Contraception - assessment

Last revised in September 2019 Next planned review by May 2021

Changes

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September 2019 — minor update. Updated to clarify that the ethical and legal issues that need to be considered when assessing suitability for contraception apply to women with learning disabilities, not people with learning difficulties.

May 2019 — minor update. Topic updated in line with the Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines *Overweight, Obesity and Contraception* [FSRH, 2019 (/contraception-assessment#!references)].

December 2017 — minor update. Added information about fetal malformations and effectiveness of hormonal contraceptives as an effect of topiramate.

August to September 2016 — reviewed. A literature search was conducted in August 2016 to identify evidence-based guidelines, UK policy, systematic reviews, and key randomized controlled trials published since the last revision of the topic. Minor structural changes have been made.

Previous changes

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July 2014 — minor update. Update to the 'Have I got the right topic section?' to state that this CKS topic does not cover the management or contraceptive choice in women who have cardiovascular disease. Links have been inserted within the topic to the new Faculty of Sexual and Reproductive Health guidance on women who have cardiovascular disease.

August 2013 — minor update. Added a text to clarify that when used for the purpose of oestrogen replacement therapy the levonorgestrel intrauterine system (LNG-IUS) should be retained for no longer than 5 years after insertion (the licence states 4 years), regardless of the age of the woman at insertion.

June 2013 — minor update. The 2013 Quality and Outcomes Framework (QOF) options for local implementation have been added to this topic.

May 2013 — minor update. Linking error corrected in the Epilepsy node in Scenario: Comorbidities and special situations.

March 2013 — minor update. The telephone number for NHS Direct has been updated.

February to June 2012 — reviewed. A literature search was conducted in December 2011 to identify evidence-based guidelines, UK policy, systematic reviews, and key RCTs published since the last revision of the topic. No changes to clinical recommendations have been made. However, recommendations have been rewritten for clarity, and superseded guidelines and manufacturers' Summary of Product Characteristics have been updated accordingly.

January 2012 — mirror error corrected. Clarified the UK medical eligibility criteria for the use of progestogen-only pills in women with a past history (5 years or more) of migraine with aura, at any age.

March 2011 — topic structure revised to ensure consistency across CKS topics — no changes to clinical recommendations have been made. Issued in June 2011.

February 2011 — minor update. The Faculty of Sexual and Reproductive Healthcare (FSRH) no longer recommends that additional contraception is required during or after courses of antibiotics that do not induce liver enzymes. However, additional contraceptive precautions are required if the antibiotic or illness causes vomiting or diarrhoea.

August 2010 — updated. The section on contraceptive choices in women approaching the menopause has been updated to include the FSRH guidance on *Contraception in women aged over 40 years*.

June 2010 — updated. The section on contraceptive choices in young women under 18 years of age has been updated in line with the FSRH guidance *Contraceptive choices for young people*. A prescription for Levest®, a new ethinylestradiol plus levonorgestrel combined oral contraceptive pill, has been added.

March 2010 — minor update. The section on prescribing for women with epilepsy has been updated in line with the FSRH statement on antiepileptic drugs and contraception.

February 2010 — updated to include the revised *UK medical eligibility criteria for contraceptive use*, as published by the FRSH, formerly the Faculty of Family Planning and Reproductive Healthcare (FFPRHC).

October 2009 — minor update. The advice about when to a remove a copper intrauterine device (Cu-IUD) or a levonorgestrel intrauterine system (LNG-IUS) in a woman with pelvic inflammatory disease has also been updated.

March 2009 — minor update. The QOF indicators for sexual health have been updated in the Goals and outcome measures section.

September 2008 — minor correction. Typographical and table heading corrections to UK medical eligibility criteria tables on Cu-IUD and the LNG-IUS.

April to September 2007 — converted from CKS guidance to CKS topic structure. The evidence-base has been reviewed in detail, and recommendations are more clearly justified and transparently linked to the supporting evidence.

September 2004 — updated to include the WHO Medical Eligibilty Criteria relating to contraception for 2004.

January 2004 — reviewed. Validated in March 2004 and issued in June 2004.

January 2001 — rewritten. Validated in March 2001 and issued in June 2001. Guidance on emergency contraception is no longer included in the Contraception guidance but can be found as a separate CKS topic.

December 1997 — written.

