EDITORIAL

Guidelines: a love–hate relationship?

Guidelines are without doubt helpful – someone has systematically brought all the evidence together, laid it out logically and provided recommendations. All this to assist practitioners and patients/consumers in making shared decisions around a specific health area. So, what's the problem? International guidelines, national guidelines, local guidelines, recommendations, standards, protocols…. Suddenly there is an explosion of information all relating to improving and supporting practice and people still aren't happy. But ask anyone how they keep up to date with the plethora of new research and information (more than two million clinical research articles are published annually)[1] and you hear: 'I don't', 'I hope someone will tell me', 'it's difficult', 'making sense of the literature is not easy – having time to read it all is impossible'. In general, professionals change and update their practice slowly, sometimes not at all. Yet most of us working in reproductive and sexual health know there is a need to improve and standardise the way we work and that this should be through evidence-guided practice. Guidelines help to do just that, they are not new phenomena; Plato and Hippocrates in the 4th century BC both explored the role of guidelines in medical practice. However, gone are the days of GOBSATS (good old boys sitting around tables) making decisions. We now have systematically developed guidelines addressing specific areas of medicine, involving multidisciplinary input, including the patient/consumer perspective, which result in evidence-guided recommendations. So myth, misinformation and variation in practice will be replaced with facts and improved minimum standards of care – but only *if* they are used. The Royal College of Obstetricians and Gynaecologists (among others) has been providing guidance for many years, however, they state 'that without effective methods of translating evidence into practice, benefits for patients will not be realised and resources spent on research and production of clinical guidelines will not be optimised'.[2] The development of any evidence-based guideline does not remove the need for consensus, as areas where there is an inadequacy of evidence around specific clinical questions will inevitably need to be addressed. As such, guidelines are not perfect; they can be extremely long and consequently may not be used, and the quality, context and applicability are sometimes criticised.[3–6] It is this area that causes contention, creates questions and suggests the need for thought. What do you do if you disagree with a guideline recommendation or approach? To disagree, by definition, means you are familiar with the literature, able to critically appraise research and therefore likely to make thoughtful decisions in individual circumstances or where there is uncertainty (there will always be such situations, this is normal). Mansour[6] welcomes contraceptive guidelines for professionals working in reproductive health, but discusses the adoption of World Health Organization (WHO) *Selected Practice Recommendations for Contraceptive Use* (WHOSPR) for the UK.[7] These recommendations, which specifically address contraception and the management of common side effects, followed the introduction of the WHO *Medical Eligibility Criteria for Contraceptive Use* in 1996 (updated 2000).[8] Although WHO recommendations were originally developed to improve and extend contraception provision in developing countries, they are now used internationally and have contributed enormously to standardising the approach to contraceptive use. The UK adaptation of WHOSPR used a formal consensus process[9] to produce guidance specifically to suit UK practice. This process recognised that not all UK health professionals would agree with them and that comprehensive advice about every clinical situation could not be provided. However, some concerns have focused on their approach and the need to provide more than just the evidence. Mansour questions the UK adaptation approach,[9] which supports relaxing some of the more cautious recommendations. As an example, she cites Depo-Provera® and the timing of emergency contraception in relation to late repeat injections. Mansour suggests that a developing country approach is not always appropriate for women in developed countries where litigation is more likely, even when evidence is scarce. Whilst she supports the need for a pragmatic approach to contraceptive provision, she is concerned that time constraints may prevent lengthy individual discussions with women, and suggests that WHOSPR for the UK should state best-known safe practice, even if this is more cautious. MacGregor,[5] in addressing evidence-based medicine (EBM), argues that 'it is helpful to have a review of the current evidence available in order to provide women with accurate information when discussing contraception. However, it is not sufficient just to provide 'evidence'. EBM must consider that clinicians need practical guidance with decision making.' Yet how do you provide something that suits everybody? You can't. All of us know that guidelines are not static: they need to evolve as new evidence becomes available and by listening to users' concerns. The reality for professionals using guidelines is that discussion about a course of action needs to be accompanied by information that quantifies any risk or benefit there might be if choices are to be given. People want to know: *What is the risk for me if I make this choice?* If this cannot be answered either from evidence or consensus how can we be sure of good safe practice? Consumer information is vital around health choices and medical decisions should 'mirror' evidence-based guidance. 'User-involvement' in guideline development can help make guidelines practical for professionals and 'real' for consumers. Where guidelines do provide clear evidence-based approaches, they should be used to improve and update manufacturers' product data and their patient information leaflets. Product data is often out of date, does not always reflect current practice, and results in women continually questioning why the manufacturer's information differs from advice given by their health professional. Processes should be put in place to address these inconsistencies. As guidelines become increasingly the norm, will it become more difficult for a practitioner to act outside a guideline? Hurwitz,[10] in discussing the legal considerations of clinical practice guidelines, reflects concerns that guidelines will erode clinical abilities, diminish clinical judgement and reduce medical practice to 'cookbook' medicine. However, his conclusion is that 'appropriate interpretation and application are likely to generate better care and safer medico-legal strategy than either uncritical disregard or unthinking compliance'.

