

# IPPF Medical Bulletin

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## IMAP Statement on the Health needs of perimenopausal women

### Introduction

The menopause is the time in a woman's life when menstruation ceases permanently due to reduced ovarian hormone secretion, which occurs naturally or is induced by surgery, chemotherapy or radiation, and natural reproductive capacity comes to an end. Natural menopause is recognized after 12 months of amenorrhoea which is not associated with a pathological cause. Most women experience menopause between 45 and 58 years of age, with the global average at 51 years.<sup>1</sup>

The menopausal transition takes place gradually, can span several years, and often begins with variations in menstrual cycle length in response to rising levels of follicle-stimulating hormone (FSH). Stages of the menopausal transition are described in the following terms:

- **Premenopause**, the time up to the beginning of the perimenopause, but the term is also used to define the time up to the last menstrual period
- **Perimenopause**, or the climacteric, is the transition period during which the menstrual cycle and hormonal changes are occurring, but there have been fewer than 12 months of amenorrhoea. The body undergoes various physiological changes, attributable to the reduced secretion of ovarian hormones, mainly oestrogens, and to the ageing process. The perimenopause is a stage in the continuum of a woman's life; her health at this period will be largely determined by previous health status, reproductive patterns, lifestyle and environmental factors
- **Postmenopause**. This begins at the time of the last menstrual period, although it is not recognized until after 12 months of amenorrhoea.

The health and well-being of perimenopausal women are strongly

influenced by their social, cultural and economic circumstances. Many women experience disturbing symptoms, usually self-limiting and not life threatening, but nonetheless unpleasant. In addition, the transition from regular menstrual periods to amenorrhoea may generate anxiety. Some women fear pregnancy at a late age; others, who have been unsuccessful in their attempts to achieve motherhood, may dread the menopause as it signals the end of their reproductive life. Most women manage the menopause by themselves: only a minority seek help from healthcare providers.

### Perimenopausal symptoms

There are a number of physiological and psychological symptoms of the perimenopause.<sup>2</sup> Individual women have differing experiences of the perimenopause. The change common to all women is the cessation of menstrual periods. The physiological and psychological symptoms attributed to the perimenopausal reduction of hormone secretion can be divided into the following broad categories:

- **Menstrual changes** - may occur in the periodicity and amount of menstrual flow. In most cases, cessation of menstrual periods may occur gradually after a few cycles of decreased menstrual flow. In others, sporadic ovulation may cause heavy bleeding.
- **Vasomotor effects** - such as hot flushes and night sweats. Hot flushes refer to the spontaneous sensation of warmth, often associated with perspiration, resulting from a vasomotor response to declining oestrogen levels. Night sweats are hot flushes occurring at night, often while sleeping, resulting in disturbed sleeping patterns.
- **Urogenital symptoms** - such as vaginal dryness, vaginitis, dyspareunia, urethritis, incontinence and increased urinary frequency are more common after the menopause. Up to half of all women experience them.
- **Distress, anxiety, depression, premenstrual syndrome (PMS), irritability, and memory loss**. Estradiol cannot be considered as an effective treatment in postmenopausal women with mild to moderate depression.<sup>3</sup>
- **Migraine headaches, rapid weight increase, fatigue, irritability, tender or lumpy breasts, fibroids, or cold hands and feet** are all symptoms of the perimenopause

### Acceleration in bone mineral loss

Osteoporosis is the reduction in the quantity of bone, or atrophy of skeletal tissue, an age-related disorder characterized by decreased bone mass and loss of normal skeletal micro-architecture, leading to increased susceptibility to fractures. **Osteopenia** is a disorder in which bone resorption has exceeded bone formation. In post-menopausal women the principal cause is low oestrogen production, leading to mild thinning of the bone mass, but not as severe as osteoporosis. Osteopenia results when the formation of bone (osteoid synthesis) is insufficient to offset normal bone loss (bone lysis). Osteopenia is generally considered the first step along the road to **osteoporosis**, a serious condition in which bone density is extremely low and bones are porous and prone

to shatter. Loss of bone tissue accelerates in the years immediately after the menopause.

