

Progestin-Only Pills During Breastfeeding*

Q.1. When can progestin-only pills (POPs) be started for breastfeeding women?

Recommendations	Rationales
<p>a) If breastfeeding, POPs may be started after six weeks postpartum.</p> <p>POPs are not usually recommended in the first six weeks postpartum in breastfeeding women. The timing of postpartum initiation of POPs should consider a woman's breastfeeding intentions.</p>	<p>a) For breastfeeding women, delaying POP initiation for six weeks after delivery avoids exposing the newborn to exogenous steroids during the time of greatest neuroendocrine development. In breastfeeding women, the risk of ovulating in the first six weeks postpartum is very low. The timing of postpartum initiation of POPs should be dependent on the woman's preference, her previous experience with breastfeeding and her intentions regarding the duration of breastfeeding.</p> <ol style="list-style-type: none">1) Howie PW, McNeilly AS, Houston MJ, Cook A, Boyle H. Fertility after childbirth: postpartum ovulation and menstruation in bottle and breast feeding mothers. <i>Clinical Endocrinology</i> 1982;17:323-32.2) Diaz S, Rodriguez G, Peralta O, Miranda P, Casado ME, Salvatierra AM, et al. Lactational amenorrhea and the recovery of ovulation and fertility in fully nursing Chilean women. <i>Contraception</i> 1988;38(1):53-67.3) Visness C, Rivera R. Progestin-only pill use and pill switching during breastfeeding. <i>Contraception</i> 1995;51:279-81.

Recommendations	Rationales
<p>b) A woman who initially chooses to rely on the Lactational Amenorrhea Method (LAM) is advised to begin POPs, or whichever method she chooses to switch to when one of the following takes place:</p> <ul style="list-style-type: none">● her menses return, or● she is no longer fully or nearly fully breastfeeding, or● six months postpartum. <p>Preferably, POP packets are given to the woman before her intended start date to ensure that she is able to begin the method when she needs to. However, if she prefers, POPs can also be started when a woman is still relying on LAM (providing her with dual protection).</p>	<p>b) While relying on LAM, a postpartum woman has at least 98% protection from pregnancy for six months if she remains amenorrheic and fully or nearly fully breastfeeds (perfect use effectiveness rate). Programs sometimes encourage waiting to initiate POPs until reliance on LAM ends, because it may be more programmatically affordable and because using POPs while breastfeeding may potentially prolong lactational subfertility.</p> <ol style="list-style-type: none">1) Kennedy K, Rivera R, McNeilly A. Consensus statement on the use of breastfeeding as a family planning method. <i>Contraception</i> 1989;39(5):477-96.2) Chaudhury RR, Chompootaweep S, Dusitsin N, Friesen H, Tankeyoon M. The release of prolactin by medroxyprogesterone acetate in human subjects. <i>British Journal of Pharmacology</i> 1977;59:433-4.
<p>c) After the first six weeks postpartum, POPs can be initiated any time you can be reasonably sure a woman is not pregnant (see and POP Question 7d).</p>	<p>c) Based on current literature, including studies with other progestin-only methods, it is unlikely that there is a significant effect on the growth of breastfeeding infants whose mothers initiate POPs after the sixth postpartum week.</p> <ol style="list-style-type: none">1) WHO Task Force on Oral Contraceptives. Effects of hormonal contraceptives on milk volume and infant growth. <i>Contraception</i> 1984;30(6):505-21.2) Shaaban M, Salem H, Abdullah K. Influence of levonorgestrel contraceptive implants, Norplant, initiated early postpartum upon lactation and infant growth. <i>Contraception</i> 1985;32(6):623-35.3) Pardthaisong T, Yenchit C, Gray R. The long-term growth and development of children exposed to Depo-Provera during pregnancy or lactation. <i>Contraception</i> 1992;45:313-24.4) McCann MF, Moggia AV, Higgins JE, Potts M, Beeker C. The effects of a progestin-only oral contraceptive (levonorgestrel 0.03 mg) on breastfeeding. <i>Contraception</i> 1989;40(6):635-48.

