaesthetics are not available.<br>(Strength of recommendation: Conditional) | Low |
| *Non-steroidal anti-inflammatories (NSAIDs)*<br>Ibuprofen<br>Ketorolac<br>Naproxen<br>Ketoprofen<br>Etoricoxib<br>Indomethacin | NSAIDs may be offered routinely for IUD placement. IUDs should not be withheld if NSAIDs are not available.<br>(Strength of recommendation: Conditional) | Low |

[a] GRADE evidence assessment comprises the quality categories of very low, low, moderate and high. When a range is presented, the range reflects the GRADE quality assessment across important outcomes and/or across contraceptive methods. See the GRADE tables in section 3.1 of the web annex for outcomes explored.

This fourth edition of the SPR was also updated to reflect new recommendations made in the *Medical eligibility criteria for contraceptive use, sixth edition* (MEC) *(1)*. Use of depot medroxyprogesterone acetate (DMPA) among breastfeeding women who are less than six weeks postpartum has moved from a MEC Category 3 to a MEC Category 2 (can generally use). All other recommendations are maintained for progestogen-only contraceptive use among breastfeeding women.

# Reference for section 4

1. Medical eligibility criteria for contraceptive use, sixth edition. Geneva: World Health Organization; 2025. [Forthcoming].

# 5 Recommendations

## 5.1 How can a health worker be reasonably certain that a woman is not pregnant?

When prescribing contraception, it is important to ascertain whether a woman is pregnant or not. The ability to detect an early pregnancy will vary depending on resources and settings. Highly reliable biochemical pregnancy tests are often extremely useful, but not available in many areas. Pelvic examination, where feasible, is reliable at approximately 8–10 weeks since the first day of the last menstrual period.

The provider can be reasonably certain that the woman is not pregnant if she has no symptoms or signs of pregnancy and meets any of the following criteria.

- She has not had intercourse since her last normal menses.
- She has been correctly and consistently using a reliable method of contraception.
- She is within the first seven days of the start of her normal menses.
- She is within four weeks postpartum (for non-lactating women).
- She is within the first seven days post-abortion or post-miscarriage.
- She is fully or nearly fully breastfeeding, amenorrhoeic, and less than six months postpartum.

However, for a woman who is postpartum and is not breastfeeding, or one who is amenorrhoeic (non-postpartum), these six criteria do not apply and other means should be used to determine whether she is pregnant.

## 5.2 Intrauterine devices

Intrauterine devices (IUDs) are a long-acting method of contraception. This section provides recommendations on copper-bearing IUDs (Cu-IUDs) and levonorgestrel-releasing IUDs (LNG-IUDs). IUDs can generally be used by most women, including adolescents and nulliparous women. To help determine if women with certain medical conditions or characteristics can safely use IUDs, please refer to the *Medical eligibility criteria for contraceptive use, sixth edition* (MEC) *(1)*.

IUDs do not protect against sexually transmitted infections (STIs), including HIV. If there is a risk of HIV or any STI, the correct and consistent use of condoms is recommended. When used correctly and consistently, male and female condoms offer one of the most effective methods of protection against STIs, including HIV.

### 5.2.1 Copper-bearing IUDs (Cu-IUDs) and levonorgestrel-releasing IUDs (LNG-IUDs)

#### i. Initiation of Cu-IUDs

##### Having menstrual cycles

- Within 12 days of the start of menstrual bleeding: A Cu-IUD can be placed at the woman's convenience, not just during menstruation. No additional contraceptive protection is needed.
- More than 12 days after the start of menstrual bleeding: A Cu-IUD can be placed at the woman's convenience if it is reasonably certain that she is not pregnant. No additional contraceptive protection is needed.

##### Amenorrhoeic (non-postpartum)

- A Cu-IUD can be placed at any time if it can be determined that the woman is not pregnant. No additional contraceptive protection is needed.

### Postpartum (breastfeeding and non-breastfeeding, including post-caesarean delivery)

- Within 48 hours of delivery: A Cu-IUD can be placed, including immediately after delivery of the placenta.
  - If the delivery is by caesarean section, the Cu-IUD can be placed after delivery of the placenta, before the uterus is closed.
- From 48 hours to less than four weeks postpartum: Placement of Cu-IUDs is not usually recommended unless other more appropriate methods are not available or not acceptable (MEC Category 3).
- Four or more weeks postpartum and amenorrhoeic:
  - **Breastfeeding:** A Cu-IUD can be placed if it is reasonably certain that the woman is not pregnant. No additional contraceptive protection is needed.
  - **Non-breastfeeding:** A Cu-IUD can be placed if it can be determined that the woman is not pregnant. No additional contraceptive protection is needed.
- Four or more weeks postpartum and menstrual cycles have returned: A Cu-IUD can be placed as advised for other women having menstrual cycles.
- Women who have puerperal sepsis should not have a Cu-IUD placed immediately (MEC Category 4).

### Post-abortion

- A Cu-IUD can be placed immediately after a first-trimester abortion.
- A Cu-IUD can generally be placed immediately after a second-trimester abortion.
- A Cu-IUD should not be placed immediately after septic abortion (MEC Category 4).

### Switching from another method

- A Cu-IUD can be placed immediately if it is reasonably certain the woman is not pregnant; there is no need to wait for her next menstrual period. No additional contraceptive protection is needed.

### For emergency contraception

- A Cu-IUD can be placed within 5 days of unprotected intercourse as an emergency contraceptive.
- In addition, when the time of ovulation can be estimated, a Cu-IUD can be placed more than 5 days after intercourse, as long as placement does not occur more than 5 days after ovulation.
- Only women who are medically eligible for IUD placement can use the Cu-IUD for emergency contraception.

## ii. Initiation of LNG-IUDs

### Having menstrual cycles

- Within 7 days of the start of menstrual bleeding: An LNG-IUD can be placed at the woman's convenience, not just during menstruation. No additional contraceptive protection is needed.
- More than 7 days after the start of menstrual bleeding: An LNG-IUD can be placed at the woman's convenience if it is reasonably certain she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

### Amenorrhoeic (non-postpartum)

- An LNG-IUD can be placed at any time if it can be determined that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

### Postpartum (breastfeeding and non-breastfeeding, including post-caesarean delivery)

- Within 48 hours of delivery: An LNG-IUD can generally be placed, including immediately after the delivery of the placenta (MEC Category 2).
  - If the delivery is by caesarean section, the LNG-IUD can be placed after delivery of the placenta, before the uterus is closed.
- From 48 hours to four weeks postpartum: Use of LNG-IUDs is not usually recommended unless other more appropriate methods are not available or not acceptable (MEC Category 3).

- Four or more weeks postpartum and amenorrhoeic:
  - **Breastfeeding:** An LNG-IUD can be placed if it is reasonably certain that the woman is not pregnant. No additional contraception is needed.
  - **Non-breastfeeding:** An LNG-IUD can be placed if it can be determined that the woman is not pregnant. No additional contraceptive protection is needed.
- Four or more weeks postpartum and menstrual cycles have returned: An LNG-IUD can be placed as advised for other women having menstrual cycles.
- Women who have puerperal sepsis should not have an LNG-IUD placed (MEC Category 4).

### Post-abortion

- An LNG-IUD can be placed immediately after a first-trimester abortion.
- An LNG-IUD can generally be placed immediately after a second-trimester abortion.
- An LNG-IUD should not be placed immediately after septic abortion (MEC Category 4).

### Switching from another method

- If a woman is having menstrual cycles, an LNG-IUD can be placed immediately if it is reasonably certain the woman is not pregnant; she does not need to wait until her next menstrual period. If the woman is amenorrhoeic, an LNG-IUD can be placed immediately if it can be determined that she is not pregnant; she does not need to wait for her next menstrual period.
  - Within 7 days of the start of menstrual bleeding: An LNG-IUD can be placed. No additional contraceptive protection is needed.
  - More than 7 days after the start of menstrual bleeding: An LNG-IUD can be placed. The woman will need to abstain from sex or use additional contraceptive protection for the next 7 days.
- If the woman's previous method was an injectable contraceptive, the LNG-IUD can be placed at the time the next injection would have been due or any time before that. No additional contraceptive protection is needed.

### Remarks *(1, 2)*

The Guideline Development Group (GDG) has determined that there is an acceptably low risk of ovulation up to Day 7 of the menstrual cycle and that the probability of the woman being pregnant is therefore low before Day 8. The recommendations of the GDG for the placement of Cu-IUDs for the purposes of emergency contraception do not apply to LNG-IUDs because there are no robust data on the safety and effectiveness of LNG-IUD use for emergency contraception. Thus, until such evidence is available, the use of the LNG-IUD as an emergency contraceptive is not recommended.

As stated in the MEC, IUDs are not indicated during pregnancy and should not be used because of the risk of serious pelvic infection and septic spontaneous abortion. The GDG recognized that a checklist of criteria would be helpful to the provider in determining whether a woman who is postpartum and breastfeeding may be pregnant (see section 5.1 "How can a health worker be reasonably certain that a woman is not pregnant?"). However, for a woman who is postpartum and is not breastfeeding, or one who is amenorrhoeic (non-postpartum), these six criteria do not apply and other means should be used to determine whether she is pregnant.

## iii. Examinations and tests before providing a Cu-IUD or LNG-IUD *(3, 4)*

In healthy women, the only examinations and tests that are essential and mandatory before IUD placement are a pelvic/genital examination and an STI risk assessment. When available, a haemoglobin test and screening for HIV and other STIs will also contribute substantially to safe and effective use. Please see Table 5.1 for further information.

**Table 5.1 Examinations and tests before initiation of a Cu-IUD or LNG-IUD**

| Examination or test | Classification[a] |
|---|---|
| Breast examination by provider | C |
| Pelvic/genital examination | A |
| Cervical cancer screening | C |
| Routine laboratory tests | C |
| Haemoglobin test | B |
| STI risk assessment: medical history and physical examination | A[b] |
| STI/HIV screening: laboratory tests | B[b] |
| Blood pressure screening | C |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] The sixth edition of the MEC states: "IUD insertion may further increase the risk of PID (pelvic inflammatory disease) among women at increased risk of STIs, although limited evidence suggests that this risk is low. Current algorithms for determining increased risk of STIs have poor predictive value. Risk of STIs varies by individual behaviour and local STI prevalence. Therefore, while many women at increased risk of STIs can generally have an IUD inserted, some women at increased risk (very high individual likelihood) of STIs should generally not have an IUD inserted until appropriate testing and treatment occur" *(1)*.

## iv. Use of prophylactic antibiotics at the time of IUD placement

### Routine IUD placement (Cu-IUD or LNG-IUD)

- Prophylactic antibiotics are not generally recommended for IUD placement. However, in settings where there is a high prevalence both of cervical gonococcal and chlamydial infections and limited STI screening, such prophylaxis may be considered.
- The IUD user should be counselled to watch for symptoms of pelvic inflammatory disease (PID), especially during the first month of use.

### Remarks *(5)*

- The GDG determined that prophylactic antibiotics for IUD placement provide little, if any, benefit for women at low risk of STIs.
- These recommendations apply to healthy women; women with health conditions that warrant antibiotic prophylaxis for invasive procedures (e.g. women with cardiac valve disorders) may also need antibiotic prophylaxis for IUD placement.
- As no evidence was identified for the provision of prophylactic antibiotics prior to placement of the LNG-IUD, these recommendations were based on evidence for the Cu-IUD.

## v. Use of medication to ease interval IUD placement [new recommendations]

### Routine IUD placement (Cu-IUD or LNG-IUD)

- **Misoprostol is not recommended for routine use for IUD placement. Misoprostol might be useful in select circumstances (e.g. in clients with a recent failed placement).** Conditional recommendation
- **Where local anaesthetics (e.g. lidocaine) and trained providers are available, paracervical blocks may be offered routinely for IUD placement. IUDs should not be withheld if local anaesthetics are not available.** Conditional recommendation
- **Where topical anaesthetics (e.g. lidocaine) are available, they may be offered routinely for IUD placement. IUDs should not be withheld if local anaesthetics are not available.** Conditional recommendation
- **NSAIDs may be offered routinely for IUD placement. IUDs should not be withheld if NSAIDs are not available.** Conditional recommendation

### Remarks and evidence summary for the new recommendations

Barriers to IUD use include client concerns about anticipated pain with placement and provider concerns about ease of placement, especially among nulliparous clients. Therefore, before an IUD is placed, all clients should be counselled on the possibility of pain during placement, the risks and benefits of an IUD, and alternatives to it. They should also be told about the different options for pain management. A person-centred plan for IUD placement and pain management should be made and it should be based on client preferences.

### Misoprostol

The evidence included 14 randomized controlled trials (RCTs); the majority of the studies used a 400 µg dose of misoprostol *(6)*. The route of administration varied across trials and included vaginal, buccal, sublingual and oral administration. For clients without a recent failed IUD placement attempt, the range of timing of administration was 1–8 hours before IUD placement (see section 2.1.1 and GRADE table W.3.1 in the web annex).

- Misoprostol should not be used for routine IUD placements. Evidence suggests that misoprostol does not reduce client pain, adverse events or the need for adjunctive placement measures (e.g. cervical dilation), nor does it improve provider ease of placement, placement success or client satisfaction with the procedure.
- Misoprostol might increase client pain, preplacement abdominal cramping and/or preplacement diarrhoea.
- In women with a recent failed IUD placement, preliminary treatment with 400 µg vaginal misoprostol (200 µg administered 10 hours before and 200 µg administered 4 hours before returning to the clinic) may increase the chances of a successful placement.
- This is a conditional recommendation based on moderate-quality data.

### Local anaesthetic as a paracervical block

A paracervical block is the injection of local anaesthetic into standardized locations in the area immediately adjacent to the uterine cervix *(7)*. Evidence for local anaesthetic as a paracervical block came from six RCTs, all of which used lidocaine. Four trials used 1% lidocaine as a paracervical block (10–20 ml), and two examined 2% lidocaine as a paracervical block (10–12 ml). The timing of administration ranged from just before to at least 5 minutes before IUD placement (see section 2.1.2 and GRADE table W.3.3 in the web annex).

- Local anaesthetics as a paracervical block might reduce client pain, with few side-effects.
- The GDG noted that paracervical blocks can vary in terms of number of injection points, anaesthetic used and volume administered. A recommendation for a specific technique was not made.
- Providing paracervical blocks requires supplies of local anaesthetics, health workers who are trained in the technique, and sterile supplies for the injection. The GDG commented that IUDs should not be withheld when paracervical blocks are unavailable.
- This is a conditional recommendation based on low-quality data.

### Local anaesthetics used topically

A medicated gel, cream or spray can be applied directly to the cervix to provide pain relief during IUD placement. Twelve RCTs examined the use of topical anaesthetics for IUD placement *(7)*. Five trials examined 2% lidocaine topical gel (two intracervical, one cervical and two vaginal), one examined 10% lidocaine topical spray (intracervical) and lidocaine topical cream (intracervical), three examined 10% lidocaine topical spray (cervical) and three examined lidocaine-prilocaine cream (cervical) (see section 2.1.3 and GRADE table W.3.5 in the web annex).

- Topical anaesthetics might reduce client pain, with minimal side-effects.
- The GDG noted that generally topical anaesthetics need to be applied several minutes prior to IUD placement. This may mean that a speculum exam would take longer, which might not be acceptable to some women.
- The GDG commented that many topical anaesthetics come in multi-use tubes. Clinics will need clear protocols to prevent contamination and infection.
- This is a conditional recommendation based on low-quality data.
-

### Non-steroidal anti-inflammatory drugs

There are many different types of NSAIDs, and oral formulations that can be self-administered for pain relief are widely available. Evidence was reviewed from 12 trials on the use of NSAIDs to ease IUD placement *(8)*. Studies included a range of agents and dosages: four evaluated ibuprofen (200–800 mg), two ketorolac (20–30 mg), three naproxen (375–550 mg), one ketoprofen (150 mg), one etoricoxib (120 mg) and one indomethacin (50 mg). All the studies evaluated oral administration, except for the study on indomethacin (which evaluated rectal administration) and one of the ketorolac studies (which evaluated intramuscular injection). The majority *(10)* of the studies administered the medicine 1 hour or less before IUD placement (see section 2.1.4 and GRADE table W.3.6 in the web annex).

- NSAIDs can be offered routinely before IUD placement.
- Evidence on NSAIDs generally suggested a small to moderate decrease in client pain, and inconsistent results with client satisfaction with the procedure.
- Evidence suggests that NSAIDs do not increase side-effects (e.g. nausea, vomiting, dizziness or drowsiness).
- The GDG noted that generic forms of oral NSAIDs are widely available and a single dose is generally very well tolerated.
- This is a conditional recommendation, based on low-quality evidence.

## vi. Non-pharmacological interventions to ease interval IUD placement [new topic]

The GDG judged that the body of evidence was insufficient for making any recommendation on non-pharmacological interventions to ease IUD placement (see sections 2.2 and 3.2 in the web annex).