Most fractures in people aged more than 50 years are the result of osteoporosis. The incidences of proximal humeral, pelvic, and proximal tibial fractures also rise steeply with age, and are higher in women than in men.<sup>4</sup> The prevalence of osteoporosis in women increases markedly with age after the menopause, from 2 % at 50 years of age rising to over 25 % at 80 years.<sup>5</sup> There is an increased risk after age 70, resulting in osteoporosis, and the risk of fractures increases progressively. The International Osteoporosis Foundation assesses that, "1 in 3 women over 50 will experience osteoporotic fractures, as will 1 in 5 men".<sup>6,7,8</sup> Other risk factors include smoking, prolonged immobility, adrenocortical hyperfunction, hyperthyroidism, and deficiency of vitamin D or calcium.

Since bone density decreases with age, especially in the postmenopause, advice should be given on the benefits of adequate calcium and vitamin D.<sup>9</sup> The risk of fractures can be reduced by screening and treatment. Bisphosphonates are recommended as the first line treatment, for which the benefit has been demonstrated, although only for women with osteoporosis. Screening for osteoporosis is recommended, where resources permit. Treatments work by either inhibiting bone resorption (bisphosphonates, SERMs), stimulating bone formation (parathyroid hormone) or by a combination of mechanisms which have yet to be fully elucidated (strontium ranelate). Over 60,000 hip, 50,000 wrist and 120,000 vertebral fractures occur each year in the UK.<sup>10</sup> There is also evidence that weight-bearing exercises effect improvement.<sup>11,12,13</sup> In the frail elderly, activity to improve balance and confidence may be valuable in fall prevention.

## Malignancies

Generally, the incidence of malignancies increases with age. Those of the female reproductive system, such as endometrial cancer, and cancer of the cervix, ovaries and breast, often arise during the perimenopause and the early postmenopausal years. Early detection can improve the outcome.

## What can Member Associations do?

### Service issues

Health during the perimenopause is determined largely by health status in childhood and during the early reproductive years. Sexual and reproductive health service providers, especially contraceptive providers, mainly give healthcare to women who are in their early reproductive years. Therefore, they are in a good position to play a significant role in preventing problems associated with the menopause and ageing.

A woman who, over the years, has received contraceptive services from a family planning clinic, may well return there when she approaches the menopause. This highlights the need for staff training on issues related to the menopause.

Member Associations (MA) should consider providing perimenopausal counselling and health care as part of their sexual and reproductive health services. If MAs do not have the facilities for advising perimenopausal women on their health and contraception needs, they should refer these clients to specialist care.

### Information, education and counselling

The family planning setting offers opportunities for counselling women about many factors that can affect their health. In the perimenopausal years, the most important factor is a healthy lifestyle.

Information should be provided about the influences of

nutrition and behaviour in the reproductive years upon the quality of life after the menopause. The length of the interbirth interval is also important. Even with adequate calcium intake, bone density lost during pregnancy and lactation takes several months to be recovered after weaning is started. If the interval is shorter, the calcium content of the skeleton diminishes, and the woman will have a smaller reserve to face bone loss after menopause. A malnourished woman may need even longer intervals.

**A healthy lifestyle** is beneficial to women of all ages. It can reduce the risk of several disorders prevalent in the perimenopause. Women should be counselled about ways in which they can improve both their overall health and quality of life. The following factors should be borne in mind:

- **Smoking.** Lung cancer, heart disease and osteoporosis, which may affect post-menopausal women, have been linked to smoking. Women should be counselled about the health hazards of smoking, and encouraged and supported to give up the habit.
- **Exercise.** Brisk walking and aerobic exercises promote cardiovascular health, and weight-bearing physical activity\* slows bone loss and stimulates the regeneration of bone tissue. Therefore, moderate exercise three or four times each week should be recommended.

### Diet and exposure to sunlight

Good nutrition is essential to healthy living. Diet influences the risk of several major chronic diseases, especially cardiovascular disease, obesity and probably some malignancies. To help achieve good health, a varied and balanced diet is recommended which limits the intake of sugar, salt, alcohol and saturated animal fats. Women over 50 need at least 1,200 mg, but must not exceed 2000 - 2500 mg, of calcium per day. The calcium intake should be divided into 500-mg doses.<sup>14</sup> However, calcium absorption varies greatly from person to person and is influenced by many dietary factors. Appropriate sunlight exposure is also important in calcium and bone metabolism, which should be explained to the clients.