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Update

New evidence

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Evidence-based guidelines

- FSRH (2017). *FSRH guideline. Quick starting contraception.* Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians &Gynaecologists. www.fsrh.org (http://www.fsrh.org/) [Free Full-text (http://www.fsrh.org/documents/fsrh-clinical-guidance-quick-starting-contraception-april-2017/)]
- FSRH (2017).*CEU statement on weight and contraception: how do they influence each other?* Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians &Gynaecologists. www.fsrh.org (http://www.fsrh.org/) [Free Full-text (http://www.fsrh.org/news/ceu-statement-on-weight-and-contraception-how-do-they-influence/)]
- FSRH (2019) *FSRH Clinical Guidance: Contraceptive Choices for Young People (Updated May 2019).* Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists. www.fsrh.org (https://www.fsrh.org/home/) [Free Full-text (https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-young-people-mar-2010/)]
- FSRH (2019) *FSRH Clinical Guideline: Contraception for Women Aged over 40 Years (August 2017, amended September 2019).* The Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists. www.fsrh.org.uk (https://www.fsrh.org/home/) [Free Full-text (https://www.fsrh.org/standards-and-guidance/documents/fsrh-guidance-contraception-for-women-aged-over-40-years-2017/)]

HTAs (Health Technology Assessments)

No new HTAs since 1 September 2016.

Economic Appraisals

No new economic appraisals relevant to England since 1 September 2016.

Systematic reviews and meta-analyses

No new systematic reviews or meta-analysis since 1 September 2016.

Primary evidence

No new randomized controlled trials published in the major journals since 1 September 2016.

New policies

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No new national policies or guidelines since 1 September 2016.

New safety alerts

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No new safety alerts since 1 September 2016.

Changes in product availability

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No changes in product availability since 1 September 2016.

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Goals

To support primary healthcare professionals to assess:

- Women requesting contraception and help them find a suitable contraceptive method taking into account comorbidities and concurrent medication.
- Young women (aged under 16 years) to ensure they meet the Fraser Criteria and to help them find a suitable method of contraception.
- Women approaching the menopause to help them find a suitable method of contraception.

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Outcome measures

No outcome measures were found during the review of this topic.

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Audit criteria

No audit criteria were found during the review of this topic.

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QOF indicators

Table 1. Indicators related to contraception in the Quality and Outcomes Framework (QOF) of the General Medical Services (GMS) contract.

Indicator	Points	Achievement thresholds
The contractor establishes and maintains a register of women aged 54 years or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS	4	
The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription	3	50–90%
Data from: [BMA and NHS Employers, 2016 (/contraception-assessment#!references)]		

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QIPP – options for local implementation

No QIPP criteria were found during the review of this topic.

NICE quality standards

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- Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.
- Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.
- Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge.
- Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery.

[NICE, 2016 (/contraception-assessment#!references)]

How effective are the available contraceptive methods?

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Table 1. Summary of the efficacy of different contraceptive methods available in the UK

	Percentage of women experiencing an unintended pregnancy within the first year of use	
Method	**Typical use**	**Perfect use***
No method	85%	85%
Fertility awareness methods	24%	1–9%
Lactational amenorrhoea	2%	0.5%
Combined oral contraceptives, and progestogen-only pills	9%	0.3%
Progestogen-only injectables	6%	0.2%
Progestogen-only implant	0.05%	0.05%
Combined vaginal ring	9%	0.3%
Combined transdermal patch	9%	0.3%
Copper intrauterine device (Cu-IUD)	0.8%	0.6%
Levonorgestrel intrauterine system (LNG-IUS)	0.2%	0.2%
Female condom	21%	5%
Male condom	18%	2%
Diaphragm plus spermicide	12%	6%
Cervical cap plus spermicide (parous women)	24%	20%
Cervical cap plus spermicide (nulliparous women)	12%	9%
Withdrawal	22%	4%
Female sterilization	0.5%	0.5%
Male sterilization	0.15%	0.10%
* Used consistently and correctly		
Data from: [Trussell, 2011 (/contraception-assessment#!references); FSRH, 2015b (/contraception-assessment#!references)]		

What methods of contraception are available in the UK?