## vii. Management of menstrual abnormalities for Cu-IUD users

### Spotting or light bleeding

- Spotting or light bleeding is common during the first 3–6 months of Cu-IUD use. It is not harmful and usually decreases over time.
- If a woman desires treatment, she can be provided with a short course of NSAIDs during the days when bleeding occurs.
- In women with persistent spotting and bleeding, gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If no gynaecological problems are found, and the woman finds the bleeding unacceptable, the IUD should be removed and the woman assisted to choose another method.

### Heavier or longer menstrual bleeding than with normal menstrual periods

- Heavier or longer menstrual bleeding is common during the first 3–6 months of Cu-IUD use. Usually this is not harmful, and bleeding typically becomes lighter over time.
- The following treatment may be offered during the days when menstrual bleeding occurs:
  - NSAIDs
  - tranexamic acid (a haemostatic agent).
- Aspirin should *not* be used.
- Gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If the bleeding continues to be very heavy or prolonged, especially if there are clinical signs of anaemia, or if the woman finds the bleeding unacceptable, the IUD should be removed and the woman assisted to choose another method.
- To prevent anaemia, an iron supplement should be provided and/or the woman encouraged to eat foods high in iron.

### Remarks

The GDG noted that menstrual abnormalities are common in the first 3–6 months of IUD use and concluded that treatment during the days when bleeding occurs can sometimes be effective. The GDG indicated that aspirin should not be used to treat IUD-related menstrual bleeding because it may worsen the problem.

## viii. Management of menstrual abnormalities for LNG-IUD users

### Amenorrhoea

- Amenorrhoea does not require any medical treatment. Counselling is sufficient.
- If a woman finds amenorrhoea unacceptable, the LNG-IUD should be removed and the woman assisted to choose another method.

### Spotting or light bleeding

- Spotting or light bleeding is common with LNG-IUD use. It is not harmful and usually decreases over time.
- In women with persistent spotting and bleeding, gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If no gynaecological problems are found and the woman finds the bleeding unacceptable, the LNG-IUD should be removed and the woman assisted to choose another method.

### Heavier or longer menstrual bleeding than with normal menstrual periods

- Heavier or longer menstrual bleeding may occur during the first 3–6 months of LNG-IUD use. Usually this is not harmful, and bleeding typically becomes lighter over time.
- Gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If the bleeding continues to be very heavy or prolonged, especially if there are clinical signs of anaemia, or if the woman finds the bleeding unacceptable, the LNG-IUD should be removed and the woman assisted to choose another method.
- To prevent anaemia, an iron supplement can be provided and/or the woman encouraged to eat foods high in iron.

### Remarks

The GDG noted that the risk of heavier or longer menstrual bleeding is concentrated in the first 3–6 months of LNG-IUD use and decreases over time. No studies were available that assessed treatment alternatives.

## ix. Management of IUDs when a Cu-IUD or LNG-IUD user is found to have PID

- PID should be treated with appropriate antibiotics.
- There is no need to remove the IUD if the woman wishes to continue its use.
- If she does not want to keep the IUD, it should be removed after antibiotic treatment has been started.
- If the IUD is removed, the women should consider using emergency contraceptive pills and/or other contraceptive method(s), if appropriate.
- If the infection does not improve, the women should consider having the IUD removed while continuing antibiotics. If the IUD is not removed, antibiotics should still be continued. In both circumstances, the woman's health should be closely monitored.
- Comprehensive management for STIs should be provided, including counselling about condom use.

### Remarks *(9)*

The GDG concluded that removing the IUD provides no additional benefit once PID is being treated with appropriate antibiotics. As no evidence was identified for the LNG-IUD, the recommendations were based solely upon evidence regarding the Cu-IUD.

## x. Management of the IUD when a Cu-IUD or LNG-IUD user is found to be pregnant

- Ectopic pregnancy should be excluded.
- The health worker should explain to the woman that she is at an increased risk of first- and second-trimester miscarriage (including septic miscarriage, which may be life-threatening) and of preterm delivery if the IUD is left in place. Removing the IUD reduces these risks, although the procedure itself entails a small risk of miscarriage.
  - If she does not want to continue the pregnancy and if therapeutic termination of pregnancy is legally available, the health worker should inform her of this.
  - If she understands and accepts the risks mentioned above and she wishes to continue the pregnancy, the health worker should proceed according to the instructions below.

### If the IUD strings are visible or the IUD can be retrieved safely from the cervical canal

- The health worker should advise the woman that it is best to remove the IUD.
- If the woman agrees to IUD removal, the health worker should remove it by pulling on the strings gently.
- Whether the IUD is removed or kept, the health worker should advise the woman to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.

### If the IUD strings are not visible and the IUD cannot be safely retrieved

- Where ultrasound is available, the health worker may use it to determine the location of the IUD. If the IUD is not located, this may suggest that expulsion or perforation of the IUD has occurred.
- If ultrasound is not possible or if the IUD is determined by ultrasound to be inside the uterus, the health worker should make the risks of miscarriage, infection and preterm delivery clear to the woman and advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.

### Remarks *(10)*

The GDG concluded that removing the IUD improves pregnancy outcome if the IUD strings are visible or can be retrieved safely from the cervical canal, and that the risks of miscarriage, preterm delivery and infection are substantial if the IUD is left in place. These recommendations were based on evidence relating to the Cu-IUD. In addition, the GDG considered there to be theoretical concerns about fetal exposure to hormones in women found to be pregnant with an LNG-IUD in place. Whether there is an increased risk of fetal abnormalities as a result of this exposure, however, is unknown.

## xi. Appropriate follow-up after placement of a Cu-IUD or LNG-IUD

These recommendations address the minimum frequency of follow-up recommended for the safe and effective use of IUDs. They refer to general situations and may vary for different users and different contexts. For example, women with specific medical conditions may need more frequent follow-up visits.

- A follow-up visit is recommended after the first menses or 3–6 weeks after placement.
- Women should be advised to return at any time to discuss side-effects or other problems, or if they want to change methods.
- Women should be advised to return when it is time for the IUD to be removed.

### Remarks *(11)*

The GDG concluded that follow-up visits or contacts should include, at a minimum, counselling to address issues such as side-effects or other problems, correct and consistent use of the method, and protection against STIs. Additional assessment may be appropriate, e.g. pelvic examination to check for IUD displacement.

# References for section 5.2[6]


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[6] All references were accessed on 15 October 2025.

# 5.3 Progestogen-only contraceptives

Progestogen-only contraceptives (POCs) include progestogen-only implants, progestogen-only injectable contraceptives (POIs) and progestogen-only pills (POPs), and they are presented separately in that order within this section.

POCs can be used safely by most women. To help determine if women with a particular medical condition or characteristic can use POCs safely, please refer to the sixth edition of the *Medical eligibility criteria for contraceptive use* (MEC) *(1)*.

POCs do not protect against sexually transmitted infections (STIs), including HIV. If there is a risk of HIV or any STI, the correct and consistent use of condoms is recommended. When used correctly and consistently, male and female condoms offer one of the most effective methods of protection against STIs, including HIV.

## 5.3.1 Progestogen-only implants

Progestogen-only implants are a type of long-acting contraception. The recommendations in this guideline are based on information relating to the levonorgestrel (LNG) implant, Jadelle. Limited evidence exists for the Sino-implant (II). The extent to which the recommendations apply to etonogestrel (ETG) implants is not known. Norplant was a progestogen-only implant that was discontinued globally in 2008. Information on Norplant can be found in earlier editions of the *Selected practice recommendations for contraceptive use* (SPR).

The following different types of progestogen-only implants are considered here.

- Levonorgestrel (LNG): The LNG-containing implants are Jadelle and Sino-implant (II).
  - Jadelle is a two-rod implant, with each rod containing 75 mg of LNG.
  - Sino-implant (II) is a two-rod implant, with each rod containing 75 mg of LNG.
- Etonogestrel (ETG): The ETG-containing implants are Implanon and Nexplanon.
  - Both consist of a single-rod implant containing 68 mg of ETG.

### i. Initiation of implants

#### Having menstrual cycles

- Within 7 days of the start of menstrual bleeding: The implant can be inserted. No additional contraceptive protection is needed.
- More than 7 days after the start of menstrual bleeding: The implant can be inserted if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

#### Amenorrhoeic (non-postpartum)

- The implant can be inserted at any time if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

#### Postpartum (breastfeeding)

- Less than six weeks postpartum: An implant can generally be inserted (MEC Category 2).
- Six weeks to six months postpartum and amenorrhoeic: An implant can be inserted. If the woman is fully or nearly fully breastfeeding, no additional contraceptive protection is needed.
- More than six weeks postpartum and menstrual cycles have returned: The implant can be inserted as advised for other women having menstrual cycles.

#### Postpartum (non-breastfeeding)

- Less than 21 days postpartum: An implant can be inserted (MEC Category 1). No additional contraceptive protection is needed. It is highly unlikely that a woman will ovulate and be at risk of pregnancy during the first 21 days postpartum. However, for programmatic reasons (i.e. depending on national, regional and/or local programme protocols), some contraceptive methods may be provided during this period.
- Twenty-one or more days postpartum and menstrual cycles have not returned: An implant can be inserted if it is reasonably certain that

the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

- If menstrual cycles have returned, an implant can be inserted as advised for other women having menstrual cycles.

### Post-abortion

- The implant can be inserted immediately post-abortion. No additional contraceptive protection is needed.

### Switching from another hormonal method

- If the woman has been using her hormonal method consistently and correctly, or if it is reasonably certain that she is not pregnant, the implant can be inserted immediately; there is no need to wait for her next menstrual period.
- If the previous method was an injectable contraceptive, the implant should be inserted when the repeat injection would have been given. No additional contraceptive protection is needed.

### Switching from a non-hormonal method (other than the IUD)

- The implant can be inserted immediately if it is reasonably certain that the woman is not pregnant; there is no need to wait for her next menstrual period.
  - Within 7 days of the start of her menstrual bleeding: No additional contraceptive protection is needed.
  - More than 7 days after the start of menstrual bleeding: She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

### Switching from an IUD (including the LNG-releasing IUD [LNG-IUD])

- Within 7 days of the start of menstrual bleeding: An implant can be inserted. No additional contraceptive protection is needed. The IUD can be removed at that time.
- More than 7 days after the start of menstrual bleeding: The implant can be inserted if it is reasonably certain that the woman is not pregnant.
  - Sexually active in this menstrual cycle and more than 7 days after the start of menstrual bleeding: It is recommended that the IUD be removed at the time of her next menstrual period.
  - Not sexually active in this menstrual cycle and more than 7 days after the start of menstrual bleeding: She will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by the IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If the woman is amenorrhoeic or has irregular bleeding, the implant can be inserted as advised for other amenorrhoeic women.

### Remarks *(2–7)*

The Guideline Development Group (GDG) considered that inserting an implant on any day up to and including Day 7 of the menstrual cycle results in a low risk of an ovulatory cycle that could lead to pregnancy.

The need for additional contraceptive protection among those switching from another hormonal method will depend on the previous method used.

In the context of switching from an IUD to an implant, GDG members expressed some concern about the risk of pregnancy when removing an IUD during a cycle in which there has already been intercourse. That concern led to the recommendation that the IUD be left in place until the next menstrual period.

Whereas an estimated 48 hours of POP use was deemed necessary to achieve contraceptive effect on cervical mucus, the time required for LNG implants to exert such an effect was uncertain.

## ii. Examinations and tests needed before initiation of implants

In healthy women, no examinations or tests are essential or mandatory before initiating progestogen-only implants. However, there is special consideration for blood pressure screening; it is desirable to have blood pressure measurements taken before initiating implants. Nevertheless, in settings where blood pressure measurements are unavailable, women should not be denied the use of implants simply because their blood pressure cannot be taken. Please see Table 5.2 for further information on examinations and tests.

**Table 5.2 Examinations and tests to be given before initiation of implants**

| Examination or test | Classification[a] |
|---|---|
| Breast examination by provider | C |
| Pelvic/genital examination | C |
| Cervical cancer screening | C |
| Routine laboratory tests | C |
| Haemoglobin test | C |
| STI risk assessment: medical history and physical examination | C |
| STI/HIV screening: laboratory tests | C |
| Blood pressure screening | N/A[b] |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] It is desirable to have blood pressure measurements taken before the initiation of implants. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and hormonal methods are among the few methods that are widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

### Remarks

The examinations or tests noted apply to persons who are presumed to be healthy. These classifications focus on the relationship of the examinations or tests to the safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some of the examinations or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

## iii. Continuation of LNG-releasing implants (duration of use)

These recommendations are based on information relating to the LNG implant, Jadelle. The product labelling for an ETG implant (Implanon) states that the implant can be left in place for up to three years. The product labelling for Sino-implant (II) states that the implant can be left in place for up to four years.

### Jadelle

For a woman weighing less than 80 kg:

- she can have the implants left in place for up to five complete years.

For a woman weighing 80 kg or more:

- she should seriously consider having her implants removed after four complete years of use because of their reduced effectiveness.

### Remarks

Some but not all studies have found that Jadelle implants became slightly less effective for heavier women after four or more years of use. As a precaution, women weighing over 80 kg may need to have their implants replaced after four years for greatest effectiveness. Regarding the duration of use of Sino-implant (II), the GDG agreed that the evidence supports the product labelling for four years duration of continuous use. Women using Jadelle are much less likely to get pregnant than women using no contraception. However, if a pregnancy does occur in a Jadelle user it is more likely to be ectopic (i.e. develop outside the womb) than if no contraceptive were used. Ectopic pregnancies are uncommon, occurring in 1–2% of all pregnancies.

## iv. Management of menstrual abnormalities for implant users

These recommendations are based on information relating to the LNG implant, Jadelle. The extent to which the treatment recommendations apply to Sino-implant (II) and ETG implants (Implanon) is not known.

### Amenorrhoea

- Amenorrhoea does not require any medical treatment. Counselling is sufficient.
- If a woman finds amenorrhoea unacceptable, the implant(s) should be removed and she should be assisted to choose another contraceptive method.

### Spotting or light bleeding

- Spotting or light bleeding is common during implant use, particularly in the first year, and is not harmful.

- In women with persistent spotting or bleeding, or in women with bleeding after a period of amenorrhoea, gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If pelvic inflammatory disease or an STI is diagnosed, the woman can continue using implants while receiving treatment and should be counselled on condom use.
- If no gynaecological problems are found and the woman desires treatment, non-hormonal and hormonal options are available:
  - Non-hormonal: non-steroidal anti-inflammatory drugs (NSAIDs)
  - hormonal (if medically eligible): low-dose combined oral contraceptives (COCs) or ethinyl estradiol.
- If the woman does not desire treatment, or the treatment is not effective, and she finds the bleeding unacceptable, the implant(s) should be removed and she should be assisted to choose another method.

### Heavy or prolonged bleeding (more than 8 days or twice as much as the woman's usual menstrual period)

- Gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If no gynaecological problems are found and the woman desires treatment, non-hormonal and hormonal options are available:
  - non-hormonal: NSAIDs
  - hormonal (if medically eligible): COCs or ethinyl estradiol.
- If the woman does not desire treatment, or the treatment is not effective, and the bleeding becomes a threat to her health or is not acceptable to her, the implant(s) should be removed and she should be assisted to choose another method.

### Remarks *(8–19)*

Menstrual abnormalities are common when implants are used, and counselling about such abnormalities before the initiation of implant use is essential to alleviate concerns and encourage continuation of the method. The GDG reviewed the limited data available regarding treatment for light or heavy bleeding and determined that the following drugs are modestly effective:

- Non-hormonal drugs: NSAIDs
  - ibuprofen
  - mefenamic acid
- Hormonal drugs
  - COCs
  - ethinyl estradiol.

## v. Appropriate follow-up after initiation of implants

These recommendations address the minimum frequency of follow-up for the safe and effective use of implants. The recommendations refer to general situations and may vary for different users and different contexts. For example, women with specific medical conditions may need more frequent follow-up visits. For implants:

- No routine follow-up visit is required.
- Women should be advised to return at any time to discuss side-effects or other problems, or if they want to change the method.
- Women should be advised to return when it is time to have the implant(s) removed.

### Remarks

The GDG concluded that follow-up visits or contacts should include, at a minimum, counselling to address issues such as side-effects or other problems, correct and consistent use of the method, and protection against STIs. Additional assessment may be appropriate.

### 5.3.2 Progestogen-only injectable contraceptives (POIs)

These injectable contraceptives include depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN).

Three formulations are considered here:

DMPA-IM: 150 mg of DMPA given intramuscularly

DMPA-SC: 104 mg of DMPA given subcutaneously

NET-EN: 200 mg of NET-EN given intramuscularly.