### Psychological aspects

Misconceptions and fears about what is going to happen in the perimenopausal years, or after menopause, are factors that may influence a woman's response to physiological changes or therapeutic measures. The best preparation is for women to consider the perimenopause as a normal stage of life and they should be informed and counselled on what to expect before they reach the perimenopause.

### Importance of family support

MAs should educate men and other family members about this phase in women's lives, so that they can be supportive to women's needs.

### Preventive health care

Where national or local screening programmes for reproductive cancers exist, women seeking advice about the menopause should be encouraged to accept or request screening. In addition, health providers should use this opportunity to offer all women appropriate and available screening for breast and cervical cancer whether or not they have symptoms. Women with abnormal uterine bleeding should either be evaluated and treated or referred to other facilities, especially after menopause, to rule out cancer of the endometrium.

MAs should also consider referral for osteoporosis screening if available.

\* exercise that utilises the body's own weight, or external weights

## Contraception

Ovarian function fluctuates during the perimenopausal years, therefore contraception is necessary until the woman has been amenorrhoeic for one year. (For further information regarding methods of contraception, see IMAP's "Statement on Contraception for women over 35".)

Those women who, after proper counselling, choose to use a hormonal method up to the menopause, should be advised to consider discontinuing this after the age of 50. They must use other methods of contraception (mainly barriers, such as condoms) until it is certain that they have reached the menopause.

The presence of vasomotor symptoms, such as hot flushes, indicates that a woman is menopausal. Where the necessary laboratory facilities are available, an increased follicle stimulating hormone (FSH), in two blood samples six weeks apart, confirm that a woman has reached the menopause. At that time she can choose to discontinue hormonal contraception and, if it is available and affordable, to begin hormone treatment (HT).

Women who have a copper IUD in place should have it removed only if it causes complications. The LNG-IUS can be used during perimenopause as it helps to balance the changing hormone levels at this stage, providing additional protection to the endometrium.

## Hormone treatment (HT)

**Risk assessment** for cardiovascular disease should include: the measurement of body mass index, blood pressure and lipid levels, if possible. Women with a history of breast cancer, coronary heart disease, stroke, dementia, or venous thrombosis should not use HT, as it increases the risk of further disease. However, the risk of colorectal cancer decreases with HT

HT is aimed at restoring the oestrogen to average pre-menopausal levels. **Oestrogen-only HT** is available as oral tablets, transdermal patches or gels, nasal sprays, and implants, although availability differs across Regions. Oral therapy can be started at a low dose as this has been shown to relieve flushes. The dose can be increased if, after a few weeks, there is inadequate relief of symptoms. Women who have had a hysterectomy (whether or not retaining the ovaries) can use oestrogen alone; the addition of progestogen is required for women with a uterus, to reduce endometrial hyperplasia, which is increased even with low doses of oestrogen. **Combined HT**, which contains oestrogen with cyclical progestogens, induce regular endometrial transformation and withdrawal bleeds, thus preventing the development of endometrial abnormalities. However, new, continuous regimens offer the advantages of a combined preparation without withdrawal bleeding. Progestogen is available as an oral tablet, transdermal patch, or intra-uterine system (IUS). The IUS provides good protection of the endometrium and, unlike other combined hormone replacement therapies, offers both contraception and less bleeding for perimenopausal women.

Combined continuous regimens (oestrogen and progesterone daily) can be used when the woman has been post-menopausal for more than one year; before this, sequential regimens (oestrogen daily with progestogen 10-14 days each month) are appropriate. Combined continuous regimens in early menopause may cause irregular bleeding, as oestrogen production from the ovaries fluctuates.

For women who are still menstruating, oestrogen should be started on the first day of the menstrual bleed, and progestogen given 14 days later. Withdrawal bleeding should then start around the usual time of the period. Common side effects include irregular bleeding, which settles after a few months, nausea and breast tenderness. These usually decrease over time, but can be further reduced by lowering the dose of hormones.

Any hormonal therapy, including progestogen alone, is considered to be contra-indicated for women with previous breast cancer.

## Relief of perimenopausal symptoms

Indicators for HT are hot flushes, night sweats and vaginal dryness. A woman's perception of the severity of her symptoms should be the deciding factor for offering treatment, not hormone levels, as they fluctuate throughout the perimenopause. Symptoms can improve within four weeks of starting treatment. HT has been used successfully for many years for the relief of menopausal symptoms (particularly vasomotor disturbances and vaginal atrophy). Vaginal hormonal creams and gels help to alleviate vaginal dryness, which can cause discomfort during sexual intercourse.