Recommendations	Rationales
<p>d) Even if POPs are inadvertently initiated during pregnancy, there is no known risk to the fetus.</p> <p>e) Non-hormonal methods are preferable to hormonal methods during breastfeeding because they have no effect on breastfeeding and the infant is not exposed to exogenous steroids. However, the World Health Organization (WHO) lists POPs as Category 1 after six weeks postpartum, and women should be given a choice of contraceptive methods.</p>	<p>d) Epidemiologic studies have found no significant effect on fetal development or malformations due to taking hormonal methods in early pregnancy.</p> <ol style="list-style-type: none">1) Bracken MB. Oral contraception and congenital malformations in offspring: a review and meta-analysis of the prospective studies. <i>Obstetrics and Gynecology</i> 1990;76:552-7.2) Wiseman RA, Dodds-Smith IC. Cardiovascular birth defects and antenatal exposure to female sex hormones: a re-evaluation of some base data. <i>Teratology</i> 1984;30(3):359-70.3) Simpson JL, Phillips OP. Spermicides, hormonal contraception and congenital malformations. <i>Advances in Contraception</i> 1990;6:141-67. <p>e) Although the amount of exogenous progestins in breastmilk is extremely low, it is prudent to try to minimize infant exposures to any drug.</p> <ol style="list-style-type: none">1) Institute of Reproductive Health. Guidelines for breastfeeding in family planning and child survival programs. Washington, DC: IRH, 1992.2) World Health Organization. Improving access to quality care in family planning: medical eligibility criteria for contraceptive use. Geneva: WHO, 1996.

Q.2. Are there special considerations when a breastfeeding woman is switching from progestin-only pills (POPs) to other hormonal methods?

Recommendations	Rationale
<p>No. A breastfeeding woman can switch from POPs to another hormonal method any time the new method is appropriate.</p> <p>No back-up method is necessary when the new method is initiated if the woman has been breastfeeding, and has been taking the POPs fairly consistently. Estrogen-containing methods should generally not be used by breastfeeding women prior to six months postpartum or preferably any time during long-term breastfeeding.</p>	<p>As long as the woman is breastfeeding and taking the POPs fairly consistently, she is fully protected through the transition to the new hormonal method.</p> <ol style="list-style-type: none">1) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6). <p>Clinical trial data indicate that the pregnancy protection conferred by POP use during breastfeeding is high, indicating a synergistic pregnancy prevention effect for breastfeeding while using POPs. In addition, women in lactational amenorrhea have additional protection due to their lowered fecundity.</p> <ol style="list-style-type: none">1) Dunson T, McLaurin V, Grubb G, Rosman A. A multicenter clinical trial of a progestin-only oral contraceptive in lactating women. <i>Contraception</i> 1993;47:23-35.2) Kennedy KI, Visness C. Contraceptive efficacy of lactational amenorrhoea. <i>Lancet</i> 1992;339:227-30.

Q.3. If a woman is using progestin-only pills (POPs) during breastfeeding, when should she be advised to switch to another method?

Recommendations	Rationale
a) Women can rely on POPs after the first six weeks postpartum, and safely use them during the entire duration of breastfeeding.	a) In general, POPs are highly effective, and safe, during breastfeeding. 1) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6). 2) Dunson TR, McLaurin VL, Grubb G, Rosman A. A multicenter clinical trial of a progestin-only oral contraceptive in lactating women. <i>Contraception</i> 1993;47:23-35.
b) Women can continue using POPs after they stop breastfeeding, provided that they have been informed of the advantages and disadvantages of the method and are willing to use the POPs correctly and consistently. It is not mandatory for a woman to switch from POPs to another family planning (FP) method after she stops breastfeeding or at six months postpartum.	b) POPs are an effective contraceptive method, even when not breastfeeding, if used correctly and consistently. However, all women should be informed of the advantages and disadvantages of POPs in the absence of breastfeeding, especially that POPs need to be used consistently and correctly to provide effective pregnancy protection (e.g., the pill should be taken at the same time each day), and that they often cause irregular menstrual bleeding. 1) Visness C, Rivera R. Progestin-only pill use and pill switching during breastfeeding. <i>Contraception</i> 1995;51:279-81. 2) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6). 3) World Health Organization. Improving access to quality care in family planning: medical eligibility criteria for contraceptive use. Geneva: WHO, 1996.
c) Breastfeeding women using POPs should be advised not to switch to combined oral contraceptives (COCs), or other methods containing estrogen, until at least six months postpartum.	c) Even low-dose (30 mcg) COCs decrease breastmilk production and alter its composition. 1) WHO Task Force on Oral Contraceptives. Effects of hormonal contraceptives on milk volume and infant growth. <i>Contraception</i> 1984;30:505-21. 2) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6).