Note: The efficacy of DMPA-SC is likely to be maintained when administered in the upper arm, which may be acceptable to women in addition to subcutaneous injection in the abdomen or thigh *(20)*.

#### i. Initiation of POIs

If the woman cannot have the injection at the time of the consultation, arrangements can be made for her to have the injection at a later date through an appropriate service.

##### Having menstrual cycles

- Within 7 days of the start of menstrual bleeding: The first POI injection can be given. No additional contraceptive protection is needed.
- More than 7 days after the start of menstrual bleeding: The first POI injection can be given if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

##### Amenorrhoeic

- The first injection can be given at any time if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

##### Postpartum (breastfeeding)

- Less than six weeks postpartum and primarily breastfeeding: The first POI injection can generally be given within the first six weeks postpartum (MEC Category 2) *(1, 21)*. This represents a change from earlier editions of the MEC, when POIs were MEC Category 3 (a condition where the theoretical or proven risks usually outweigh the advantages of using the method).
- Six weeks to six months postpartum and amenorrhoeic: The first POI injection can be given. If the woman is fully or nearly fully breastfeeding, no additional contraceptive protection is needed.
- Six months or longer postpartum and menstrual cycles have returned: The first injection can be given as advised for other women having menstrual cycles.

##### Postpartum (non-breastfeeding)

- Less than 21 days postpartum: The first POI injection can be given. No additional contraceptive protection is needed. It is highly unlikely that a woman will ovulate and be at risk of pregnancy during the first 21 days postpartum. However, for programmatic reasons (i.e. depending on national, regional and/or local programme protocols), some contraceptive methods may be provided during this period.
- Twenty-one or more days postpartum and menstrual cycles have not returned: The first injection can be given if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.
- If menstrual cycles have returned, the first injection can be given as advised for other women having menstrual cycles.

##### Post-abortion

- The first injection can be given immediately post-abortion. No additional contraceptive protection is needed.

##### Switching from another hormonal method

- If the woman has been using her hormonal method consistently and correctly, or if it is reasonably certain that she is not pregnant, the first POI injection can be given immediately; there is no need to wait for her next menstrual period.
- If the woman's previous method was another injectable contraceptive, she should have the first POI injection when the repeat injection would have been given. No additional contraceptive protection is needed.

### Switching from a non-hormonal method (other than the IUD)

- The first injection can be given immediately if it is reasonably certain that the woman is not pregnant; there is no need to wait for her next menstrual period.
  - Within 7 days of the start of menstrual bleeding: No additional contraceptive protection is needed.
  - More than 7 days after menstrual bleeding started: She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

### Switching from an IUD (including the LNG-IUD)

- Within 7 days of the start of menstrual bleeding: The first injection can be given. No additional contraceptive protection is needed. The IUD can be removed at that time.
- More than 7 days after the start of menstrual bleeding: The first injection can be given if it is reasonably certain that the woman is not pregnant.
  - If the woman has been sexually active in this menstrual cycle and it is more than 7 days since the start of menstrual bleeding: It is recommended that the IUD be removed at the time of her next menstrual period.
  - If the woman has not been sexually active in this menstrual cycle and it is more than 7 days since the start of menstrual bleeding: She will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by the IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If the woman is amenorrhoeic or has irregular bleeding, she can have the injection as advised for other amenorrhoeic women.

### Remarks *(5, 6, 20, 22)*

The GDG considered that an injection given up to Day 7 of the menstrual cycle results in a low risk of an ovulatory cycle that could lead to pregnancy.

The need for additional contraceptive protection among those switching from another hormonal method will depend on the previous method used.

In the context of switching from an IUD to an injectable, there was some concern about the risk of pregnancy when removing an IUD within a cycle where there has already been intercourse. That concern led to the recommendation that the IUD be left in place until the next menstrual period.

Whereas an estimated 48 hours of POP use was deemed necessary to achieve a contraceptive effect on cervical mucus, the time required for POIs to exert such an effect was uncertain.

In their review of the evidence, the GDG noted that DMPA-SC efficacy is maintained when administered in the upper arm, which may be acceptable to women in addition to subcutaneous injection in the abdomen or thigh.

## ii. Examinations and tests needed before the initiation of POIs

In healthy women, no examinations or tests are essential or mandatory before initiating POIs (strong recommendation). However, there is special consideration for blood pressure screening; it is desirable to have blood pressure measurements taken before the initiation of POIs. It is important to note that in settings where blood pressure measurements are unavailable, women should not be denied use of POIs simply because their blood pressure cannot be taken (strong recommendation). Please see Table 5.3 for further information on examinations and tests.

### Table 5.3 Examinations and tests to be given before initiation of POIs

| Examination or test | Classification[a] |
|---|---|
| Breast examination by provider | C |
| Pelvic/genital examination | C |
| Cervical cancer screening | C |
| Routine laboratory tests | C |
| Haemoglobin test | C |
| STI risk assessment: medical history and physical examination | C |
| STI/HIV screening: laboratory tests | C |
| Blood pressure screening | N/A[b] |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe

and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] It is desirable to have blood pressure measurements taken before the initiation of POIs. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and hormonal methods are among the few methods that are widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

### Remarks

The examinations or tests noted apply to persons who are presumed to be healthy.

These classifications focus on the relationship of the examinations or tests to safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some of the examinations or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

## iii. Timing for repeat POIs (reinjection) for continuation of method

### Reinjection interval

- Repeat DMPA injections should be provided every three months.
- Repeat NET-EN injections should be provided every two months.

### Early for an injection

- The repeat injection of DMPA and NET-EN can be given up to two weeks early.

### Late for an injection

- The repeat DMPA injection can be given up to four weeks late without requiring additional contraceptive protection. The repeat NET-EN injection can be given up to two weeks late without requiring additional contraceptive protection.
- If the woman is more than four weeks late for a repeat DMPA injection or more than two weeks late for a repeat NET-EN injection, the injection can be given 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 using emergency contraception, if appropriate.

### Switching between DMPA and NET-EN

- Using DMPA and NET-EN injections interchangeably is not recommended.
- If it becomes necessary for a woman to switch from one to the other, the switch should be made at the time the repeat injection would have been given.

### For a repeat POI when the previous injectable contraceptive type and/or timing of injection is unknown

- The injection can be given if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.
- The woman may wish to consider using emergency contraception, if appropriate.

### Remarks *(20, 23)*

The GDG considered the risk of ovulation to be minimal within four weeks of the scheduled time for repeat DMPA injection (three months) and two weeks of the scheduled time for repeat NET-EN injection (two months).

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

The mechanisms of action, the medical eligibility criteria and the side-effects of DMPA and NET-EN are similar. Therefore, it is safe to stop using one and start using the other.

Whereas an estimated 48 hours of POP use was deemed necessary to achieve a contraceptive effect on cervical mucus, the time required for POIs to exert such an effect was uncertain.

In their review of the evidence, the GDG noted that DMPA-SC efficacy is maintained when administered in the upper arm, which may be acceptable to women in addition to subcutaneous injection in the abdomen or thigh.

## iv. Management of menstrual abnormalities during use of POIs

These recommendations refer to DMPA-IM and NET-EN-IM formulations; it may be that treatment will be the same among women using DMPA-SC.

### Amenorrhoea

- Amenorrhoea does not require any medical treatment. Counselling is sufficient.
- If the woman still finds amenorrhoea unacceptable, the injectable contraceptive should be discontinued and the woman assisted to choose another method.

### Spotting or light bleeding

- Spotting or light bleeding is common during POI use, particularly in the first injection cycle, and is not harmful.
- In women with persistent spotting or bleeding or in women with bleeding after a period of amenorrhoea, gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If an STI or pelvic inflammatory disease (PID) is diagnosed, the woman can continue her injections while receiving treatment and be counselled on condom use.
- If no gynaecological problems are found and she finds the bleeding unacceptable, short-term treatment with NSAIDs may be helpful. If she decides to discontinue the injectable contraceptive, she should be assisted to choose another method.

### Heavy or prolonged bleeding (more than 8 days or twice as much as the woman's usual menstrual period)

- The provider should explain that heavy or prolonged bleeding is common in the first injection cycle.
- If heavy or prolonged bleeding persists, gynaecological problems should be excluded when clinically warranted. If a gynaecological problem is identified, the condition should be treated or the woman referred for care.
- If the bleeding becomes a threat to the health of the woman or it is not acceptable to her, the injectable contraceptive should be discontinued. The woman should be assisted to choose another method. In the meantime, short-term treatment with either ethinyl estradiol or NSAIDs may be helpful.
- To prevent anaemia, an iron supplement should be provided and/or the woman encouraged to eat foods containing iron.

### Remarks *(24–31)*

The GDG noted that menstrual abnormalities are common with use of POIs and that counselling about such abnormalities before initiation of POI use is essential to alleviate concerns and encourage continuation of the method.

The GDG reviewed the limited data available 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):

For spotting or light bleeding:

- NSAIDs
  - mefenamic acid
  - valdecoxib.

For heavy or prolonged bleeding:

- NSAIDs
  - mefenamic acid
  - valdecoxib
- hormonal drugs
  - ethinyl estradiol.

### 5.3.3 Progestogen-only pills (POPs)

POPs contain only a progestogen and no estrogen.

#### i. Initiation of POPs

POPs may be provided to a woman in advance with appropriate instructions on pill initiation, provided she is medically eligible.

##### Having menstrual cycles

- Within 5 days of the start of menstrual bleeding: POPs can be initiated. No additional contraceptive protection is needed.
- More than 5 days after the start of menstrual bleeding: POPs can be initiated if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 2 days.

##### Amenorrhoeic

- POPs can be initiated at any time if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 2 days.

##### Postpartum (breastfeeding)

- Less than six weeks postpartum: POPs can generally be initiated (MEC Category 2). If the woman is fully or nearly fully breastfeeding, no additional contraceptive protection is needed.
- Six weeks to six months postpartum and amenorrhoeic: POPs can be initiated. If she is fully or nearly fully breastfeeding, no additional contraceptive protection is needed.
- More than six weeks postpartum and menstrual cycles have returned: POPs can be initiated as advised for other women having menstrual cycles (MEC Category 1).

##### Postpartum (non-breastfeeding)

- Less than 21 days postpartum: POPs can be initiated. No additional contraceptive protection is needed. It is highly unlikely that a woman will ovulate and be at risk of pregnancy during the first 21 days postpartum. However, for programmatic reasons (i.e. depending on national, regional and/or local programme protocols), some contraceptive methods may be provided during this period.
- Twenty-one or more days postpartum and menstrual cycles have not returned: POPs can be initiated if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 2 days.
- Menstrual cycles have returned: POPs can be initiated as advised for other women having menstrual cycles.

##### Post-abortion

- POPs can be initiated immediately post-abortion. No additional contraceptive protection is needed.

##### Switching from another hormonal method

- POPs can be initiated immediately if the woman has been using her hormonal method consistently and correctly or if it is reasonably certain that she is not pregnant; there is no need to wait for her next menstrual period.
- If the woman's previous method was an injectable contraceptive, POPs can be initiated when the repeat injection would have been given. No additional contraceptive protection is needed.

##### Switching from a non-hormonal method (other than the IUD)

- Within 5 days of the start of menstrual bleeding: POPs can be initiated. No additional contraceptive protection is needed.
- More than 5 days after the start of menstrual bleeding: POPs can be initiated if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 2 days.

##### Switching from an IUD (including the LNG-IUD)

- Within 5 days of the start of menstrual bleeding: POPs can be initiated. No additional contraceptive protection is needed. The IUD can be removed at that time.

- More than 5 days after the start of menstrual bleeding: POPs can be initiated if it is reasonably certain that the woman is not pregnant.
  - Sexually active in this menstrual cycle: It is recommended that the IUD be removed at the time of her next menstrual period.
  - Not sexually active in this menstrual cycle: She will need to abstain from sex or use additional contraceptive protection for the next 2 days. If that additional protection is to be provided by the IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If the woman is amenorrhoeic or has irregular bleeding, POPs can be initiated as advised for other amenorrhoeic women.

### Remarks *(5, 6, 32)*

The GDG considered the risk of ovulation when starting POPs within the first 5 days of menstruation to be acceptably low. Suppression of ovulation was considered to be less reliable when starting after Day 5. An estimated 48 hours of POP use was deemed necessary to achieve the contraceptive effects on cervical mucus.

The need for additional contraceptive protection among those switching from another hormonal method will depend on the previous method used.

There was some concern about the risk of pregnancy when removing an IUD within a cycle where there has already been intercourse. That concern led to the recommendation that the IUD be left in place until the next menstrual period.

## ii. Examinations and tests needed before the initiation of POPs

In healthy women, no examinations or tests are essential or mandatory before initiating POPs. However, there is special consideration for blood pressure screening; it is desirable to have blood pressure measurements taken before initiation of POPs. It is important to note that in settings where blood pressure measurements are unavailable, women should not be denied use of POPs simply because their blood pressure cannot be taken. Please see Table 5.4 for further information on examinations and tests.

**Table 5.4 Examinations and tests to be given before the initiation of POPs**

| Examination or test | Classification[a] |
|---|---|
| Breast examination by provider | C |
| Pelvic/genital examination | C |
| Cervical cancer screening | C |
| Routine laboratory tests | C |
| Haemoglobin test | C |
| STI risk assessment: medical history and physical examination | C |
| STI/HIV screening: laboratory tests | C |
| Blood pressure screening | N/A[b] |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] It is desirable to have blood pressure measurements taken before the initiation of POPs. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and hormonal methods are among the few methods that are widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

### Remarks

The examinations or tests noted apply to persons who are presumed to be healthy.

These classifications focus on the relationship of the exams or tests to safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some of the examinations or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

## iii. Number of packs of POPs that should be provided at initial and return visits

### Initial and return visits

- Up to one year's supply of pills may be provided, depending on the woman's preference and anticipated use.

- Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.
- The re-supply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.

### Remarks

The GDG concluded that restricting the number of cycles of pills provided can result in unwanted discontinuation of the method and increased risk of pregnancy.

## iv. Management of vomiting and/or severe diarrhoea while using POPs

### Vomiting (for any reason) within 2 hours after taking an active (hormonal) pill

- The woman should take another active pill.

### Severe vomiting or diarrhoea for more than 24 hours

- The woman should continue taking pills (if she can) despite her discomfort.
- If severe vomiting or diarrhoea continues for 2 or more days, she should follow the procedures for missed pills.

### Remarks *(33)*

The GDG found no direct evidence to address this question but considered the effects of vomiting or diarrhoea to be similar to those of missing pills.

## v. Management of missed POPs

### Having menstrual cycles (including those who are breastfeeding) and missed 1 or more pills by more than 3 hours

- The woman should take one pill as soon as possible and then continue taking the pills daily, 1 each day. She should also abstain from sex or use additional contraceptive protection for the next 2 days. She may wish to consider using emergency contraception, if appropriate.

### Breastfeeding and amenorrhoeic and missed one or more pills by more than 3 hours

- The woman should take one pill as soon as possible and then continue taking the pills daily, 1 each day. If she is less than six months postpartum, no additional contraceptive protection is needed.

### Remarks *(32, 34)*

The GDG considered the inconsistent or incorrect use of pills to be a major reason for unintended pregnancy and highlighted the importance of taking POPs at approximately the same time each day. An estimated 48 hours of POP use was deemed necessary to achieve the contraceptive effects on cervical mucus.

Existing recommendations (from the previous edition of the SPR, and the global handbook on family planning *[35]*) are provided for situations when a user misses 1 or more pills by more than 3 hours. For women taking the 75 µg desogestrel-containing POPs, the recommendation both for women having menstrual cycles and those who are breastfeeding and amenorrhoeic applies when 1 or more pills have been missed by more than 12 hours.

## vi. Appropriate follow-up after initiation of POPs

These recommendations address the minimum frequency of follow-up recommended for the safe and effective use of POPs. The recommendations refer to general situations and may vary for different users and in different contexts. For example, women with specific medical conditions may need more frequent follow-up visits.

### POPs (not breastfeeding)

- No annual follow-up visit is required, but a follow-up contact after initiation is recommended at about three months.
- The woman should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.

### POPs (breastfeeding)

- No routine follow-up visit is required.

- The woman should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.
- The woman should be advised that when she either ceases or significantly reduces frequency of breastfeeding, she should return for further contraceptive advice and counselling.

### Remarks

The GDG concluded that follow-up visits or contacts should include, at a minimum, counselling to address issues such as side-effects or other problems, correct and consistent use of the method, and protection against STIs. Additional assessment may be appropriate.

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# 5.4 Combined hormonal contraceptives

Combined hormonal contraceptives (CHCs) are contraceptive products that contain an estrogen combined with a progestogen. This section gives recommendations for the use of various CHCs, including combined oral contraceptives (COCs), the combined contraceptive patch (the patch), the combined contraceptive vaginal ring (CVR) and combined injectable contraceptives (CICs). In this section, COCs, the patch and the CVR will be addressed first, followed by CICs.