The lowest dose of HT should be used, for symptom relief. Short-term use is also clinically appropriate, as hot flushes cease naturally within a few years of menopause for about two thirds of women.

HT makes incontinence worse, but vaginal oestrogen preparations benefit dyspareunia and decrease recurrent urinary tract infection in susceptible women. Response can take one or two months.

## Duration of HT use

The use of HT is not recommended beyond five years, as negative outcomes then outweigh positive benefits. Studies have shown a significant increase in stroke, deep vein thrombosis and gall bladder disease for both the combined and oestrogen-only treatments, with additional increases in breast cancer and dementia for women on combined therapy, who are older than 65 years.

## Prevention of osteoporosis

HT, both the combined and oestrogen-alone types, has been shown to prevent bone loss in post-menopausal women. Combined HT is preferred, due to the increased risk of endometrial cancer related to oestrogen-alone treatment. The risk of fracture is highest in later life; however, most studies have shown that long-term use is required to prevent osteoporosis. Moreover, once the oestrogen therapy is discontinued, bone loss begins; so even this duration of therapy may have little residual effect on bone density in women 75 years of age and older, who have the highest risk of fracture.

For many women, HT relieves the symptoms of oestrogen deficiency. There are others who, although free of troublesome symptoms, have significant risk factors for certain conditions, such as osteoporosis. However, HT has side effects and long-term risks (particularly breast cancer) and the decisions to start it, and to continue, must depend on how the client perceives the balance between the potential benefits and risks. IMAP recommends short-term use of HT under close medical monitoring, using the lowest dose that relieves perimenopausal symptoms, with positive lifestyle modifications and extensive counselling, especially concerning the risks.

Statement by the International Medical Advisory Panel, 1997, revised in 2009. IPPF reserves the right to amend this Statement in the light of further developments in the field.

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### Suggested reading

[http://www.medscape.com/viewarticle/718376\\_9](http://www.medscape.com/viewarticle/718376_9) (Estradiol/Estradiol-Progestogen Treatment)

## The World Health Organization's Medical eligibility criteria for contraceptive use: example of a national adaptation

Kathryn M. Curtis

The World Health Organization's *Medical eligibility criteria for contraceptive use* (WHO MEC), which provides guidance about whether women with certain medical conditions, characteristics, or exposures can safely use specific contraceptive methods, was first published in 1996. The current, fourth edition of the WHO MEC contains over 1800 individual recommendations, addressing 18 contraceptive methods and over 160 medical conditions and sub-conditions.<sup>1</sup> The Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC) has supported this effort by co-ordinating the identification, critical appraisal, and synthesis of the scientific evidence on which the guidance is based.<sup>2</sup> These global recommendations have been widely incorporated into national family planning policy and programmes around the world and are available (in the third edition) in multiple languages.

WHO has always intended its global guidance to be adapted by policy makers at the local level and considers its guidance as a reference to be used in the preparation of national or programme guidelines.<sup>1</sup> In 2005, the United Kingdom went through a formal process of adapting the WHO guidance to create the *UK Medical eligibility criteria for contraceptive use*.<sup>3</sup> While the WHO guidance has been used by various organizations in the United States, the CDC recently used a formal adaptation process to create the *US Medical eligibility criteria for contraceptive use* (US MEC). The process included determining the scope of the adaptation; conducting systematic reviews of the evidence for the relevant recommendations; using the evidence to adapt a small number of existing WHO recommendations and to develop recommendations for some additional medical conditions; and disseminating, implementing, and evaluating the US MEC.<sup>4</sup>

### Determining the scope of the adaptation

It would not be feasible to adapt each of the recommendations for use in the United States, nor would it be necessary, as the scientific evidence on which the WHO recommendations are based would be the same. Therefore, CDC decided to accept the majority of the WHO classifications for the United States. However, in some cases, either because of the identification of new evidence or context-specific situations in the United States (e.g., delivery of family

planning services, or diagnosis and treatment or management of medical conditions), some of the WHO classifications needed to be adapted for best implementation of the guidance in the United States. CDC considered adaptation for a small subset of WHO classifications, and whether there might be additional medical conditions for which recommendations could be added.