Recommendations	Rationale
d) Breastfeeding women can switch to non-hormonal methods at any time, as appropriate.	d) If not inserted with 48 hours of delivery, postpartum IUDs are usually not inserted until uterine involution is complete. Progestin-releasing IUDs are not inserted until six weeks postpartum, even if involution is complete before six weeks, to avoid the theoretical risks of infant steroid exposure. Diaphragms are not fitted until involution is complete. <ol style="list-style-type: none">1) O'Hanley K, Huber D. Postpartum IUDs: keys for success. <i>Contraception</i> 1992;45:351-61.2) Wiley A. The Diaphragm. In: Corson S, Derman R, Tyrer L, editors. <i>Fertility Control</i>. Boston: Little, Brown & Company, 1985:223-32.3) World Health Organization. <i>Improving access to quality care in family planning: medical eligibility criteria for contraceptive use</i>. Geneva: WHO, 1996.

Q.4. Can progestin-only pills (POPs) be used when not breastfeeding?

Recommendations	Rationale
<p>Yes, if taken consistently and correctly. Many women gain experience with and confidence in POPs during breastfeeding and should be allowed to continue POPs after breastfeeding if POPs are the woman's method of choice.</p>	<p>POPs are an effective contraceptive method even when the woman is not breastfeeding if taken consistently and correctly.</p> <p>POPs are a useful alternative for many women who want to use oral contraceptives (OCs) but for whom COCs are not appropriate.</p> <p>Women should be informed of the advantages and disadvantages of POPs, especially that POPs need to be used consistently and correctly to provide effective pregnancy protection (e.g., the pill should be taken at the same time each day) and that POPs often cause irregular menstrual bleeding. Unless a woman is breastfeeding, a back-up method of contraception should be used if a POP is taken more than three hours after her regularly scheduled time (See Question 7e).</p> <p>1) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6).</p>

Q.5. How many POP cycles should be given at the first visit for a new user? At subsequent visits?

Recommendations	Rationale
<p>a) New user?</p> <p>Postpartum women who plan to use the lactational amenorrhea method (LAM) can be given their pill cycles immediately postpartum, with instructions to begin taking them (see Question 1) when any of the LAM criteria no longer apply. Women who plan to rely on LAM for six months can be given at least a six month supply (to begin when the LAM criteria no longer apply), so they will have contraceptive protection for at least one year.</p> <p>Up to 13 cycles (a full year's supply) can be given, although only three or four may be programmatically feasible. The greatest need is to guarantee continuous, ready access.</p> <p>b) Subsequent visits?</p> <p>There is no compelling medical reason for a routine return visit concerning POP use, but clients should be encouraged to return at any time with concerns, problems or questions.</p> <p>For first-time users of POPs, programs may encourage a three-month follow-up visit for counseling to assess whether the client is satisfied with the method and is correctly using the method, to reinforce instructions, and to help clients with the management of side effects.</p>	<p>a) The woman's convenience is important. To avoid running out of pills, the woman should have ready access to more POP cycles. Ideally, she should be able to obtain plenty of POP cycles at her visit.</p> <p>While some providers suspect that clients who receive multiple pill cycles may "share" these with friends, such "sharing" is likely to be as safe and effective as over-the-counter distribution systems.</p> <p>b) The extremely low dose of progestins in POPs make them a very safe method of contraception. The greatest health risk from POPs is pregnancy due to method failure, which is preventable by assuring adequate POP supply and correct, consistent method use.</p> <ol style="list-style-type: none"> 1) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6). 2) Harlap S, Kost K, Forrest JD. Preventing pregnancy, protecting health: a new look at birth control choices in the United States. Washington, D.C.: The Alan Guttmacher Institute, 1991.