CHCs can be safely used by most women. To help determine if women with certain medical conditions or characteristics can safely use CHCs, please refer to the sixth edition of the *Medical eligibility criteria for contraceptive use* (MEC) *(1)*.

CHCs do not protect against sexually transmitted infections (STIs), including HIV. If there is a risk of HIV or any STI, the correct and consistent use of condoms is recommended. When used correctly and consistently, male and female condoms offer one of the most effective methods of protection against STIs, including HIV.

## 5.4.1 Combined oral contraceptives (COCs), the combined contraceptive patch and the combined contraceptive vaginal ring (CVR)

The recommendations on COCs in this guideline refer to low-dose COCs containing not more than 35 µg of ethinyl estradiol, combined with a progestogen. The recommendations in this guideline are the same for all COC formulations, irrespective of their progestogen content.

The patch releases 20 µg of ethinyl estradiol and 150 µg of norelgestromin daily.

The CVR releases 15 µg of ethinyl estradiol and 120 µg of etonogestrel daily.

COCs, the patch and the CVR are typically dosed with 21–24 consecutive days of hormone followed by 4–7 hormone-free days. However, dosing regimens that have fewer or no hormone-free days are also used.

### i. Initiation of COCs, the patch and the CVR

A woman may be provided with COCs, patches or CVRs in advance with appropriate instructions on initiation, provided she is medically eligible.

#### Having menstrual cycles

- Within 5 days of the start of menstrual bleeding: COCs, the patch and the CVR can be initiated. No additional contraceptive protection is needed.
- More than 5 days after the start of menstrual bleeding: COCs, the patch and the CVR can be initiated if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

#### Amenorrhoeic

- COCs, the patch and the CVR can be initiated at any time if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

#### Postpartum (breastfeeding)

- Less than six weeks postpartum and primarily breastfeeding: The woman should not use COCs, the patch or the CVR (MEC Category 4).
- Six weeks to six months postpartum and primarily breastfeeding: Use of COCs, the patch or the CVR is generally not recommended unless other more appropriate methods are not available or not acceptable (MEC Category 3).
- More than six months postpartum and amenorrhoeic: COCs, the patch and the CVR can be initiated as advised for other amenorrhoeic women.
- More than six months postpartum and menstrual cycles have returned: COCs, the patch and the CVR can be initiated as advised for other women having menstrual cycles.

### Postpartum (non-breastfeeding)

- Less than 21 days postpartum: Use of COCs, the patch or the CVR is generally not recommended unless other more appropriate methods are not available or not acceptable (MEC Category 3). It is highly unlikely that a woman will ovulate and be at risk of pregnancy during the first 21 days postpartum. However, for programmatic reasons (i.e. depending on national, regional and/or local programme protocols), some contraceptive methods may be provided during this period.
- Twenty-one or more days postpartum: For women with no other risk factors for venous thromboembolism, COCs, the patch and the CVR can generally be initiated (MEC Category 2).
- Medically eligible and menstrual cycles have not returned: COCs, the patch and the CVR can be initiated immediately if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.
- Medically eligible and menstrual cycles have returned: COCs, the patch and the CVR can be initiated as advised for other women having menstrual cycles.

### Post-abortion

- COCs, the patch and the CVR can be initiated immediately post-abortion. No additional contraceptive protection is needed.

### Switching from another hormonal method

- If the woman has been using her hormonal method consistently and correctly or if it is reasonably certain that she is not pregnant, COCs, the patch and the CVR can be initiated immediately; there is no need for the woman to wait for her next menstrual period.
- If a woman's previous method was an injectable contraceptive, COCs, the patch or the CVR should be initiated when the woman would have received her repeat injection. No additional contraceptive protection is needed.

### Switching from a non-hormonal method (other than the IUD)

- Within 5 days of the start of menstrual bleeding: COCs, the patch and the CVR can be initiated. No additional contraceptive protection is needed.
- More than 5 days after the start of menstrual bleeding: COCs, the patch and the CVR can be initiated immediately if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

### Switching from an intrauterine device (IUD), including levonorgestrel-releasing IUD (LNG-IUD)

- Within 5 days of the start of menstrual bleeding: COCs, the patch and the CVR can be initiated. No additional contraceptive protection is needed. The IUD can be removed at that time.
- More than 5 days after the start of menstrual bleeding: COCs, the patch and the CVR can be initiated if it is reasonably certain that the woman is not pregnant.
  - If the woman has been sexually active in this menstrual cycle, it is recommended that the IUD be removed at the time of her next menstrual period.
  - If the woman has not been sexually active in this menstrual cycle, she will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by the IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If the woman is amenorrhoeic or has irregular bleeding, COCs, the patch or the CVR can be initiated as advised for other amenorrhoeic women.

### Remarks *(2–4)*

The Guideline Development Group (GDG) considered the risk of ovulation within the first 5 days of menstruation to be acceptably low. Suppression of ovulation was considered to be less reliable when starting COCs after Day 5. Seven days of continuous COC use was deemed necessary to reliably prevent ovulation.

Recommendations for when to start COCs, the patch and the CVR are based primarily on evidence related to COCs and on limited evidence on the patch and CVR. Pending further evidence, the GDG concluded that the evidence available on when to start COCs applies to the patch and CVR.

The need for additional contraceptive protection among those switching from another hormonal method will depend on the previous method used.

There was some concern about the risk of pregnancy when removing an IUD within a cycle where there has already been intercourse. That concern led to the recommendation that the IUD be left in place until the next menstrual period.

## ii. Examinations and tests needed before the initiation of COCs, the patch and the CVR

In healthy women, no examinations or tests are essential or mandatory before initiating COCs, the patch or the CVR. However, there is special consideration for blood pressure screening; it is desirable to have blood pressure measurements taken before the initiation of COCs, the patch and the CVR. It is important to note that in settings where blood pressure measurements are unavailable, women should not be denied use of COCs, the patch or the CVR simply because their blood pressure cannot be taken. Please see Table 5.5 for further information on examinations and tests.

### Table 5.5 Examinations and tests to be given before the initiation of COCs, the patch and the CVR

| Examination or test | Classification[a] |
|---|---|
| Breast examination by provider | C |
| Pelvic/genital examination | C |
| Cervical cancer screening | C |
| Routine laboratory tests | C |
| Haemoglobin test | C |
| STI risk assessment: medical history and physical examination | C |
| STI/HIV screening: laboratory tests | C |
| Blood pressure screening | N/A[b] |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] It is desirable to have blood pressure measurements taken before initiation of COCs, the patch and the CVR. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and hormonal methods are among the few methods that are widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

## iii. Number of packs of COCs that should be provided

### Initial and return visits

- Up to one year's supply of pills should be provided, depending on the woman's preference and anticipated use.
- Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.
- The re-supply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.

### Remarks

The GDG concluded that restricting the number of cycles of pills issued can result in unwanted discontinuation of the method and increased risk of pregnancy.

## iv. Management of vomiting and/or severe diarrhoea while using COCs

### Vomiting (for any reason) within 2 hours of taking an active (hormonal) pill

- The woman should take another active pill.

### Severe vomiting or diarrhoea for more than 24 hours

- The woman should continue taking pills (if she can) despite her discomfort.
- If severe vomiting or diarrhoea continues for 2 or more days, she should follow the procedures for missed pills.

### Remarks *(5)*

The GDG found no direct evidence to address this question but considered the effects of vomiting or diarrhoea to be similar to those of missing pills.

## v. Management of missed COCs

### For pills containing 30–35 µg of ethinyl estradiol

If the woman has missed 1 or 2 active (hormonal) pills in a row, or started a pack 1 or 2 days late:

- She should take an active (hormonal) pill as soon as possible and then continue taking pills daily, 1 each day.
  - If she has missed 2 or more active (hormonal) pills in a row, she can take the first missed pill and then either continue taking the rest of the missed pills (1 each day) or discard them to stay on schedule.
  - Depending on when she remembers that she missed the pill(s), she may take 2 pills on the same day (one at the moment of remembering, and the other at the regular time) or even at the same time.
- No additional contraceptive protection is needed.

If the woman has missed 3 or more active (hormonal) pills in a row, or started a pack 3 or more days late:

- She should take an active (hormonal) pill as soon as possible and then continue taking pills daily, 1 each day.
  - If she has missed 2 or more active (hormonal) pills in a row, she can take the first missed pill and then either continue taking the rest of the missed pills (1 each day) or discard them to stay on schedule.
  - Depending on when she remembers that she missed the pill(s), she may take 2 pills on the same day (one at the moment of remembering, and the other at the regular time) or even at the same time.
- She should also use condoms or abstain from sex until she has taken active (hormonal) pills for 7 days in a row.
- If the woman missed the pills in the third week, she should finish the active (hormonal) pills in her current pack and start a new pack the next day. She should not take the 7 inactive pills.
- If the woman missed the pills in the first week and had unprotected sex, she may wish to consider using emergency contraception.

### For pills containing up to 20 µg of ethinyl estradiol

If the woman has missed 1 active (hormonal) pill or started a pack 1 day late:

- She should follow the instructions above for "If the woman has missed 1 or 2 active (hormonal) pills in a row, or started a pack 1 or 2 days late".

If the woman has missed 2 or more active (hormonal) pills in a row, or started a pack 2 or more days late:

- She should follow the instructions above for "If the woman has missed 3 or more active (hormonal) pills in a row, or started a pack 3 or more days late".

### For pills containing up to 20 µg or 30–35 µg of ethinyl estradiol

If the woman has missed any inactive (non-hormonal) pills:

- She should discard the missed inactive (non-hormonal) pill(s) and then continue taking pills daily, 1 each day.

## vi. Management of dosing errors during patch use

### Extension of the patch-free interval (i.e. if a woman forgets to apply a new patch after the 7-day patch-free interval)

- If the patch-free interval is extended for up to 48 hours (i.e. if the total patch-free interval is more than 7 days and up to 9 days), a new patch should be applied as soon as possible. The woman should keep the same patch-change day, meaning that she should start or change the patch on the scheduled patch start/change day just as she would without a dosing error (i.e. keep to the scheduled day as if she had not forgotten to apply the new patch). No additional contraceptive protection is needed.
- If the patch-free interval is extended for longer than 48 hours (i.e. if the total patch-free interval is more than 9 days), a new patch should be applied as soon as possible. The woman should keep to the same patch-change day. She should also use condoms or abstain from sex until she has

worn a patch for 7 days in a row. If unprotected sexual intercourse occurred during the previous 5 days, she may wish to consider using emergency contraception.

### Unscheduled detachment of the patch

- If the patch becomes detached for 48 hours or less, a new patch should be applied as soon as possible (if detachment occurs less than 24 hours after the patch was applied, the woman can try to reapply the same patch or replace it with a new patch). The woman should keep to the same patch-change day. No additional contraceptive protection is needed.
- If the patch becomes detached for more than 48 hours, a new patch should be applied as soon as possible. The woman should keep to the same patch-change day.
  - The woman should also use condoms or abstain from sex until she has worn a patch for 7 days in a row.
  - If the unscheduled detachment occurred during the third week of patch use, the woman should omit the patch-free week by finishing the third week of patch use and starting a new patch immediately. If she is unable to start a new patch immediately after the third week of patch use, she should also use condoms or abstain from sex until she has worn a patch for 7 days in a row.
  - If the unscheduled detachment occurred during the first week of patch use and unprotected sexual intercourse occurred during the previous 5 days, the woman may wish to consider using emergency contraception.

### Extended use of the patch

- If patch removal and reapplication is delayed by up to 48 hours (i.e. if patch use is extended from 7 days to up to 9 days) during Weeks 1–3 of patch use, a new patch should be applied as soon as possible. The woman should keep to the same patch-change day. No additional contraceptive protection is needed.
- If patch removal and reapplication is delayed by more than 48 hours (i.e. if patch use is extended from 7 days to more than 9 days) during Weeks 2–3 of patch use, while a woman is using the first or second patch of her cycle, the patch should be removed or replaced as soon as possible. She should keep to the same patch-change day. She should also use condoms or abstain from sex until she has worn a patch for 7 days in a row.
- If delayed removal occurs during Week 4 of patch use (i.e. the scheduled hormone-free week), while a woman is using the third patch of her cycle, she should remove the patch as soon as possible. She should keep to the same patch start day for starting the new patch. No additional contraceptive protection is needed.

## vii. Management of dosing errors during CVR use

### Extension of CVR-free interval (i.e. if a woman forgets to insert a new CVR after the 7-day CVR-free interval)

- If the CVR-free interval is extended for up to 48 hours (i.e. if the total CVR-free interval is more than 7 days and up to 9 days), a new CVR should be inserted as soon as possible. The woman should keep to the same CVR-removal day, meaning that she should insert/remove the CVR on the scheduled CVR-insertion/removal day as she would without a dosing error. No additional contraceptive protection is needed.
- If the CVR-free interval is extended for more than 48 hours (i.e. if the total CVR-free interval is more than 9 days), a new CVR should be inserted as soon as possible. The woman should keep to the same CVR-removal day. She should also use condoms or abstain from sex until she has worn a CVR for 7 days in a row. If unprotected sexual intercourse occurred during the previous 5 days, she may wish to consider using emergency contraception.

### Unscheduled removal of CVR (i.e. CVR is removed before the end of the cycle)

- If the CVR is removed for up to 48 hours at an unscheduled time, it should be reinserted as soon as possible. The woman should then keep the CVR in place until the removal day as originally scheduled. No additional contraceptive protection is needed.
- If the CVR is removed for more than 48 hours at an unscheduled time, it should be reinserted as soon as possible. The woman should then

keep the CVR in place until the removal day as originally scheduled.

- The woman should also use condoms or abstain from sex until she has worn a CVR for 7 days in a row.
- If the unscheduled removal of the CVR occurred during the third week of CVR use, the woman should omit the CVR-free week by finishing the third week of CVR use and starting a new CVR immediately. If she is unable to start a new CVR immediately after the third week of CVR use, she should use condoms or abstain from sex until she has worn a CVR for 7 days in a row.
- If the unscheduled removal of CVR occurred during the first week of CVR use and unprotected sexual intercourse occurred during the previous 5 days, the woman may wish to consider using emergency contraception.

### Extended use of CVR

- If the same CVR is used for up to 28 days (less than four weeks), then additional contraception is not needed. A hormone-free interval can be taken, if desired, but should not exceed 7 days.
- If the same CVR is used for 28–35 days (at least four weeks but less than five weeks), insert a new CVR and skip the hormone-free interval. No additional contraceptive protection is needed.

### Remarks *(3, 4, 6, 7)*

The GDG considered the inconsistent or incorrect use of pills to be a major reason for unintended pregnancy. Seven days of continuous COC use was deemed necessary to reliably prevent ovulation. Women who frequently miss pills or experience usage errors with the patch or CVR should consider an alternative contraceptive method that is less dependent on the user to be effective (e.g. IUD, implant or injectable contraceptive).

Most of the studies on late or missed doses of CHCs that were considered by the GDG examined COCs. However, two studies examined the patch, and seven studies examined the CVR. The GDG noted that the evidence for "missed pill" recommendations is primarily derived from studies of women using 30–35 µg ethinyl estradiol pills.

Many women (including those whose pill packs are marked with the days of the week) follow a pill-taking schedule that involves starting on a certain day of the week. When such a woman misses pills, it is necessary to discard the missed pills if she is to maintain her schedule. Other women may prefer not to discard missed pills, but they may have menses at other than expected intervals.

## viii. Principles underlying the GDG's recommendations

The following four principles underpin the GDG's recommendations.

- It is important to resume COC, patch or CVR use (take an active pill, reapply or apply a new patch, or reinsert or insert a new CVR) as soon as possible when doses have been missed.
- If doses are missed, the chance that pregnancy will occur depends not only on the duration of missed doses (i.e. how many days of pill, patch or CVR use were missed), but also on when those doses were missed. Based on data regarding ovulation, the GDG determined that missing 3 or more active (hormonal) pills (2 or more for pills containing not more than 20 µg ethinyl estradiol) at any time during the cycle warrants additional precautions. The risk of pregnancy is greatest when active (hormonal) pills are missed at the beginning or at the end of the series of active pills, i.e. when the hormone-free interval is extended. Although there is limited evidence on dosage errors with patch and CVR use, these methods are considered to be similar to COC use, and thus these principles have been extrapolated to patch and CVR use.
- Limited evidence on pills containing not more than 20 µg ethinyl estradiol suggests that there may be a higher risk of pregnancy when these pills are missed than when pills containing 30–35 µg ethinyl estradiol are missed. Accordingly, the GDG recommended a more cautious approach when pills containing not more than 20 µg of ethinyl estradiol are missed.
- Field experience from the first edition of the *Selected practice recommendations for contraceptive use* (SPR) highlighted the need for simple "missed pill" recommendations.