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The following methods of contraception are currently available in the UK:

- **Oral preparations:**
  - Combined oral contraceptive (COC). For more information, see Scenario: Combined oral contraceptive (/contraception-combined-hormonal-methods#!scenario) in the CKS topic on Contraception - combined hormonal methods (/contraception-combined-hormonal-methods).
  - Progestogen-only pill (POP). For more information, see Scenario: Progestogen-only pill (/contraception-progestogen-only-methods#!scenario) in the CKS topic on Contraception - progestogen-only methods (/contraception-progestogen-only-methods).
- **Combined transdermal patch (CTP).** For more information, see Scenario: Combined transdermal patch (/contraception-combined-hormonal-methods#!scenario:1) in the CKS topic on Contraception - combined hormonal methods (/contraception-combined-hormonal-methods).
- **Combined vaginal ring (CVR)**. For more information, see Scenario: Combined vaginal ring (/contraception-combined-hormonal-methods#!scenario:2) in the CKS topic on Contraception - combined hormonal methods (/contraception-combined-hormonal-methods).
- **Long-acting reversible contraceptives (LARCs):**
  - Injections and implants (for more information, see the CKS topic on Contraception - progestogen-only methods (/contraception-progestogen-only-methods)):
    - Progestogen-only injectables.
    - Progestogen-only implant.
  - Intrauterine devices (for more information, see the CKS topic on Contraception - IUS/IUD (/contraception-iusiud)):
    - Copper intrauterine device (Cu-IUD).
    - Levonorgestrel intrauterine system (LNG-IUS).
- **Barrier methods and spermicides** (for more information, see the CKS topic on Contraception - barrier methods and spermicides (/contraception-barrier-methods-and-spermicides))**:**
  - Male condom.
  - Female condom.
  - Diaphragm or cap, plus spermicide.
- **Sterilization** (for more information, see the CKS topic on Contraception - sterilization (/contraception-sterilization))**:**
  - Male sterilization: vasectomy.
  - Female sterilization: tubal occlusion.
- **Natural family planning** (for more information, see the CKS topic on Contraception - natural family planning (/contraception-natural-family-planning))**:**
  - Fertility awareness–based methods (FAM).
  - Lactational amenorrhoea method (LAM).
- **Emergency contraception** (for more information, see the CKS topic on Contraception - emergency (/contraception-emergency)):
  - Oral levonorgestrel.
  - Oral ulipristal acetate.
  - Cu-IUD.

Scenario: Issues to discuss and consider

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How should I assess a woman to help her choose an acceptable method of contraception?

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- **Assess** all women requesting contraception to ensure the method of contraception she is considering is suitable.
  - Additional assessments may be required depending on the chosen method. For more information, see Scenario: Assessment for specific contraceptive methods (/contraception-assessment#!scenario:4).
- **Exclude pregnancy** — if pregnancy has been reasonably excluded, any suitable method of contraception can be considered.
  - If the woman's choice of contraception is not available or suitable at the time of presentation, offer one of the following as a bridging method:
    - Barrier method (for example condoms).
    - Combined hormonal contraception (pill, transdermal patch, or vaginal ring).
    - Progestogen-only pill.
    - Progestogen-only injectable.
  - If pregnancy cannot be excluded and the woman wishes to start hormonal contraception without delay, see the section on Unable to confirm pregnancy (/contraception-assessment#!scenarioRecommendation:4).
- **Identify** any relevant medical conditions or medication that could affect the choice of contraception.
  - Check the UK Medical Eligibility Criteria for contraceptive use (https://www.fsrh.org/standards-and-guidance/uk-medical-eligibility-criteria-for-contraceptive-use/) to ensure that her preferred method is not contraindicated.

        - If the woman is considering sterilization, or natural family planning, the World Health Organization Medical eligibility criteria for contraceptive use (http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1) should be checked as these issues are not covered by UKMEC.
    - Take a clinical history and perform a clinical examination, including blood pressure, and body mass index.
    - Factors which influence contraceptive choice include:
        - Comorbidities and other conditions — breastfeeding; menorrhagia; fibroids; previous ectopic pregnancy; diabetes mellitus; epilepsy; headache and migraine; cardiovascular disease (CVD) risk factors; obesity; smoking; hypertension; sexually transmitted infections (STIs) or pelvic inflammatory disease (PID); and venous thromboembolism (VTE).
        - Concurrent medication — liver enzyme-inducing drugs (such as medicines used to treat epilepsy, anti-retrovirals and St John's Wort) can affect some forms of contraception.
            - Avoid less effective methods of contraception (such as fertility awareness-based methods) if the woman is taking teratogenic drugs (for example lithium or warfarin).
        - Age of the woman — approaching the menopause or under 18 years.
- **Consider** any relevant ethical and legal issues if the woman has a learning disability, or if a girl is under 16 years of age.
- **Discuss** what method of contraception the woman is considering and her understanding of that method, its efficacy, risks and adverse effects, advantages and disadvantages and how to use it.
- **Also discuss** the woman's:
    - Requirements for contraception, the importance of avoiding pregnancy, future plans for having children, and the attitudes of her partner and family towards contraception.
    - Personal beliefs and views about contraception.
    - Sexual health risks.
        - If the woman is at risk of an STI or HIV (including during pregnancy and postpartum), recommend correct and consistent use of condoms, either alone or with another method of contraception. For more information, see the section on Sexually transmitted infections (/contraception-assessment#!scenarioRecommendation:2).
        - For more information on barrier methods of contraception, see the CKS topic on Contraception - barrier methods and spermicides (/contraception-barrier-methods-and-spermicides).
- **Provide verbal and/or written advice** about alternative methods of contraception, in particular, long-acting reversible contraception (copper intrauterine device, levonorgestrel intrauterine system, progestogen-only injectables, progestogen-only implant, and the combined vaginal ring).