Q.6. When breastfeeding, is there a best time of day to take progestin-only pills (POPs)?

Recommendations	Rationale
<p>a) POPs may be taken at any time of the day for effective use during breastfeeding. The client may wish to select a certain time to help her remember to take a pill every day; it may help to link this time to a daily event.</p> <p>b) However, if a woman continues taking POPs after breastfeeding cessation, then it is important to take the POP at the same time every day, preferably late afternoon or four to five hours before the usual time of sexual activity, so that the pill's effect on the cervical mucus is at its maximum by the time sexual activity occurs.</p>	<p>a) Breastfeeding women have additional protection due to their lower fecundity. Clinical trial data indicate that the pregnancy protection conferred by POP use during breastfeeding is extremely high. The synergistic pregnancy protection by POP use in combination with breastfeeding should sufficiently eliminate a client's risk of conception, even if she takes POPs at different times of the day.</p> <ol style="list-style-type: none">1) Dunson T, McLaurin V, Grubb G, Rosman A. A multicenter clinical trial of a progestin-only oral contraceptive in lactating women. <i>Contraception</i> 1993;47:23-35.2) Wright SW, Fotherby K, Fairweather F. Effect of daily small doses of norgestrel on ovarian function. <i>Journal of Obstetrics and Gynecology of the British Commonwealth</i> 1970; 77:65-8. <p>b) The most immediate contraceptive effect of POPs is the alteration of cervical mucus. The POP's effect on cervical mucus peaks approximately four to five hours after ingestion of the pill, and is essentially gone by 24 hours after taking one POP.</p> <ol style="list-style-type: none">1) McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. <i>Contraception</i> 1994;50(6).2) Chretien FC, Sureau C, Neau C. Experimental study of cervical blockage induced by continuous low-dose oral progestogens. <i>Contraception</i> 1980;22:445-56.

Q.7. Are back-up methods advisable in the following situations?

Recommendations	Rationale
<p>a) If a breastfeeding client is taking antibiotics, including anti-tuberculosis medications?</p> <p>Back-up methods are not usually required, unless the woman is taking rifampin/rifampicin.</p> <p>With the exception of rifampin/ rifampicin, antibiotics are unlikely to significantly reduce the effectiveness of POPs in breastfeeding women.</p> <p>If the breastfeeding woman is taking rifampin/rifampicin, she should know that rifampin/rifampicin:</p> <ul style="list-style-type: none"> ● passes through breastmilk (with potential infant side effects), ● may increase breakthrough bleeding, and ● lowers progesterin levels, possibly significantly reducing the effectiveness of POPs. 	<p>a) Broad-spectrum antibiotics such as ampicillin, erythromycin and tetracycline have not been shown to decrease effectiveness of POPs in careful clinical studies.</p> <p>Rifampin/rifampicin, which is used primarily for treating tuberculosis, induces hepatic enzymes and increases the liver metabolism of progestins, thus decreasing the effectiveness of POPs. The enzyme-inducing effects of rifampin/rifampicin last about four weeks after short-term use and eight weeks after long-term use.</p> <p>Griseofulvin, an anti-fungal antibiotic and another hepatic enzyme inducer, has not been proven to reduce POP effectiveness in humans, but may increase menstrual irregularities.</p> <p>Rifampin/rifampicin is passed in breastmilk (milk:plasma ratio of 0.2 to 0.6). Griseofulvin may also be passed in breastmilk. Infant exposure to rifampin/rifampicin or griseofulvin is appropriate only when the maternal benefits outweigh the potential risks to the infant.</p> <ol style="list-style-type: none"> 1) Back DJ, Orme ML. Drug interactions. In: Goldzieher JW, Fotherby K (editors.). <i>Pharmacology of the Contraceptive Steroids</i>. New York: Raven Press, 1994:407-25. 2) Fotherby K. Interactions with oral contraceptives. <i>American Journal of Obstetrics and Gynecology</i> 1990;163:2153-9. 3) <i>Drug Facts and Comparisons</i>. St. Louis: Facts and Comparisons, June 1996, p. 358 and October 1990, p.387a 4) World Health Organization. <i>Improving access to quality care in family planning: medical eligibility criteria for contraceptive use</i>. Geneva: WHO, 1996. 5) Baciewicz AM, Self TH, Bekemeer WB. Update on rifampin drug interactions. <i>Archives of Internal Medicine</i> 1987;147(3):565-8.