### ix. Appropriate follow-up after initiation of COCs, the patch or the CVR

These recommendations address the minimum frequency of follow-up recommended for safe and effective use of these methods. The recommendations refer to general situations and may vary for different users and different contexts. For example, women with specific medical conditions may need more frequent follow-up visits.

- An annual follow-up visit is recommended.
- There are added benefits from a three-month follow-up contact after initiation.
- The woman should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.

#### Remarks *(8–11)*

The GDG concluded that follow-up visits or contacts should include, at a minimum, counselling to address issues such as side-effects or other problems, correct and consistent use of the method, and protection against STIs. Additional assessment may be appropriate.

## 5.4.2 Combined injectable contraceptives (CICs)

Two CIC formulations are considered here:

- Cyclofem: medroxyprogesterone acetate 25 mg plus estradiol cypionate 5 mg
- Mesigyna: norethisterone enanthate 50 mg plus estradiol valerate 5 mg.

### i. Initiation of CICs

If the woman cannot have the injection at the time of the consultation, arrangements may be made for her to have the injection at a later date through an appropriate service.

#### Having menstrual cycles

- Within 7 days of the start of menstrual bleeding: The first CIC injection can be given. No additional contraceptive protection is needed.
- More than 7 days after the start of menstrual bleeding: The first CIC injection can be given if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

#### Amenorrhoeic

- The first CIC injection can be given at any time if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

#### Postpartum (breastfeeding)

- Less than six weeks postpartum and primarily breastfeeding: CICs should not be used (MEC Category 4).
- Six weeks to six months postpartum and primarily breastfeeding: Use of CICs is generally not recommended (MEC Category 3) unless other more appropriate methods are not available or not acceptable.
- More than six months postpartum and amenorrhoeic: The first CIC injection can be given as advised for other amenorrhoeic women.
- More than six months postpartum and menstrual cycles have returned: The first CIC injection can be given as advised for other women having menstrual cycles.

#### Postpartum (non-breastfeeding)

- Less than 21 days postpartum: Use of CICs is generally not recommended unless other more appropriate methods are not available or not acceptable. It is highly unlikely that a woman will ovulate and be at risk of pregnancy during the first 21 days postpartum. However, for programmatic reasons (i.e. depending on national, regional and/or local programme protocols), some contraceptive methods may be provided during this period.
- Twenty-one or more days postpartum and menstrual cycles have not returned: The first CIC injection can be given immediately if it is reasonably certain that the woman is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

- Twenty-one or more days postpartum and menstrual cycles have returned: The first CIC injection can be given as advised for other women having menstrual cycles.

### Post-abortion

- The first CIC injection can be given immediately post-abortion. No additional contraceptive protection is needed.

### Switching from another hormonal method

- If the woman has been using her hormonal method consistently and correctly or if it is reasonably certain that she is not pregnant, the first CIC injection can be given immediately; there is no need to wait for her next menstrual period.
- If a woman's previous method was another injectable contraceptive, the CIC injection should be given when the repeat injection would have been given. No additional contraceptive protection is needed.

### Switching from a non-hormonal method (other than the IUD)

- The first CIC injection can be given immediately if it is reasonably certain that the woman is not pregnant; there is no need to wait for her next menstrual period.
  - Within 7 days of the start of menstrual bleeding: No additional contraceptive protection is needed.
  - More than 7 days after the start of menstrual bleeding: She will need to abstain from sex or use additional contraceptive protection for the next 7 days.

### Switching from an IUD (including the LNG-IUD)

- Within 7 days of the start of menstrual bleeding: The first CIC injection can be given. No additional contraceptive protection is needed. The IUD can be removed at that time.
- More than 7 days since the start of menstrual bleeding: The first CIC injection can be given if it is reasonably certain that the woman is not pregnant.
  - Sexually active in this menstrual cycle: It is recommended that the IUD be removed at the time of her next menstrual period.
  - Not sexually active in this menstrual cycle: She will need to abstain from sex or use additional contraceptive protection for the next 7 days. If that additional protection is to be provided by the IUD she is using, it is recommended that this IUD be removed at the time of her next menstrual period.
- If the woman is amenorrhoeic or has irregular bleeding, the injection can be given as advised for other amenorrhoeic women.

### Remarks *(3, 4, 12, 13)*

The GDG considered that a CIC injection given up to Day 7 of the menstrual cycle results in a low risk of an ovulatory cycle that could lead to pregnancy.

The need for additional contraceptive protection among those switching from another hormonal method will depend on the previous method used.

There was some concern about the risk of pregnancy when removing an IUD within a cycle where there has already been intercourse. That concern led to the recommendation that the IUD be left in place until the next menstrual period.

## ii. Examinations and tests needed before initiation of CICs

In healthy women, no examinations or tests are essential or mandatory before initiating CICs. However, there is special consideration for blood pressure screening; it is desirable to have blood pressure measurements taken before initiation of CICs. It is important to note that in settings where blood pressure measurements are unavailable, women should not be denied use of CICs simply because their blood pressure cannot be measured. Please see Table 5.6 for further information on examinations and tests.

**Table 5.6 Examinations and tests to be given before the initiation of CICs**

| Examination or test | Classification[a] |
|---|---|
| Breast examination by provider | C |
| Pelvic/genital examination | C |
| Cervical cancer screening | C |
| Routine laboratory tests | C |
| Haemoglobin test | C |
| STI risk assessment: medical history and physical examination | C |
| STI/HIV screening: laboratory tests | C |
| Blood pressure screening | N/A[b] |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] It is desirable to have blood pressure measurements taken before initiation of CICs. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and hormonal methods are among the few methods that are widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

## iii. Timing for repeat CIC injections (reinjection) for continuation of method

### Reinjection interval

- Repeat CIC injections should be provided every four weeks.

### Early for an injection

- When the reinjection interval cannot be adhered to, the repeat injection can be given up to 7 days early but this may disrupt bleeding patterns.

### Late for an injection

- When the reinjection interval cannot be adhered to, the repeat injection can be given up to 7 days late without requiring additional contraceptive protection.
- If the woman is more than 7 days late for an 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 using emergency contraception, if appropriate.

### Remarks *(14–18)*

The risk of ovulation was considered by the GDG to be minimal during the early part of the second month after the last injection.

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[8] All references were accessed on 18 June 2025.

# 5.5 Emergency contraception

Emergency contraception (EC), or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first few days after intercourse. It is also intended for emergency use following unprotected intercourse, contraceptive failure or misuse (such as forgotten pills or torn condoms), rape or coerced sex.

This section provides recommendations on four methods of EC: the copper-bearing intrauterine device (Cu-IUD) for EC and three different types of emergency contraceptive pills (ECPs): ulipristal acetate ECPs (UPA-ECPs), levonorgestrel-only ECPs (LNG-ECPs) and combined estrogen–progestogen ECPs (combined ECPs).

Emergency contraception is safe to use for most women. To help determine if women with a particular medical condition or characteristic can safely use EC, please refer to the sixth edition of the *Medical eligibility criteria for contraceptive use* (MEC) *(1)*.

There are several options for EC. The Cu-IUD is an effective EC method that reduces the risk of pregnancy by more than 99% if it is placed within 120 hours of intercourse *(2–5)*. ECPs also substantially reduce the risk of pregnancy. However, it is important to note that the effectiveness of each method varies according to individual circumstances, including the type of ECP chosen, the day of the menstrual cycle, and the length of time between unprotected intercourse and the initiation of ECPs. In addition, the effectiveness of ECPs may be reduced if there are additional acts of unprotected intercourse in the same cycle, if other medicines are used (e.g. cytochrome P450 3A4 [CYP 3A]) enzyme inducers), or if body weight or body mass index is high *(6–7)*.

Emergency contraception does not protect against sexually transmitted infections (STIs), including HIV. If there is a risk of HIV or any STI, the correct and consistent use of condoms is recommended. When used correctly and consistently, male and female condoms offer one of the most effective methods of protection against STIs, including HIV.

## 5.5.1 Copper-bearing IUDs (Cu-IUDs) for EC, and emergency contraceptive pills (ECPs)

### i. Regimens – one of the following options should be selected

- Cu-IUD for EC
- UPA-ECPs: Single dose – one 30 mg tablet
- LNG-ECPs:
  - Single dose (preferred LNG regimen): 1.50 mg (two 0.75 mg tablets)
  - Split dose: one dose of 0.75 mg, followed by a second dose of 0.75 mg 12 hours later
- Combined ECPs:
  - Split dose: one dose of 100 µg of ethinyl estradiol plus 0.50 mg of LNG, followed by a second dose of 100 µg of ethinyl estradiol plus 0.50 mg of LNG 12 hours later.

### ii. Timing

- The Cu-IUD can be placed up to 120 hours after unprotected intercourse.
- Ideally, UPA-ECPs, LNG-ECPs or combined ECPs should be taken as soon as possible after unprotected intercourse, within 120 hours. However, the woman should be advised that the effectiveness of the ECP(s) is reduced the longer the interval between having unprotected intercourse and taking ECP(s). UPA-ECPs may be more effective between 72 hours and 120 hours after unprotected intercourse than other ECPs.

#### Remarks *(2,8–16)*

The Guideline Development Group (GDG) reviewed evidence that the sooner ECPs are taken after unprotected intercourse, the more effective they are. They should ideally be taken within 72 hours. The evidence also indicated that ECPs are still effective between 72 hours and 120 hours but effectiveness

is reduced, particularly after 96 hours. One study suggests that UPA-ECPs are more effective than LNG-ECPs between 72 and 120 hours after unprotected intercourse; no studies were identified that compared UPA-ECPs directly to combined ECPs. Effectiveness after 120 hours is unknown.

The GDG considered evidence that UPA-ECPs and LNG-ECPs are preferable to combined ECPs because they cause less nausea and vomiting.

The GDG also considered evidence that the single-dose regimen of LNG-ECPs is at least as effective as the split-dose regimen of LNG-ECPs (see details above). Programmes can provide either the single- or split-dose option, depending on the preparations that are available. The GDG, however, considered the single-dose option to be preferable to the split-dose option because of compliance considerations.

## iii. Provision of an advance supply of ECPs

- An advance supply of ECPs may be given to a woman to ensure that she will have them available when needed and can take them as soon as possible after unprotected intercourse.

### Remarks *(17–23)*

The GDG noted that an advance supply cannot be given in some countries, and, in those circumstances, an advance prescription may be given.

The GDG reviewed evidence that a woman is more likely to use ECPs after unprotected intercourse if she has been given an advance supply and that providing an advance supply does not affect contraceptive use patterns, increase the frequency of ECP use, or increase the frequency of unprotected intercourse.

## iv. Use of EC by users of other methods of contraception

Users of other methods of contraception may wish to consider using EC in the following circumstances, as needed.

- Progestogen-only injectable (POI) contraceptive users: If the woman is more than two weeks late for a depot medroxyprogesterone acetate (DMPA) or norethisterone enanthate (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 using EC, if appropriate.
- Progestogen-only pill (POP) users: If a woman having menstrual cycles (including a woman who is breastfeeding) has missed 1 or more pills by more than 3 hours, she may wish to consider using EC, if appropriate.
- Combined oral contraceptive (COC) users (pills containing 30–35 µg of ethinyl estradiol): If a woman has missed 3 or more active (hormonal) pills in the first week (including starting a pack 3 or more days late) and had unprotected sex, she may wish to consider using EC.
- Combined injectable contraceptive (CIC) users: If the woman is more than 7 days late for an 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 using EC, if appropriate.
- Standard Days Method (SDM) users: If the woman has unprotected intercourse on Days 8–19 of her cycle, she may wish to consider using EC, if appropriate.

## v. Prevention of nausea and vomiting when taking ECPs

- LNG-ECPs or UPA-ECPs are preferable to combined ECPs because they cause less nausea and vomiting.
- Routine use of anti-emetics before taking ECPs is not recommended, but pretreatment with certain anti-emetics can be considered, depending on availability and clinical judgement.

### Remarks *(16, 24–29)*

The GDG considered that many women will not experience nausea or vomiting when taking ECPs and that it is difficult to predict which women will experience nausea or vomiting. Although the GDG did not recommend routine use of anti-emetics before taking ECPs, it noted that anti-emetics are effective in some women and can be offered when appropriate.

When providers are deciding whether to offer anti-emetics to women taking ECPs, they should consider the following.

- Nausea and vomiting are more likely to occur in women taking combined ECPs than in women taking LNG-ECPs or UPA-ECPs.
- Evidence indicates that anti-emetics reduce the occurrence of nausea and vomiting in women taking combined ECPs.
- Women who take anti-emetics may experience other side-effects from the anti-emetics.
- In some settings, the availability of anti-emetics may be constrained.

From the limited evidence that the GDG considered, it could not be established whether taking ECPs with food alters the risk of nausea or vomiting.

### vi. Management of vomiting in women after taking ECPs

#### Vomiting within 2 hours of taking a dose of pills (LNG-ECPs or combined ECPs)

- Another ECP dose should be taken as soon as possible. If the woman is taking combined ECPs, she may want to use an anti-emetic before taking the second dose.
- If vomiting continues, a repeat ECP dose can be given vaginally.

#### Vomiting within 3 hours of taking a dose of UPA-ECP

- Another UPA dose should be taken as soon as possible.

#### Remarks

The GDG noted that LNG-ECPs and UPA-ECPs are less likely to cause nausea and vomiting than are combined ECPs.

The GDG considered that 2 hours is sufficient for hormone absorption of LNG-ECPs or combined ECPs and that no action is required if a woman vomits after this time. Three hours was considered sufficient for absorption of UPA.

## 5.5.2 Resumption or initiation of regular contraception after using EC

### i. After using a Cu-IUD for emergency contraception

- No additional contraceptive protection is needed if a woman has a Cu-IUD placed.

### ii. After using LNG-ECPs and combined ECPs

#### Timing

- Following the administration of LNG-ECPs or combined ECPs, a woman may resume her contraceptive method, or start any contraceptive method immediately, including a Cu-IUD. If she wishes to start the LNG-IUD, it can be placed at any time if it can be determined that she is not pregnant.
  - If she does not start immediately but returns later for a hormonal method, she may start combined hormonal contraceptives (COCs, patch, CVR or injectable contraceptives) or progestogen-only contraceptives (POPs, DMPA or NET-EN injectable contraceptives or implants) at any time if it is reasonably certain that she is not pregnant.
  - If she does not start immediately but returns for an IUD, she can have it placed at any time if it is reasonably certain that she is not pregnant. If she is amenorrhoeic, she can have an IUD placed at any time if it can be determined that she is not pregnant.

#### Need for additional contraception

- The woman should be advised to abstain from sexual intercourse or use barrier contraception for 2 days after starting POPs or 7 days after starting combined hormonal contraceptives (COCs, patch, CVR or injectable contraceptives) or other progestogen-only contraceptives (DMPA or NET-EN injectable contraceptives, implants or LNG-IUD) and to have early pregnancy testing at the appropriate time, if warranted (e.g. if no withdrawal bleed occurs within three weeks).

### Remarks

As stated in the MEC, the IUD is not indicated during pregnancy and should not be used because of the risk of serious pelvic infection and septic spontaneous abortion. The GDG recognized that the checklist of six criteria will be helpful to the provider in determining whether a woman who is postpartum and breastfeeding may be pregnant (see section 5.1 "How can a health worker be reasonably certain that a woman is not pregnant?"). However, for a woman who is postpartum and not breastfeeding, or one who is amenorrhoeic (non-postpartum), these six criteria do not apply and other means should be used to determine whether she is pregnant.

## iii. After using UPA-ECPs

### Timing

- Following the administration of UPA-ECPs, the woman may resume or start any progestogen-containing method (either combined hormonal contraceptives [CHCs] or progestogen-only contraceptives [POCs]) on the sixth day after taking UPA. She can have an LNG-IUD placed immediately if it can be determined that she is not pregnant.
  - If she does not start on the sixth day but returns later for a hormonal method, she may start CHCs (COCs, patch, CVR or CICs) or POCs (POPs, DMPA or NET-EN injectable contraceptives, implants or the LNG-IUD) at any time if it is reasonably certain that she is not pregnant. If she is amenorrhoeic, she can have the LNG-IUD placed at any time if it can be determined that she is not pregnant.
- Following administration of UPA-ECPs, she can have the Cu-IUD placed immediately.
  - If she does not start immediately but returns for the Cu-IUD, she can have it placed at any time if it is reasonably certain that she is not pregnant. If she is amenorrhoeic, she can have the Cu-IUD placed at any time if it can be determined that she is not pregnant.