The WHO MEC was assessed by three different methods. First, we compared recommendations in the WHO MEC to current standard guidance used in the United States, to identify inconsistencies among different sources of guidance. We also informally talked to leaders in the field of family planning in the United States to gather opinions on which items in the WHO MEC should be considered for adaptation and what new items might be considered. Finally, we asked a small group of experts to conduct a thorough review of the WHO MEC and make suggestions on the scope of the adaptation. In June 2008, CDC convened a meeting of this small group, which consisted of eight family planning experts who were familiar with both the WHO MEC and with current practice in the US. Using the information available from the three assessments, CDC then determined the scope of the adaptation.

### Conducting systematic reviews of the evidence

We conducted systematic reviews of the scientific evidence for each of the existing WHO MEC recommendations considered for adaptation, and for each of the medical conditions considered for addition to the guidance. We followed standard recommendations for conducting and reporting results of systematic reviews,<sup>5,6</sup> and we graded the strength and quality of the evidence using the system of the United States Preventive Services Task Force.<sup>7</sup> Each systematic review was peer-reviewed by two to three experts prior to its use in the adaptation process.

### Using the evidence to adapt the WHO MEC for the United States

In February 2009, CDC held a meeting of 31 experts, who were invited to provide their individual perspective on the scientific evidence that was presented and the discussions that followed about the potential recommendations. This group included a wide range of health care providers with expertise in contraceptive safety and provision. For each topic discussed, the evidence from the systematic review was presented and an expert in the specific medical condition (e.g., rheumatoid arthritis) examined the specific issues that might affect contraceptive safety. Based on these discussions, CDC finalized the recommendations for the US MEC. Research gaps were also considered during discussions on contraceptive safety for women with specific medical conditions.

**Table. Medical eligibility criteria modified or added to the US Medical eligibility criteria for contraceptive use, 2010**

Existing WHO MEC recommendation	New medical conditions
Breastfeeding and hormonal contraception	History of bariatric surgery
Postpartum IUD insertion	Peripartum cardiomyopathy
Valvular heart disease and IUDs	Rheumatoid arthritis
DVT/PE and hormonal contraception	Endometrial hyperplasia
Ovarian cancer and IUDs	Inflammatory bowel disease
Fibroids and IUDs	Solid organ transplantation

IUD = intrauterine device

DVT/PE = deep vein thrombosis / pulmonary embolism

For all the topics discussed (see Table), some type of adaptation or addition was made. The modifications to existing WHO MEC recommendations included changes for women who are postpartum (breastfeeding or not), or have deep vein thrombosis/pulmonary embolism (DVT/PE), valvular heart disease, ovarian

cancer or uterine fibroids. New recommendations were developed for women with a history of bariatric surgery, peripartum cardiomyopathy, rheumatoid arthritis, endometrial hyperplasia, inflammatory bowel disease, or solid organ transplantation.

### Dissemination, implementation, evaluation

Dissemination, implementation, and evaluation of the US MEC are critical to ensure that the potential beneficial effect of the guidance on family planning practice is maximized. CDC is working closely with its partners, including other federal agencies and professional and service organizations, to achieve wide dissemination and implementation of this new guidance. Strategies include dissemination through professional organizations, presentations at professional conferences of family planning providers, publications in peer-reviewed journals and professional newsletters, and the development of training tools and job aids. CDC plans to evaluate the effects of the guidance through surveys of family planning providers' attitudes and practices.

A key challenge for evidence-based guidance documents is keeping the recommendations current as new scientific evidence becomes available. For this guidance, we will continue to work with WHO to identify and assess all new relevant, scientific evidence, and to determine whether changes in the recommendations are warranted. We will also identify and assess any new literature for the recommendations and medical conditions that are specific to the US MEC. The complete US guidance, and any updates, can be found on the CDC US Medical eligibility criteria for contraceptive use website: <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm>.

We anticipate that the US MEC will have a substantial impact on family planning practice in the United States, largely through assisting providers to counsel their clients better regarding safe contraceptive choices – including restricting use when there is evidence of risk, but also in facilitating use where there is evidence

of safety. Because of differences around the world in the prevalence, diagnosis, and treatment of medical conditions and in the contexts of health care delivery, it is important for countries to ensure that global evidence-based guidance is adapted to meet their specific needs. The WHO evidence-based guidance is a highly regarded resource, developed by experts from all over the world, upon which countries and other organizations can rely when developing their own national protocol and standards for family planning services.

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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