Recommendations	Rationale
<p>b) If a breastfeeding client is taking anticonvulsants?</p> <p>Yes, usually. The common anticonvulsants, hydantoin (e.g., phenytoin), barbiturates (e.g., phenobarbital, primidone), and probably carbamazepine significantly decrease the effectiveness of oral contraceptives. POPs are not recommended if using these enzyme-inducing anticonvulsants.</p> <p>Additionally, because anticonvulsants are excreted in breastmilk, and because there is a potential for serious adverse reactions in nursing infants, women taking hydantoin, barbiturates, or carbamazepine for chronic seizure control may be advised to explore safe alternatives to breastfeeding.</p> <p>Injectable contraceptives, such as Depo Provera®, will be effective despite anticonvulsant use, but infant exposure to the anticonvulsants will continue.</p> <p>Non-hormonal methods will continue to be effective despite anticonvulsant use.</p>	<p>b) The hepatic enzyme-inducing effects of most anticonvulsants probably decrease pregnancy protection and increase rates of irregular bleeding among some POP users. It should be noted however that POPs may decrease the probability of seizures among users of anticonvulsants.</p> <p>Because of the dangers of fetal exposure to most anticonvulsants, full protection against pregnancy is essential. Although increased doses of POPs might be effective, they might also further increase bleeding irregularities.</p> <p>1) Mattson RH, Rebar RW. Contraceptive methods for women with neurologic disorders. <i>American Journal of Obstetrics and Gynecology</i> 1993;168:2027-32</p> <p>If a woman ingests hydantoin, barbiturates, or carbamazepine, her breastmilk will contain significant quantities of these substances. In areas where safe alternatives to breastfeeding exist, and where maternal seizures cannot otherwise be controlled, women on long-term anti-seizure medications may be advised to consider safe alternatives to breastfeeding, to avoid chronic infant drug exposure.</p> <p>1) Drug Facts and Comparisons. St. Louis: Facts and Comparisons, July 1996, pp. 282-4. 2) World Health Organization. Improving access to quality care in family planning: medical eligibility criteria for contraceptive use. Geneva: WHO, 1996. 3) Anderson GD, Graves NM. Drug interactions with antiepileptic agents. <i>CNS Drugs</i> 1994;2(4):268-79.</p>
<p>c) If a breastfeeding client is taking anti-malarial medication?</p> <p>No back-up is needed.</p> <p>There is no evidence that anti-malarial medications reduce the effectiveness of OCs.</p> <p>Chloroquine and related anti-malarials are excreted in breastmilk.</p>	<p>c) Chloroquine, primaquine and tetracycline have not shown any effect on OC hormonal levels, and are not known to reduce the effectiveness of POPs.</p> <p>A nursing infant may consume about half of a mother's 300 mg chloroquine dose over 24 hours; the maternal milk: blood ratio may be about 0.36. Children are especially sensitive to chloroquine and primaquine.</p>