### Need for additional contraception

- The woman should be advised to abstain from sexual intercourse or use barrier contraception from the time she takes UPA until she is protected by her new method of contraception. If regular hormonal contraception is initiated 6 days after taking UPA, she will need to continue to abstain from sexual intercourse or use barrier contraception in accordance with the recommendations for contraceptive initiation (e.g. an additional 2 days for POPs or an additional 7 days for all other hormonal methods). She should also be advised to have pregnancy testing at the appropriate time, if warranted (e.g. if no withdrawal bleed occurs within three weeks). She does not need to abstain from sexual intercourse or use additional contraceptive protection if she has a Cu-IUD placed.

### Remarks *(30)*

UPA (an anti-progestogen) and progestogen-containing contraceptive methods may interact, potentially decreasing the effectiveness of either drug. The GDG determined that starting a regular progestogen-containing method (including a combined hormonal method) on the sixth day after taking UPA was sufficient time to avoid potential drug interaction while sperm is viable in the female genital tract after unprotected intercourse.

The GDG considered that if delaying initiation of progestogen-containing methods for 6 days after use of UPA is unacceptable to a woman, she may start any method immediately and will need early pregnancy testing at the appropriate time (e.g. if no withdrawal bleed occurs within three weeks).

The GDG determined that if regular hormonal contraception is initiated on the sixth day after taking UPA, continuing to abstain from sexual intercourse or using barrier contraception for the length of time recommended for routine contraceptive initiation (e.g. an additional 2 days for POPs or an additional 7 days for all other hormonal methods) would be sufficient to prevent pregnancy.

As stated in the MEC, the IUD is not indicated during pregnancy and should not be used because of the risk of serious pelvic infection and septic spontaneous

abortion. The GDG recognized that the checklist of six criteria would be helpful to the provider in determining whether a woman who is postpartum and breastfeeding may be pregnant (see section 5.1 "How can a health worker be reasonably certain that a woman is not pregnant?"). However, for a woman who is postpartum and non-breastfeeding, or one who is amenorrhoeic (non-postpartum), these six criteria do not apply and other means should be used to determine whether she is pregnant.

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# 5.6 Standard Days Method

Standard Days Method (SDM) is a type of fertility-awareness-based (FAB) method. Such methods – which also include the Ovulation Method, the TwoDay Method and the sympto-thermal method – can be used in combination with abstinence or barrier methods during the fertile time. Specifically, with SDM, a woman with a regular cycle of 26–32 days in length should avoid unprotected intercourse on Days 8–19. For details of all FAB methods, please refer to *Family planning: a global handbook for providers (1)*.

SDM can be used safely by most women. Women with conditions that make pregnancy an unacceptable risk should be advised that this method may not be appropriate for them because of the relatively high failure rates among typical users. To help determine if women with certain medical conditions or characteristics can safely use SDM, please refer to the sixth edition of the *Medical eligibility criteria for contraceptive use* (MEC) *(2)*.

SDM does not protect against sexually transmitted infections, including HIV. If there is a risk of HIV or any STI, the correct and consistent use of condoms is recommended. When used correctly and consistently, male and female condoms offer one of the most effective methods of protection against STIs, including HIV.

## 5.6.1 Initiation of SDM

### i. Initial provision of SDM for women whose menstrual cycles are within the 26–32 day range

- Another method of contraception should be provided for protection on Days 8–19 if the woman desires. Supplies should be given in advance.

### ii. SDM users who have unprotected intercourse between Days 8 and 19

- Use of emergency contraception should be considered, if appropriate.

### iii. Use of SDM by women who have two or more cycles outside the 26–32 day range, within any one year of use

- The woman should be advised that the method may not be appropriate for her because of a higher risk of pregnancy. She should be assisted to consider another method.

#### Remarks *(3–5)*

The Guideline Development Group (GDG) concluded that the probability of pregnancy is increased when the menstrual cycle is outside the 26–32 day range, even if unprotected intercourse is avoided between days 8–19.

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# 5.7 Male sterilization

Male sterilization, or vasectomy, is a low-risk procedure that involves occlusion of the vas deferens and can be performed in an outpatient setting. Both the no-scalpel and conventional incision procedures are quick, safe and effective. Sterilization should be regarded as a permanent method and all individuals and couples considering this option should be counselled accordingly, to ensure that every client makes a voluntary, informed decision. Particular care must be taken in the case of young people, men who have not yet been fathers, and clients with mental health problems, including depressive conditions. In addition to receiving counselling about the permanence of this method, all clients should be carefully counselled about the availability of alternative, long-acting, highly effective methods for women. The national laws and existing norms for the delivery of sterilization procedures must be considered in the decision-making process.

There is no medical condition that would be an absolute contraindication for male sterilization, although some conditions and circumstances will require that certain precautions are taken. To help determine if men with certain medical conditions or characteristics can safely have a vasectomy, please refer to the sixth edition of the *Medical eligibility criteria for contraceptive use* (MEC) *(1)*. For further details on vasectomy please refer to *Family planning: a global handbook for providers (2)*.

Sterilization does not protect against sexually transmitted infections, including HIV. If there is a risk of HIV or any STI, the correct and consistent use of condoms is recommended. When used correctly and consistently, male and female condoms offer one of the most effective methods of protection against STIs, including HIV.

## 5.7.1 Vasectomy

### i. Reliance on a vasectomy for contraception

- The man should be advised to wait three months before relying on his vasectomy for contraception.
- During this period, he may resume sexual activity, but he or his partner will need to use additional contraceptive protection.
- Semen analysis, where available, can confirm contraceptive effectiveness after the three-month waiting period.

#### Remarks *(3–92)*

The Guideline Development Group (GDG) considered that vasectomy is highly effective when the procedure is properly performed and when the man waits for three months after the vasectomy before having unprotected intercourse. The GDG reviewed evidence that a three-month waiting period after vasectomy is long enough for most men to be assured of the effectiveness of their vasectomy but noted that semen analysis, where available, is the most reliable means to document this.

The GDG also reviewed evidence that having had 20 ejaculations after a vasectomy (in the absence of a three-month waiting period) is not a reliable determinant of vasectomy effectiveness. The man, however, may resume sexual activity (while using contraceptive protection) during the three-month waiting period after his vasectomy in order to clear any remaining sperm from his semen.

### ii. Examinations and tests before providing vasectomy

In healthy men, only a genital examination is essential and mandatory before a vasectomy is carried out. However, blood pressure screening is desirable for procedures performed under local anaesthesia. Please see Table 5.7 for further information.

## Table 5.7 Examinations and tests to be given before providing a vasectomy

| Examination or test | Classification[a] |
|---|---|
| Genital examination | A |
| Routine laboratory tests | C |
| Haemoglobin test | C |
| STI risk assessment: medical history and physical examination | C |
| STI/HIV screening: laboratory tests | C |
| Blood pressure screening | C[b] |

[a] Class A: The examination or test is essential and mandatory in all circumstances for safe and effective use of the contraceptive method; Class B: The examination or test contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing the examination or test should be balanced against the benefits of making the contraceptive method available; Class C: The examination or test does not contribute substantially to safe and effective use of the contraceptive method.

[b] For procedures performed using local anaesthesia.

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# 6 Programmatic implications

The following issues need to be addressed when applying the recommendations in this document to national programmes:

- informed choice of methods and informed consent;
- elements of quality of care;
- essential screening procedures for administering the contraceptive methods;
- provider training and skills; and
- referral and follow-up for contraceptive use, as appropriate.

Service-delivery practices that are essential for the safe use of a particular contraceptive method should be distinguished from practices that may be appropriate for good health care but are not related to use of the method. The promotion of good health-care practices unrelated to safe contraception should not be considered a prerequisite and should not be an obstacle to the provision of a contraceptive method, but should be complementary to it.

Adaptation of global guidelines to national programmes is not always an easy task and is best done by those well acquainted with prevailing local health conditions, behaviours and culture. These changes must be made within the context of ensuring informed choices and medical safety for users.

As a first step, the practice recommendations need to be considered within the context of each country, so as to be applicable to health workers who are delivering services at all levels of the national health system. Countries will need to determine how far and by what means it may be possible to extend their services to the more peripheral levels of the health system. This may involve upgrading both staff and facilities where feasible and affordable, or it may require a modest addition of equipment and supplies, and redeployment of space. It will also be necessary to address any misperceptions sometimes held by health workers and contraceptive users about the risks and side-effects of particular methods, and to look closely at the needs and perspectives of women and men during the process of facilitating an informed choice.

## 6.1 Introducing the guideline into national programmes

When introducing this guideline into a national programme for sexual and reproductive health (SRH) care, it is important to consider that this material is not simply a document that must be distributed, but rather that it presents health-care practices that must be introduced to family planning service providers through a well planned process of adaptation and implementation.

Information and advice for countries on how to adapt and implement these recommendations is available in the 2018 publication, *Implementation guide for the medical eligibility criteria and selected practice recommendations for contraceptive use guidelines (1)* and an accompanying online toolkit of resources *(2)*. The implementation guide is designed for use by policy-makers, programme managers, implementing organizations and other health-care professionals to assist in translating guidelines into practice through the principles of implementation science. The guide presents a structured process that will aid countries in their efforts to incorporate the recommendations in this document into their national family planning guidelines and protocols. The online toolkit offers practical resources that will help the implementation team to achieve the tasks within the 2018 implementation guide.

The process a country follows may vary depending upon whether the *Selected practice recommendations for contraceptive use* (SPR) guideline is being introduced for the first time or is being used to update existing service-delivery guidelines. Throughout these steps, WHO stresses the importance of the process being collaborative and participatory to foster ownership and buy-in among policy-makers, professional bodies and other national experts.

# 6.2 Additional considerations

## 6.2.1 Gender

Gender equality and access to family planning are integrally related: the right to determine whether and when to have children, how many and with whom is fundamental for every individual's empowerment and for their agency over their own bodies and lives. To implement gender-responsive care, practice standards need to take into consideration how people's social, cultural and economic circumstances, and particularly how any harmful gender norms and inequalities they may face, affect their ability to make their own decisions about contraception, their access to services, and their continued use or discontinuation of their chosen method. Approaches should be put in place that empower all individuals regardless of their circumstances. Everyone seeking contraceptive services should be treated with dignity and respect and offered high-quality care irrespective of their gender. Further information on gender equality and gender inclusiveness related to the delivery of family planning or contraceptive services is available in *Family planning: a global handbook for providers (3)*.

## 6.2.2 People with disabilities

According to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) adopted in 2006, people with disabilities must have access, on an equal basis with others, to all forms of SRH care (Article 25) as part of the general right to marry, found a family and retain their fertility (Article 23) *(4)*. Health workers often fail to offer SRH services to people with disabilities, because of the common misconception that they are not sexually active *(5)*. Provision of contraceptive services to people with disabilities however, requires health workers to consider the client's preferences, the nature of the disability and the specifics of different contraceptive methods.

For example, some barrier methods may be difficult for those with limited manual dexterity to use; combined oral contraceptives (COCs) may not be an appropriate method for women with impaired circulation or immobile extremities, even in the absence of known thrombogenic mutations, because of the increased risk of deep vein thrombosis (DVT); and other methods will be preferable for individuals with intellectual or mental health disabilities who have difficulty remembering to take medication each day. For women whose disability causes them difficulty with menstrual hygiene, the impact of the contraceptive method on menstrual cycles should also be considered.

In all instances, medical decisions must be based upon informed choice, which must itself be based on adequate SRH education. When the nature of the disability makes it more challenging to discern the will and preferences of the individual, contraceptives should only be provided in a manner consistent with Article 12 of the CRPD. Specifically, in such cases a process of supported decision-making should be instituted in which individuals who are trusted by the person with the disability (or disabilities), for example a personal ombudsman and other support persons, jointly participate with the individual in reaching a decision that is, to the greatest extent possible, consistent with the will and preference of that individual. Given the history of involuntary sterilization of persons with disabilities *(5)*, it is especially important to ensure that decisions about sterilization are only made with the full, uncoerced and informed consent of the individual, either alone or with support.

## 6.2.3 Adolescents

Adolescents in many countries lack adequate access to the contraceptive information and services that are necessary to protect their SRH and uphold their rights. There is an urgent need to implement programmes that both meet the contraceptive needs of adolescents and remove barriers to services. In general, adolescents are eligible to use the same methods of contraception as adults, and must have access to a variety of contraceptive choices. Age alone does not constitute a medical reason for denying any method to adolescents. While some concerns have been expressed about the use of certain contraceptive methods by adolescents (e.g. the use of progestogen-only injectable [POI] contraceptives by those under 18), these concerns must be balanced against the advantages of preventing unintended pregnancy. To help determine if adolescents with certain medical conditions or characteristics can safely use particular

contraceptive methods, please refer to the *Medical eligibility criteria for contraceptive use, sixth edition* (MEC) *(6)*.

Political and cultural factors may affect adolescents' ability to access contraceptive information and services. For example, unmarried adolescents in particular may be prevented from obtaining contraceptive services because of restrictive laws and policies. Even when adolescents are able to obtain contraceptive services, they may not attempt to do so because of fear that their confidentiality will not be respected, or that health workers may be judgemental. All adolescents, regardless of marital status, have a right to privacy and confidentiality in health matters, including reproductive health care. Appropriate SRH services, including contraception, should be available and accessible to all adolescents by law or policy or in practice, without necessarily requiring authorization by parents or guardians.

Social and behavioural issues should also be taken into account when adolescents select a contraceptive method. For example, in some settings, adolescents are also at increased risk for sexually transmitted infections (STIs), including HIV. While adolescents may choose to use any of the available contraceptive methods, in some cases, using methods that do not require a daily regimen may be more convenient. Adolescents, married or unmarried, have also been shown to be less tolerant of side-effects and therefore have high discontinuation rates. Method choice may also be influenced by factors such as sporadic patterns of intercourse and the need to conceal sexual activity and/or contraceptive use. For instance, sexually active adolescents who are unmarried have very different needs from those who are married and want to postpone, space or limit pregnancy. Expanding the number of methods available to choose from can lead to improved satisfaction, increased acceptance and increased prevalence of contraceptive use. Proper education and counselling – both before and at the time of method selection – can help adolescents decide how to meet their particular needs and make informed and voluntary decisions. Every effort should be made to prevent the costs of services and/or methods from limiting the options available to adolescents.

### 6.2.4 Postpartum family planning

The postpartum period offers multiple opportunities for health workers to assist their clients with family planning decision-making. Moreover, the immediate postpartum period (within 48 hours of delivery) is an ideal time to address family planning needs, given that patients are frequently already interacting with the health system, and many contraceptive methods are appropriate immediately after childbirth, including progestogen-only methods and permanent surgical contraception.

Recommendations on which hormonal and non-hormonal contraceptive methods are safe to initiate are influenced by several factors that are changeable during the postpartum period, such as breastfeeding status, uterine involution, venous thromboembolism risk and – in the case of intrauterine devices (IUDs) – expulsion risk. Extending family planning services through the first year after delivery is appropriate in view of the changing needs and preferences of women during this period.

To guide contraceptive decision-making to determine which hormonal and non-hormonal method(s) are safe for a woman after childbirth, refer to the rows for the conditions "breastfeeding" and "postpartum" within each contraceptive method table in section 5 of the sixth edition of the MEC; and, when relevant for the individual client, refer to information about any underlying medical conditions *(6)*.

# References for section 6[12]


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3. Family planning: a global handbook for providers, 2022 edition. Geneva and Baltimore: World Health Organization Department of Sexual and Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs; 2022 (https://fphandbook.org).
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6. Medical eligibility criteria for contraceptive use, sixth edition. Geneva: World Health Organization; 2025. [Forthcoming].


[12] All references were accessed on 18 June 2025.

# 7 Dissemination of the guideline

The recommendations in this publication will be launched during the International Conference on Family Planning to be held in Bogotá, Colombia, in November 2025. Additional strategic launch events will be held during important conferences that define the global agenda for sexual and reproductive health (SRH) – such as Women Deliver and the International AIDS Conference – as well as during international and regional conferences convened by the International Federation of Gynecology and Obstetrics (FIGO), the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM). The document will be published in electronic PDF format on the WHO institutional repository for information sharing (WHO IRIS).

To increase awareness about this updated guideline, the systematic reviews that informed the *Selected practice recommendations for contraceptive use* (SPR) update and the key recommendations will be published in a special issue of *BMJ Sexual & Reproductive Health (1)*. WHO's digital contraceptive decision-support tools, such as the mobile app for *Medical eligibility criteria for contraceptive use* (MEC) *(2)*, the contraceptive delivery tool for humanitarian settings *(3)*, and the postpartum family planning compendium *(4)* will be updated. *Family planning: a global handbook for providers (5)*, the MEC wheel *(6)*, the *Digital adaptation kit for family planning* (FP DAK) *(7)* and the online Family planning training resource package (FPTRP) *(8)* will also be updated accordingly. Development of derivative communication products (e.g. 1- or 2-page briefs for frontline health workers, and infographics) highlighting key counselling issues will be prepared in collaboration with WHO's implementing partners, and in consultation with the Guideline Development Group (GDG) following the publication of this new edition of the SPR.

