CONTRACEPTION GUIDANCE FROM MODEL BEST EVIDENCE PROCESS

The World Health Organization (WHO) and US agency and academic partners have established a state-of-the-science system for staying abreast of best contraception evidence. The system is used to update WHO guidance about who can use specific contraceptive methods safely¹ and how to safely and effectively use contraceptive methods deemed appropriate.² WHO and many countries rely on this guidance for policies and programming.

In 2002, WHO and its partners established a system to identify and assess potentially relevant evidence for contraceptive eligibility/use as it becomes available and to use relevant better-quality evidence to develop new systematic reviews or update existing reviews. This Continuous Identification of Research Evidence (CIRE) program maintains a database that is searchable by method, condition, and practice (available from: http://www.infoforhealth.org/cire/). Over 40 systematic reviews have resulted, and 10 have recently been published in a special issue of Contraception (reviews in the issue involve intrauterine devices, regret after female sterilization, and a series of hormonal contraception topics, and are not listed separately in this column).³

To complement the most recent editions of its contraception manuals, WHO makes updated guidance available on a web page (available from: http://www.who.int/reproductive-health/family_planning/updates.html). Mohllajee and colleagues have described the system.⁴

Comment: It is increasingly recognized that children may be more vulnerable to effects of toxic exposures than adults, and that early exposures can have long-term consequences. Results of this review and uncertainties about many other exposures have far-reaching implications for policy, practice, research, and education.


Surveying 25 North American academic maternity units, Kotaska and colleagues found that low-dose oxytocin augmentation practices predominate, as recommended by leading North American obstetric societies. By contrast, they found that high-dose oxytocin protocols and other active management of labor features were used in 7 of 8 randomized controlled trials that compared epidural analgesia with parenteral opioids and reported oxytocin augmentation dosages and cesarean rates. In the low-dosage trial, which may be similar to current conditions in North America, the cesarean rate was much higher in the epidural than the opioid group. In the remaining high-dosage trials, cesarean rates were lower and group differences were not found. The authors hypothesize that high-dose oxytocin can counter the slowing effect of epidural analgesia on labor and avoid excess cesareans. Similarly, Klein carried out a subgroup analysis of the current Cochrane review of effects of epidural analgesia for labor pain. Although the overall review found no association between epidural and cesarean, analysis of the 4 trials in which women received it before active labor found that epidural was associated with increased likelihood of cesarean.

Comment: Most women giving birth in the United States experience epidural analgesia, and its impact on cesarean section has been controversial. These reviews offer plausible explanations for discrepant research results and identify conditions that may influence this relationship.

Recent Evidence-Based Reviews