Recommendations	Rationale
<p>d) If it is a breastfeeding client's first cycle of POPs?</p> <p>No back-up is needed.</p> <p>However, if a breastfeeding woman has resumed menstruating and is beginning the pills later than the first seven days of her cycle, some programs recommend that she use a back-up method for seven days after beginning POPs.</p> <p>e) If a breastfeeding client has missed pills?</p> <p>If the breastfeeding woman is still amenorrheic, missed pills are of minimal consequence.</p> <p>For a breastfeeding woman who has already returned to menses, if two or more pills are missed, the woman should:</p> <ul style="list-style-type: none"> ● resume taking a pill as soon as she remembers, ● take the next pill at the regular time that day (for added protection), and ● use a back-up method or abstinence for 48 hours (some programs recommend use of a back-up method for up to seven days). 	<p>c) Weighing the nutritional value of the milk to the child against the effects of the chloroquine, clients are usually not advised to stop breastfeeding while on anti-malarial treatment, unless safe alternatives to breastmilk are available.</p> <ol style="list-style-type: none"> 1) Drug Facts and Comparisons. St. Louis: Facts and Comparisons June 1996, pp. 358 and 387a. <p>d) The cervical mucus thickens enough to prevent sperm penetration within 24 hours. Also, the synergistic protection against pregnancy conferred by concurrent POP use and breastfeeding should sufficiently eliminate a client's risk of conception. Thus, a back-up method for a full seven days may not be necessary.</p> <ol style="list-style-type: none"> 1) Chretien FC, Sureau C, Neau C. Experimental study of cervical blockage induced by continuous low-dose oral progestogens. <i>Contraception</i> 1980;22:445-56. 2) Kesseru-Koos E. Influence of various hormonal contraceptives on sperm migration in vivo. <i>Fertility and Sterility</i> 1971;22:584-603. 3) Moghissi KS, Syner FN, McBride LC. Contraceptive mechanism of microdose norethindrone. <i>Obstetrics and Gynecology</i> 1973;41:585-94. <p>e) After missing one pill, breastfeeding women previously taking POPs are estimated to be sufficiently subfertile that the probability of the woman becoming pregnant is extremely low.</p> <p>The most immediate effect of POPs is on cervical mucus, each tablet offering protection for approximately 24 hours. Clinical trial data indicate that the pregnancy protection conferred by POP use during breastfeeding is high, indicating a synergistic pregnancy prevention effect for breastfeeding while using POPs. In addition, women in lactational amenorrhea have additional protection due to their lowered fecundity.</p> <ol style="list-style-type: none"> 1) Kesseru-Koos E. Influence of various hormonal contraceptives on sperm migration in vivo. <i>Fertility and Sterility</i> 1971;22:584-603. 2) Dunson T, McLaurin V, Grubb G, Rosman A. A multicenter clinical trial of a progestin-only oral contraceptive in lactating women. <i>Contraception</i> 1993;47:23-35. 3) Kennedy KI, Visness C. Contraceptive efficacy of lactational amenorrhoea. <i>Lancet</i> 1992;339:227-30.

Recommendations	Rationale
<p>f) If a breastfeeding client has severe diarrhea and/or vomiting?</p> <p>If a woman is breastfeeding and amenorrheic, no back-up method is needed since the synergistic effect of both breastfeeding and POP use should provide sufficient pregnancy protection.</p> <p>If a breastfeeding woman has resumed menstruating, some programs recommend use of a back-up method for 48 hours or for 7 days after the severe vomiting or diarrhea stops.</p>	<p>f) The synergistic protection conferred by POP use and breastfeeding should sufficiently eliminate a client's risk of conception, because women in lactational amenorrhea have additional protection due to their lowered fecundity.</p> <ol style="list-style-type: none">1) Dunson T, McLaurin V, Grubb G, Rosman A. A multicenter clinical trial of a progestin-only oral contraceptive in lactating women. <i>Contraception</i> 1993;47:23-35.2) Orme M, Back DJ, Breckenridge AM. Clinical pharmacokinetics of oral contraceptive steroids. <i>Clinical Pharmacokinetics</i> 1983; 8:95-136.3) Kennedy KI, Visness C. Contraceptive efficacy of lactational amenorrhoea. <i>Lancet</i> 1992;339:227-30.

Classification of Selected Procedures for Progestin-only Pills (POPs) during Breastfeeding