A comprehensive dissemination plan will be implemented, which will include widespread dissemination through the WHO regional and country offices, ministries of health of WHO Member States, the United Nations agency cosponsors of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) – i.e. the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), WHO and the World Bank, as well as WHO collaborating centres, national and international professional organizations, governmental and nongovernmental partner organizations working in the area of SRH, and civil society groups engaged in SRH projects. The WHO Secretariat Team will work closely with SRH advisors in the six WHO regional offices to conduct a series of regional events during 2025 and 2026. WHO will also collaborate with the Implementing Best Practices (IBP) network to organize webinars in English, French and Spanish to disseminate the fourth edition of the SPR.

Once translations of the document become available in other official United Nations languages, opportunities to ensure effective dissemination will be actively sought.

# References for section 7[13]


1. WHO Medical eligibility criteria 6th edition and Selected practice recommendations 4th edition: Evidence for the update. BMJ Sex Reprod Health. 2025;51(Suppl1).
2. New App for WHO's Medical eligibility criteria for contraceptive use [news release]. World Health Organization; 29 August 2019 (https://www.who.int/news/item/29-08-2019-new-app-for-who-s-medical-eligibility-criteria-for-contraceptive-use).
3. Contraceptive delivery tool for humanitarian settings. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/276553).
4. The Postpartum Family Planning Compendium [website]. World Health Organization; undated (https://postpartumfp.srhr.org/).
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7. Digital adaptation kit: family planning: operational requirements for implementing WHO recommendations in digital systems. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341997).
8. Training Resource Package for Family Planning [website]. United States Agency for International Development, World Health Organization, United Nations Population Fund; 2024 (https://www.fptraining.org/)


[13] All references were accessed on 18 June 2025.

# 8 Knowledge gaps and areas for further research

As part of its deliberations and considerations, the Guideline Development Group (GDG) identified an array of knowledge gaps related to the recommendations within the *Selected practice recommendations for contraceptive use* (SPR) guidelines, where further research could strengthen the existing body of evidence and contribute towards improvements in client-centred contraceptive services. While recognizing the list of topics is neither complete nor exhaustive, the GDG's list aims to stimulate researchers and institutions supporting research on contraception to pursue these topics within their research portfolios.

## Medication for intrauterine device (IUD) placement

- More evidence on effective and acceptable medication to reduce pain during IUD placement is a research priority.
- Methodologically rigorous studies that assess client-oriented pain outcomes are urgently needed.
- More evidence on the use of medication to ease IUD placement within 48 hours and after four weeks postpartum is encouraged.
- A greater understanding is needed of the implications of offering medication to ease IUD placement in the context of task shifting to other health worker cadres.
- Research to evaluate the implementation of the recommendations at the country level, including an assessment of health workers' practice in the use of medication to ease IUD placement, is needed.
- Data on contraceptive failure rates with typical use of modern contraceptives, from global data, is needed.
- An examination of how unnecessary tests or examinations introduce cost barriers to contraceptive services is needed.

## Non-pharmacological interventions

- Robust research on effective and acceptable non-pharmacological interventions to reduce pain during IUD placement is needed.

# 9 Monitoring and evaluating the impact of the recommendations

Based on a comprehensive evaluation plan, a survey targeting ministries of health, WHO offices and partners, professional organizations and civil society will be fielded to assess the extent and effectiveness of the dissemination of the guideline and recommendations evaluate the level of implementation of the recommendations through national policies, and identify areas for further refinement and research gaps relating to medical eligibility criteria for contraceptive use as detailed in the *Medical eligibility criteria for contraceptive use, sixth edition* (MEC).

# 10 Updating the recommendations

WHO will initiate a review of all the recommendations in this document in five years' time. In the interim, WHO will continue to monitor the body of evidence informing these recommendations and will convene additional consultations, as needed, should new evidence necessitate the reconsideration of existing recommendations. Such updates may be particularly warranted for issues where the evidence base may change rapidly. Any interim recommendations would be made available on WHO's web pages for sexual and reproductive health (SRH) and Human Reproduction Programme (HRP): https://www.who.int/hrp. WHO encourages research aimed at addressing key unresolved issues related to the safe and effective use of contraceptives. WHO also invites comments and suggestions for improving this guideline (email to: srhcfc@who.int).

# Annex 1

# Declarations of interests from the Guideline Development Group members

Of the 19 experts who participated in this work, seven declared an interest related to contraception. The World Health Organization (WHO) Secretariat Team and the Guideline Steering Group (GSG) reviewed all declarations and found that two participants, Anna Glasier and Carolina Sales Vieira, had disclosed academic conflicts of interest that were sufficient to preclude them from participating in the deliberations or development of recommendations relevant to emergency contraceptive pills (ECPs) and levonorgestrel-releasing intrauterine devices (LNG-IUDs), respectively.

**Sharon Cameron** works at National Health Service (NHS) Lothian in the United Kingdom of Great Britain and Northern Ireland as a principal investigator (PI) for a multisite clinical trial on depot medroxyprogesterone acetate (DMPA) administered subcutaneously every six months. In 2023, NHS Lothian received £29 000 from FHI 360 towards this research. Cameron does not receive any direct income from this work. She heads the European Advisory Board on very early medical abortion, for which she receives the equivalent of a one-day consultant fee (€1500) each year. These declarations of interest were considered insignificant as this product and the areas declared were not part of the issues for discussion. Cameron was therefore confirmed as a Guideline Development Group (GDG) member and Co-Chair.

**Alison Edelman** works with the Oregon Health & Science University (OHSU), which is a research site for a trial on the extended use of contraceptive implants. This is an investigator-initiated sponsored trial funded by MERCK/Organon. The primary objective of the trial, for which she is the PI, is to study the effectiveness and bleeding patterns of individuals using the contraceptive implant (Nexplanon) past the three-year duration approved by the United States Food and Drug Administration, with follow-up to the end of Year 5. No direct emoluments are accrued by Edelman. This trial is current. In 2020, OHSU was a research site for progestogen-only pill studies (not currently available on market), and Edelman was the site PI for a sponsored trial examining the effects of missed or late progestogen-only pills and whether this might impact ovulation rates. The study ended in 2020. Edelman is a co-author of two articles in *Up to date* (a subscription-based website providing resources for medical professionals containing evidence-based reviews). She is the author of the reviews for two topics on the website (management of contraceptive-induced menstrual changes, and obesity and contraception). She received royalties which originally were only US$ 1 per year but as subscriptions have grown they have amounted to approximately US$ 3000/year. These declarations of interest were considered insignificant as the products and areas declared were not part of the issues for discussion. Edelman was therefore confirmed as a GDG member and Co-Chair.

**Anna Glasier** is as an expert consultant to HRA Pharma (France) providing specialist clinical and medical advice to the Hana team at HRA Pharma to help inform and educate consumers for the last 13 years. She has been involved in work to get ulipristal emergency contraception (EC) licensed and then later approved as an over-the-counter EC by the European regulatory authority and other regulatory authorities. She also worked with HRA to get a desogestrel progestogen-only pill (POP) approved as a pharmacy medicine in the United Kingdom and a norgestrel POP approved for over-the-counter use in the United States of America (USA). She continues to help the company in their attempt to get a desogestrel POP approved for over-the-counter use in Spain, Italy and Germany. Remuneration for this work is undisclosed but she says it is significant. This work is current. This declaration of interest was deemed potentially significant because of the work on ECPs, which were under discussion in this update. Remuneration from this work is also substantial. In the light of this relationship with a company that manufactures ECPs, Glasier did not take part in the discussions on ECPs at the July 2024 meeting and absented herself from the meeting room when these issues were discussed.

**Andy Gray** is a member of the South African National Essential Medicines List Committee, which is responsible for the selection of medicines and the development of standard treatment guidelines in the public sector. Gray serves on three technical advisory committees at the South African Health Products Regulatory Authority: the Names and Scheduling Committee (of which he is Chair); the Pharmacovigilance Committee; and the Legal Committee. He is the Chair of the Proposal Review Committee for UNITAID, a funding mechanism primarily addressing HIV, tuberculosis and malaria, but also maternal and child health, in low- and middle-income countries. The declaration of interests were considered insignificant, and they involved work with Member State entities. Gray was therefore confirmed as a GDG member and Co-Chair.

**Philip Hannaford** has been the Chair of the Medicines for Women's Health Expert Advisory Group (under the auspices of the United Kingdom's Commission on Human Medicines) since 2020, where he provides expert opinion on regulatory matters relating to contraceptives. He receives £250. The declaration of interest was considered insignificant; he was therefore confirmed as a GDG member and Co-Chair.

**Enriquito Lu** was the Technical Unit Director for Family Planning/Reproductive Health at Jhpiego until February 2021, where his role was to support the organization's global portfolio of projects involving ministries of health, which he was helping to implement high-quality family planning and reproductive health services that were compliant with best practice. Since June 2021, he has been working with Jhpiego on a part-time basis as Senior Advisor with the Family Planning/ Reproductive Health unit supporting initiatives on comprehensive family planning in the Asia Pacific Economic Cooperation (APEC) forum. Lu was a member of the Organizing and Steering Committee and a session lead of the sixth International IUD Symposium convened by a consortium of organizations – Columbia University, Population Council, FHI 360 and NIH, for which he received an honorarium of US$ 1000. This work ended in July 2022. Until 2021, Lu was a member of the Organizing and Steering Group running a virtual course providing technical updates on reproductive heath services for the South Asia Regional Office of the IPPF Member Association for clinicians and programme managers, funded by IPPF SEARO. He received an honorarium of US$ 1000. This work ended in 2021. These declarations of interest were considered insignificant, and he was confirmed as a GDG member.

**Carolina Sales Vieira** served on the Global Advisory Board for Organon until September 2022. Currently she gives ad hoc lectures for Organon nationally and internationally, upon invitation. She also provides training on implant insertion for doctors from the public and private sectors because part of her institution's role is as a national reference centre for family planning and long-acting reversible contraception. Although the training is sponsored by Organon, they do not influence its content. Sales Vieira receives an honorarium of up to US$ 5000 per year. She has served on the Medical Advisory Board for Bayer and given ad hoc lectures and presentations in national and regional meetings. She also provides training on hormonal IUD insertion (six times per year), again due to her university's role as a national reference centre for this. The industry pays for the training for doctors who have been invited by the university; however, they play no role in devising the content of the training or in delivering it. Sales Vieira receives an honorarium of around US$ 6000 per year, while the university receives US$ 3000 per year. She served on the National Medical Advisory Board for Exeltis until 2021. Currently she gives presentations in national and regional meetings two or three times a year, sponsored by Exeltis, for which she receives about US$ 3000 per year. These declarations of interest were considered potentially significant, given the association with pharmaceutical firms involved in the manufacturing of LNG implants and the honorarium above the allowable threshold. To this end, Sales Vieira did not take part in discussions or decision-making on LNG implants during the GDG meeting.

The following GDG members had no conflicts of interest declared, and internet searches and public scrutiny did not reveal any undeclared conflicts of interest. They therefore participated in the GDG meetings fully, including discussions, decision-making and voting on recommendations: Rachid Bezad, Geeta Chhibber, Maria del Carmen Cravioto, Nasser El Kholy, Elimase Kamanga Gama, Anne-Beatrice Kihara, Seni Kouanda, Catia Marzolini, Mari Nagai, Herbert Peterson, Farida Shah and Dirgha Raj Shrestha.

## Expertise of GDG members

**Rachid Bezad:** Obstetrics and gynaecology, reproductive health development including family planning, contraception, infertility, maternal health, sexually transmitted infections (STIs), research, medical pedagogy, programme management and implementation

**Sharon Cameron:** Complex family planning, research; evidence-based guideline development; implementing reproductive health services in low-resource settings; curriculum development, programme development; innovations; capacity building and training; scientific editing

**Geeta Chhibber:** Obstetrics and gynaecology, capacity building and training, programme implementation, human resources for health, midwifery education, guideline and training material development; quality improvement

**Maria del Carmen Cravioto:** Contraceptive endocrinology, epidemiological research, guideline development, academia, clinical practice, programme implementation

**Alison Edelman:** Obstetrics and gynaecology, complex family planning, evidence-based guideline development, curriculum development, programme development; innovations; capacity building and training; scientific editing

**Nasser El Kholy:** Obstetrics and gynaecology, STIs, HIV, breastfeeding, health reform and family medicine, capacity building, guideline development, manging health programmes

**Anna Glasier:** Reproductive medicine, research, high-level advocacy, obstetrics and gynaecology

**Andy Gray:** Pharmacology, pharmaceutical policy, antiretroviral therapy in resource-constrained settings, IT-based health-care solutions; pharmacovigilance; essential medicines; scientific editing; development and assessment of medicines; guideline development

**Philip Hannaford:** Clinical practice, epidemiology, women's health, primary care, research and knowledge exchange, pharmacovigilance

**Elimase Kamamga Gama:** User perspectives, nursing and midwifery, advocacy, programme management, community engagement

**Anne-Beatrice Kihara:** Health advocacy, sexual and reproductive health (SRH) rights, programme implementation, development of guidelines and training packages, adolescent SRH, clinical practice, capacity building, high-level advocacy

**Seni Kouanda:** Epidemiology, implementation science, public health, research, training, programme monitoring and evaluation, scientific writing, ethics

**Enriquito Lu:** Research and innovation, guideline and training curricula development, smart technologies, programme development and implementation, community engagement in reproductive health, health systems strengthening, monitoring and evaluation, e-learning

**Catia Marzolini:** Clinical pharmacology, drug-drug interactions, clinical research, infectious diseases, guideline development, antiretrovirals, pharmacy practice

**Mari Nagai:** Health systems strengthening, health workforce, universal health coverage, maternal and newborn health, vulnerable and isolated populations, health governance policy and strategy, service delivery, programme implementation and evaluation

**Herbert Peterson:** Public health, medical epidemiology, health sciences research, obstetrics and gynaecology, implementation science, maternal and neonatal health, preventive medicine, policy formulation and programming

**Farida Shah:** Nursing and midwifery, community health nursing, health economics, health workforce planning and management, quality improvement, programme development and management, primary health care, humanitarian settings

**Dirgha Raj Shrestha:** Reproductive health programming, primary health care management, public health, quality assurance, policy formulation and strategic planning, guideline development, programme implementation, service-delivery innovations, financial management

**Carolina Sales Vieira:** Obstetrics and gynaecology, reproductive endocrinology and infertility, complex family planning, women's health, policy development, contraceptive development, implementation of family planning programmes, academia, capacity building in family planning

# Annex 2

# Methods for the development of the *Selected practice recommendations for contraceptive use*

# A2.1 Development of the earlier editions of the SPR

This fourth edition of the *Selected practice recommendations for contraceptive use* (SPR) builds on a process initiated in 2000 that resulted in the 2002 publication of the first edition of the SPR guideline *(1)*. Following the publication of the first edition of the SPR, the guideline was revised in 2004 *(2)* and five recommendations were further updated in 2008 *(3)*. In 2016, the third edition of the SPR was published and included five new contraceptive methods, 19 priority topics and 75 new recommendations *(4)*. With the third edition, several key aspects of the updating process were adjusted to be in closer alignment with the requirements set forth in the *WHO handbook for guideline development,* authored by the Guidelines Review Committee (GRC) Secretariat *(5)*. Specifically, these adjustments included:

- the creation of groups with varying roles to undertake the revision;
- the convening of an additional consultation meeting to define the scope of the revision, giving priority to areas where inequity, controversy or uncertainty exists, and those for which new evidence has emerged, including drafting questions relating to population, intervention, comparator and outcome (PICO) to guide the preparation of systematic reviews; and
- the application of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to evidence review and recommendation formulation *(6)*.

For each revision, a multidisciplinary Guideline Development Group (GDG) of experts is assembled to review newly published evidence pertaining to the topics addressed in the guideline. (During the previous SPR revisions, this group was called the Expert Working Group.)

The GRC was established by the WHO Director-General in 2007 to ensure that WHO guidelines were of a high methodological quality and were developed through a transparent, evidence-based decision-making process. The recommendations updated in 2008 and 2016 were reviewed and approved by the GRC.

To ensure that the recommendations remain current between GDG meetings, new evidence is identified through an ongoing comprehensive bibliographic search (the Continuous Identification of Research Evidence, or CIRE system) *(7)*. This evidence is synthesized and reviewed. In circumstances where new evidence warrants further evaluation, the GDG is tasked with evaluating such evidence and issuing interim recommendations if necessary.