Most of us welcome guidelines and recognise they are 'tools not rules' or 'must do's'. In addition, some of us actively participate in their development and promotion,

ensuring they are reflected in consumer information. However, these comments, questions and criticisms are valid and suggest the need for greater critical debate and input into the guideline process. This should include the role of 'expert consensus' where evidence is less strong, and wider consultation with more practitioners and users before final publication to ensure the best practical uptake *and* use. In this way we will support improved knowledge and work towards truly harmonised practice for the future.

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OVERVIEW

Contraception in Europe: accessibility and availability

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Introduction

At its special session from 30 June–2 July 1999, the United Nations General Assembly discussed the implementation of the Programme of Action from the Cairo International Conference on Population and Development in 1994. The United Nations General Assembly reaffirmed its commitment to the goal of reproductive health for all and stated that 'Governments should strive to ensure that by 2015 all primary health and family planning facilities are able to provide ... the widest available range of safe and effective family planning and contraceptive methods ...'. Five years later, this commitment has yet to be fulfilled, even in European countries. How can we measure progress in the fulfilment of the Programme? Do we have proper indicators for this measurement? And last, but not least, what if health care providers were able to provide safe and effective family planning methods, but the population was not able and not ready (for various reasons) to ask for and use these methods?

It seems pertinent to look at the availability and accessibility of contraception throughout Europe, as this may help to assess the progress in implementation of the Cairo Programme of Action in European countries.

Demographic and social trends among families in Europe

The total population of Europe in 2003[1] was approximately 726 million; 51.5% live in Eastern/Central Europe and 48.5% in Western/Northern Europe. Women represent approximately 52% of the European population. In some countries (Belarus, Lithuania, Latvia, Poland, Portugal, Russia, Ukraine and Hungary) the number of women exceeds 106 per 100 men, but the excess of women is especially high among the elderly all over Europe. Demographic projections for Europe in 2050 predict a declining population (down to approximately 632 million) and a decreased population growth rate of –0.1% per year (projection for the years 2000–2005). During the same period, the total fertility rate (TFR) for Europe is expected to reach 1.38 (in comparison, TFRs for Europe in the years 1990 and 2000 were 1.67 and 1.48, respectively). The lowest TFRs (approximately 1.10) are expected to be in Bulgaria, Latvia, Slovenia and Spain; the highest TFR values (>1.80) are predicted for Ireland, France, Norway and some Balkan countries. Lowering the TFR depends on changes in lifestyle and understanding of the 'ideal number of children in the family' with its natural consequence; postponement of first birth and reduction in the total number of children (preferably to one or two). The average age at which women in many European countries have their first child is between 28 and 30 years. Conversely, there are very young women (15–19 years of age) who have already given birth. The average European birth rate per 1000 women aged 15–19 years is around 20, but in some countries (e.g. the Balkan and Baltic countries) these rates are approaching 30 and above. Countries that have high birth rates in very young women have a low usage of modern methods of contraception.

Number of children in the family: an essential human right

It is important that couples have easy access to a wide range of methods of birth control so they can freely exercise their