Procedure	Class	Rationale
Pelvic examination (speculum and bimanual)	C	<ul style="list-style-type: none"> • A pelvic exam is not necessary to ensure safe use of POPs as a contraceptive method¹. • In some cases, a pelvic exam may help evaluate the question of pregnancy if a menstrual history suggests the possibility beyond six weeks duration. In this case it is Class A. • Conditions which would restrict use of POPs should be identified by the client's history before method initiation.
Blood pressure	C	Current evidence does not demonstrate any notable effect of POPs on blood pressure ^{2,3} .
Breast examination	C	POPs do not cause breast cancer ^{4,5} . Lumps that are suspicious as cancer should be evaluated. While any hormonal treatment may in theory cause such lumps to grow, pregnancy causes much higher hormonal levels; therefore, potential malignancies of the breast should not be a reason to delay a woman's access to the use of this contraceptive method.
Sexually transmitted disease (STD) screening by lab tests (for asymptomatic persons)	C	The presence of an STD will not affect the safe use of POPs. Clients at risk of STDs (by personal history or socio-demographic risk factors) should be offered STD screening where possible.
Cervical cancer screening	C	POPs have no known relation to risk of cervical cancer ⁶ .
Routine, mandatory lab tests (e.g., cholesterol, glucose, liver function tests)	D	The effect of POPs on cholesterol, blood glucose and normal liver function are slight, and of no demonstrated clinical significance ⁶⁻⁸ .
Proper infection prevention procedures	C	Proper infection prevention procedures are not applicable to POP use.

Procedure	Class	Rationale
<p>Specific counseling points for POP use:</p> <ul style="list-style-type: none"> ● efficacy ● common side effects, including alterations in bleeding patterns (e.g. frequent or irregular bleeding, extended amenorrhea) ● correct use of method (including instructions for missed pills) ● signs and symptoms for which to see a health provider ● STD protection (when/as appropriate) 	<p>A</p>	<p>Accurate client education is essential for maximum quality of family planning services.</p> <ul style="list-style-type: none"> ● Appropriate counseling about common contraceptive side effects at the time of method selection can lead to improved client satisfaction and contraceptive continuation. ● Irregular or absent menstrual bleeding is the single most common side effect of POPs, and the chief complaint leading to discontinuation⁹. ● POPs are highly effective if taken correctly and consistently. However, POPs are less effective than COCs after weaning. ● The woman should be encouraged to return if she has any problems or at any time she has questions or concerns.

KEY:

Class A = essential and mandatory or otherwise important in all circumstances, for safe and effective use of the contraceptive method

Class B = medically/epidemiologically rational in some circumstances to optimize the safe and effective use of the contraceptive method, but may not be appropriate for all clients in all settings

Class C = may be appropriate for good preventive health care, but not materially related to safe and effective use of the contraceptive method

Class D = not materially related to either good routine preventive health care or to the safe and effective use of the contraceptive method

Citations for Procedures Table:

- 1) Huber DH, Huber SC. Screening oral contraceptive candidates and inconsequential pelvic examinations. *Studies in Family Planning* 1975;6(2):49-51.
- 2) Ball MJ, Ashwell E, Gillmer MDG. Progestagen-only oral contraceptives: comparison of the metabolic effects of levonorgestrel and norethisterone. *Contraception* 1991;44(3):223-33.
- 3) Wilson ESB, Cruickshank J, McMaster M, Weir RJ. A prospective controlled study of the effect on blood pressure of contraceptive preparations containing different types and dosages of progestogen. *British Journal of Obstetrics and Gynaecology* 1984;91:1254-60.
- 4) Stanford JL, Thomas DB. Exogenous progestins and breast cancer. *Epidemiologic Reviews* 1993;15(1):98-107.
- 5) UK National Case-Control Study Group. Oral contraceptive use and breast cancer risk in young women. *Lancet* 1989;1:973-82.
- 6) World Health Organization. Improving access to quality care in family planning: medical eligibility criteria for contraceptive use. Geneva: WHO, 1996.
- 7) Miale JB, Kent JW. The effects of oral contraceptives on the results of laboratory tests. *American Journal of Obstetrics and Gynecology* 1974;120(2):264-72.
- 8) Korba VD, Paulson SR. Five years of fertility control with microdose norgestrel: an updated clinical review. *Journal of Reproductive Medicine* 1974;13(2):71-5
- 9) Belsey EM, WHO Task Force on Long-acting Systemic Agents for Fertility Regulation. The association between vaginal bleeding patterns and reasons for discontinuation of contraceptive use. *Contraception* 1988;38(2):207-25.

For further information see McCann MF, Potter LS. Progestin-only oral contraception: a comprehensive review. *Contraception* 1994;50(6).