# A2.2 Development of the fourth edition of the SPR

## A2.2.1 Contributors to guideline development

The groups responsible for the development of the fourth edition of the SPR included a WHO Secretariat Team (led by the Contraception and Fertility Care [CFC] unit of the WHO Department of Sexual and Reproductive Health and Research [SRH]), supported by a WHO Guideline Steering Group (GSG), an Evidence Synthesis Team (EST) (including a guideline methodologist and systematic review teams) and a GDG. The GDG comprised experts from all six WHO regions who reviewed the evidence and proposed recommendations to guide the update. In addition to the GDG members' participation in the GDG meetings to develop the recommendations, a subset of the GDG membership with extensive experience of advising WHO on family planning recommendations and guidelines since their inception in 2003 – including the GDG co-chairs – was consulted during the planning and drafting stages of the SPR to clarify any outstanding issues raised by the recommendations. An External Review Group (ERG) peer-reviewed the draft guideline for clarity of content and recommendations.

The full list of the members of the WHO Secretariat Team, the EST, the GDG and the ERG can be found in the Acknowledgements section of this document.

### A2.2.2 Prioritization of topics for the revision process

On 8–10 November 2022, the first of two GDG meetings (a scoping meeting) was convened in Montreux, Switzerland, to initiate the process for the development of the fourth edition of the SPR. Prior to the meeting, the CIRE system was used to identify recommendations from the third edition of the SPR for which new evidence was available *(7)*.

To further inform decision-making with respect to clinical questions and priorities, the WHO Secretariat Team reached out to a broad group of stakeholders with expertise in family planning and familiarity with the guideline, including individuals from several implementing agencies, professional societies, and WHO regional and country offices, as well as the ministry of health in each of the WHO Member States. They were invited to complete a 26-question anonymous, online survey available in English, French, Portuguese, Russian and Spanish, and to forward the link for the survey to others in their professional communities familiar with the WHO *Medical eligibility criteria for contraceptive use* (MEC) and SPR, during the period from 10 January to 28 February 2022. The survey included a list of key areas for consideration during the process of updating the MEC and SPR. Respondents were asked to rank the various outcomes pertaining to topics that had been identified as priority questions within the third edition, as well as to suggest other outcomes and questions of clinical importance to be considered for review during the development of the fourth edition. Respondents were also asked to give input regarding the format of the guideline. Representing all six WHO regions, 335 individuals submitted completed surveys; these results were presented to the GDG during the meeting in November 2022 to inform the prioritization process.

At this first GDG meeting, the task for the GDG was to prioritize topics for review and consideration at the second GDG meeting, to be convened at a later date (in July 2024), such that there would be time in between the meetings to prepare systematic reviews on those prioritized topics. At the first GDG meeting, the WHO Secretariat Team presented brief summaries they had prepared covering new evidence so that the GDG members could determine whether the existing recommendations in the SPR remained consistent or had become inconsistent with the updated body of evidence. By the end of the three-day meeting, the topics had been allocated into three groups as follows: (i) recommendations considered to be possibly inconsistent with the updated body of evidence (i.e. requiring an updated systematic review and discussion at a second GDG meeting); (ii) recommendations considered to be consistent with the updated body of evidence, and recommendations for which no new evidence had been identified through the CIRE system (i.e. not requiring further review during the SPR revision process, and therefore reaffirmed by the GDG); and (iii) new practice recommendations/topics selected for review and possible inclusion in the new edition of the SPR based on their global relevance and availability in multiple countries. The two topics prioritized for review by the GDG for the fourth edition of the SPR are presented in Box A2.1.

**Box A2.1 Prioritized topics reviewed by the GDG for the fourth edition of the SPR**

These questions relate to the two overarching topics identified as being of particular importance to the field:

- What medication can be offered to ease interval intrauterine device (IUD) placement?
- What non-pharmacological interventions can be offered to ease interval IUD placement?

All other existing recommendations from the SPR third edition were reaffirmed by the GDG in November 2022 and thus not reviewed for this fourth edition.[a]

[a] Evidence continuously monitored using the Continuous Identification of Research Evidence (CIRE) system (*7*).

For each of the topics outlined in Box A2.1, the GDG developed questions using the "PICO" format (i.e. questions with specified populations, interventions, comparators and outcomes) to serve as the framework for conducting the systematic reviews and compiling the GRADE evidence tables. The remainder of the existing recommendations were considered to be consistent with the body of published evidence and to not need to be formally reviewed for this edition.

### A2.2.3 Evidence identification and synthesis

For each of the priority topics listed in Box A2.1, systematic reviews were conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines *(8)*. The systematic reviews are published in a special issue of *BMJ Sexual & Reproductive Health (9)*. To inform the systematic reviews, multiple databases (e.g. PubMed and Cochrane databases) were searched for studies published in any language in a peer-reviewed journal. The systematic review on medication to ease IUD placement searched for peer-reviewed articles published in any language from the inception of the database until 16 August 2022. The systematic review of non-pharmacological interventions to ease IUD placement looked for evidence from database inception until 30 November 2023.

Reviews of reference lists and direct communications with experts in the field were also used to identify other studies, including those accepted by journals but not yet published (in press). Neither grey literature nor conference abstracts were included in the systematic reviews. Due to the heterogeneity of study designs, contraceptive formulations and outcome measures, meta-analyses could not always be performed.

The risk of bias for each study within a systematic review was assessed by the review authors using the Cochrane tool for assessing risk of bias in randomized trials *(10)* and a modified version of the Cochrane tool to assess risk of bias in non-randomized studies (ROBINS-I) *(11)*.

For each PICO question for which direct evidence was found and clinical outcomes were reported, GRADE evidence profiles were then prepared by the guideline methodologist in order to assess the quality of the summarized evidence. These evidence tables included the range of the estimates of effect for each clinical outcome assessed. A summary of the evidence from each of these systematic reviews was peer-reviewed by selected members of the GDG, and final drafts were made electronically available to all GDG members prior to the second GDG meeting. The GDG's deliberations were based upon these written and orally presented systematic reviews and the GRADE evidence tables. Further details about the development of the updated recommendations, the PICO questions and all the GRADE tables are available in the web annex.

### A2.2.4 Decision-making during the final GDG meeting

WHO convened the second and final GDG meeting on 23–25 July 2024, at WHO headquarters in Geneva, to review the evidence for the prioritized topics (Box A2.1) and, where appropriate, develop or revise specific recommendations for this fourth edition of the SPR. Members of the GDG and members of the ERG (who did not participate in the GDG meeting) submitted declaration of interest (DOI) forms to the WHO Secretariat Team: eight individuals declared an academic conflict of interest relevant to the SPR. The WHO Secretariat Team and the GSG members reviewed all DOIs and, except for two members (Anna Glasier and Carolina Sales Vieira), found no conflicts of interest sufficient to preclude anyone from participating in the deliberations or development of recommendations. Specific to the SPR, the WHO Secretariat Team and the GSG members agreed that the disclosed academic conflicts of interest were sufficient to preclude Caroline Sales Vieira from formulating recommendations or voting on issues related to levonorgestrel-releasing IUDs (LNG-IUDs) and implants. For details of the declared academic interests, see Annex 1.

The GDG considered the overall quality of the evidence, paying particular attention to the strength and consistency of the data, according to the GRADE approach to evidence review. To arrive at the service-delivery recommendations, the GDG considered the GRADE evidence-to-decision (EtD) framework, the benefits of preventing unintended pregnancy, potential harms associated with barriers to contraceptive use, and the other GRADE constructs of values and preferences.

Systematic reviews of evidence on the values and preferences of contraceptive users and health workers were used to incorporate these considerations into

the SPR guideline. One systematic review included peer-reviewed studies published between 2005 and 2020 *(12, 13)*. Articles were included if they presented primary data (qualitative or quantitative) on contraceptive users' and health workers' values, preferences, views and concerns regarding the contraceptive methods considered in the SPR. Applying a systematic search of 10 electronic databases and secondary references, 109 articles (from among 1647 citations) were deemed eligible for inclusion in the review. The studies were geographically diverse, representing all regions of the world. While most studies focused generally on women of reproductive age, some considered the views of specific groups, such as adolescents, nulliparous women, postpartum women, women seeking abortion services and women living with HIV. Six studies examined provider perspectives.

Across studies, values and preferences relating to contraceptive methods consistently centred on themes of choice, ease of use, side-effects and efficacy *(13, 14)*. Obtaining informed consent is essential. Women wanted to have a range of contraceptive options that were simple to use, had few side-effects and worked to prevent unwanted pregnancy. Women desired comprehensive, accurate information about their contraceptive options. While women generally wanted control over their final choice of method, many also wanted their health workers to participate in the decision-making process in a way that emphasized the women's values and preferences *(13)*. Providers also valued women's choices in deciding on contraceptive methods, and recommended methods based on their efficacy and safety as well as the women's preferences, although there were some gaps between provider knowledge about contraceptive method safety and their actual practices *(15)*.

Based on the findings of these systematic reviews, the GDG endorsed an approach to client preferences and values that prioritizes the availability of a wide range of contraceptive options and the removal of unnecessary medical barriers. This approach facilitates access to contraceptive services by engaging a woman's unique personal preferences in contraceptive selection as well as the values she places on possible risks and benefits *(14, 16)*. Decisions on contraceptive selection are complex, multifactorial and changeable because they are based on each woman's temporal, societal and cultural context, as well as her unique personal history and circumstances; hence, it is critical that each woman be afforded the right to choose from a wide range of contraceptive options *(13)*. Decision-making regarding contraceptive methods requires weighing the advantages and disadvantages of specific methods according to individual circumstances, perceptions and interpretations.

The topics taken up by the GDG for this new edition of the SPR focused on medication and non-pharmacological interventions to ease IUD placement. Contraceptive users reported that a common barrier to IUD use was fear of pain upon insertion *(17–19)*. Clients undergoing IUD placement would generally prefer to minimize the discomfort or pain during the procedure and would also prefer this outpatient procedure to be as quick as possible. As such, pain and discomfort experienced by the client during placement, and difficulties experienced by providers when undertaking the IUD placement procedure are among the factors contributing to low uptake and dissatisfaction with IUDs. Offering women a range of options to manage the potential pain that can be associated with IUD insertion was recognized by the GDG as an important component of high-quality family planning care. The GDG incorporated information on women's values and preferences related to choice, ease of use, side-effects and efficacy into the recommendations they formulated for contraceptive provision, ensuring that these recommendations will facilitate access to a selection of different contraceptive methods while maintaining the safety and efficacy of the methods. Decisions were all based on the evidence available.

To address any potential harms that could be caused by these recommendations, the GDG considered common barriers to safe, correct and consistent use of contraception and the benefits of preventing unintended or unwanted pregnancy. Evidence on side-effects and adverse events caused by medication or non-pharmacological interventions to ease IUD placement was also reviewed.

The SPR guideline does not recommend one contraceptive method over another; rather, it provides recommendations on how a health worker can support a woman – with accurate information, discussion and shared decision-making – to select a contraceptive method that suits her (and is medically appropriate for her based on the MEC) and to use her chosen method safely and effectively. Owing to the focus of this guideline on the safe provision of contraceptive methods, and since costs may vary widely in different

regions and settings, opportunity costs were not formally assessed during the formulation of these recommendations.

For the fourth edition of the SPR, the GRADE approach was used to classify the recommendations on the topics reviewed as "strong" or "conditional". Because the target audience for the SPR is primarily policy-makers, when the GDG classifies a recommendation as "strong" it is because the GDG is very certain that the desirable consequences outweigh the undesirable consequences and thus the recommendation can be adopted as policy in most situations, indicating that in general, for high-quality family planning care, both health workers and clients should adhere to the recommendations. Conditional recommendations are issued when the benefits of adherence to a recommendation probably outweigh the undesirable effects. However, with conditional recommendations, different choices may be appropriate for some individuals or in some settings, the benefits may not always warrant the resource requirements in all settings, and it is possible that new evidence may result in a change to the balance of risks to benefits *(5)*.

In this fourth edition, recommendations are presented in narrative form for the benefit of readers accustomed to the format of previous SPR editions. For the recommendations on which examinations and tests to use before each contraceptive method is initiated, an A-B-C classification is employed to indicate whether various procedures are necessary for the safe provision of the method. The GDG arrived at new recommendations and upheld all existing recommendations through consensus. Consensus was achieved through discussion and debate. For each recommendation, the Chair asked the other GDG members whether they agreed with the recommendation; any disagreement was documented. All the GDG members agreed with all of the recommendations in the guideline.

A draft of the entire revised SPR document was sent to the ERG, which comprised nine experts who did not participate in the GDG meeting. The ERG members served as independent peer reviewers of the MEC and SPR guidelines, whose role was to ensure technical accuracy, clear communication of the content, and applicability to various contexts and settings. All ERG members submitted DOI forms to the WHO Secretariat Team: three individuals declared conflicts of interest. The WHO Secretariat Team and the GSG reviewed all DOIs and, except for one member (Luis Bahamondes), found no conflicts of interest sufficient to preclude anyone from reviewing and commenting upon the updated draft of the SPR guideline. The WHO Secretariat Team determined that Luis Bahamondes's disclosed academic conflicts of interest were sufficient to preclude him from serving as a peer reviewer for the SPR. For details of the declared academic interests, see Annex 1. Comments received from these reviewers were addressed and incorporated into this guideline by the WHO Secretariat Team as appropriate. The final version of this document was approved by the GRC on 10 February 2025.

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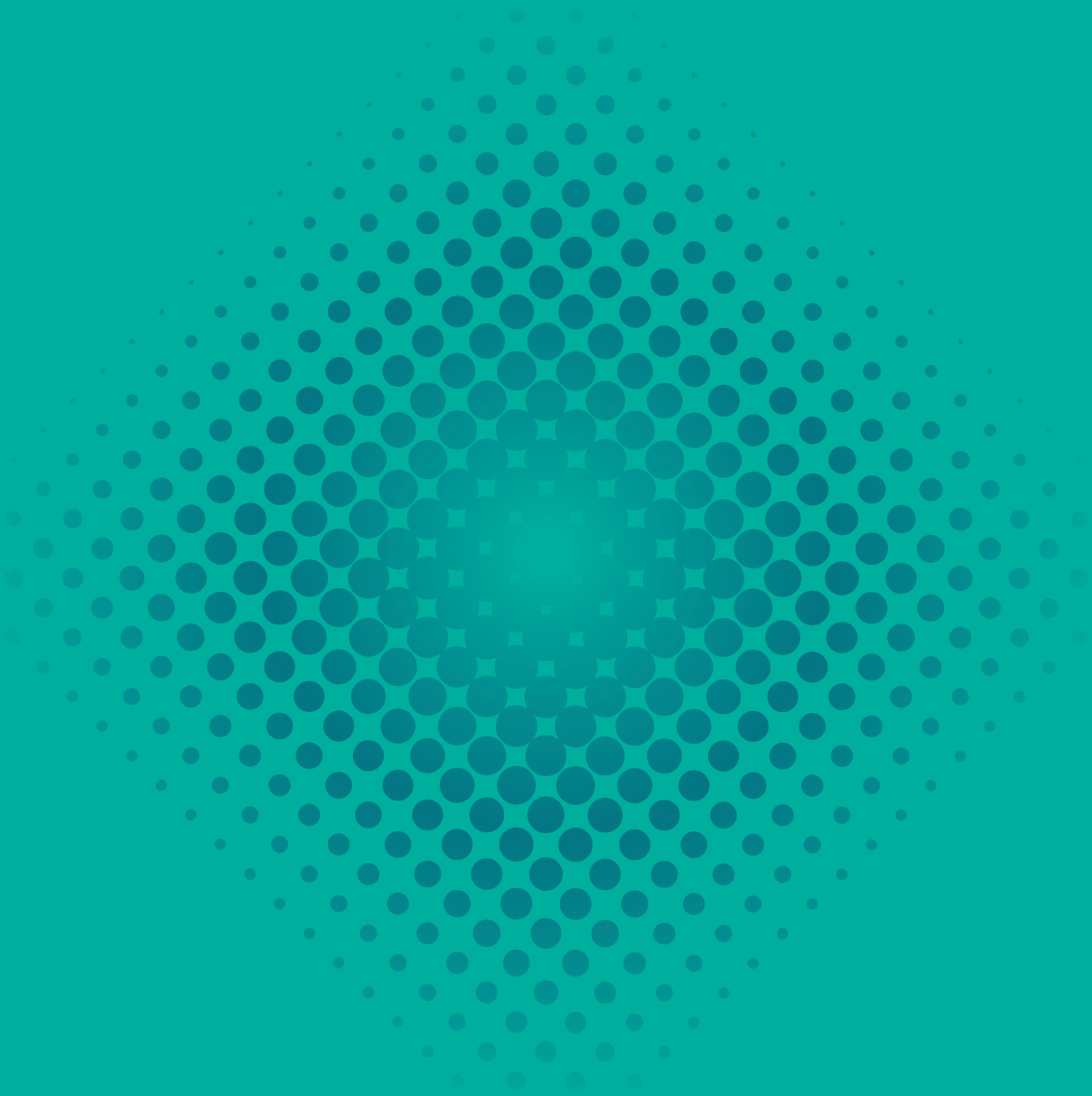

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