Basis for recommendation

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], *Male and female sterilization* [FSRH, 2014a (/contraception-assessment#!references)], *Intrauterine contraception* [FSRH, 2015a (/contraception-assessment#!references)], *Barrier methods for contraception and STI prevention* [FSRH, 2015b (/contraception-assessment#!references)], *Fertility Awareness Methods* [FSRH, 2015c (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Progestogen-only injectables* [FSRH, 2014c (/contraception-assessment#!references)], *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)], the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) *Decision-making tool for family planning clients and providers* [WHO, 2005 (/contraception-assessment#!references)], and expert opinion in a medical textbook [Hatcher, 2011 (/contraception-assessment#!references)].

What are the UK Medical Eligibility criteria for contraceptive use?

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- Consult the UK Medical eligibility criteria for contraceptive use (https://www.fsrh.org/standards-and-guidance/uk-medical-eligibility-criteria-for-contraceptive-use/) to ensure a method of contraception is suitable for the woman before recommending or prescribing it.
- The UK Medical Eligibility Criteria (UKMEC) are a set of evidence-based recommendations designed to help women select the most appropriate method of contraception depending on their personal characteristics and specific clinical conditions, without imposing unnecessary restrictions.
- The UKMEC considers the following methods of contraception:
    - Intrauterine contraception.
    - Progestogen-only contraception.
    - Combined hormonal contraception.
    - Emergency contraception.

- Personal circumstances (such as breastfeeding, postpartum or age), and clinical conditions are classification as UKMEC categories 1 to 4 (see Table 1) which indicates whether or not a method can be used.
- The UKMEC does not consider:
  - Male or female sterilization or natural family planning.
    - For information on the medical eligibility criteria for these methods, see the World Health Organization (WHO) Medical eligibility criteria for contraceptive use (http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1).
    - For sterilization, personal circumstances (such as breastfeeding, postpartum or age), and clinical conditions are classification as WHOMEC categories A, C, D or S (see Table 2) which indicates whether or not a method can be used.

Table 1. UK Medical Eligibility Criteria (UKMEC).

UKMEC Category	Definition
1	A condition for which there is no restriction for the use of the method.
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable.
4	A condition which represents an unacceptable health risk if the method is used.

Table 2. World Health Organization Medical Eligibility Criteria (WHOMEC).

WHOMEC category	Definition
A — Accept	There is no medical reason to deny sterilization to a person with this condition.
C — Caution	The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
D — Delay	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
S — Special	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

Basis for recommendation

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This information is based on the Faculty of Sexual and Reproductive Health (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization guideline *Medical eligibility criteria for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

How should I assess the risk of sexually transmitted infections (STIs)?

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- Consider the person's risk of exposure to sexually transmitted infection (STIs), including HIV:
  - Key groups at risk of STIs include young people under 25 years of age; people who frequently change sexual partners; people involved in prostitution; men who have sex with men; and people who have come from, or who have visited areas of high HIV prevalence and have been sexually active there.
  - Raise the subject sensitively — many STIs can be asymptomatic, but when symptoms are present the person may not link them to an STI.
  - Take into consideration the local prevalence of STIs, the person's age, and their sexual activity.

- Ask about their current circumstances, including current and recent sexual partners, age of onset of sexual activity, type of sexual activity, and use of alcohol and other substances.
  - Clarify terms: 'sex' can also include reference to oral and anal sex.
  - Taking alcohol or drugs can lead to risky sexual behaviour, and financial difficulties may lead to prostitution.

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Emergency contraception* [FSRH, 2011a (/contraception-assessment#!references)], the National Institute for Health and Care Excellence (NICE) guideline *One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups* [NICE, 2007 (/contraception-assessment#!references)], and expert opinion in the Family Planning Association *Handbook of sexual health in primary care* [Belfield et al, 2011 (/contraception-assessment#!references)].

How can I be reasonably certain that a woman is not pregnant?

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- Health professionals can be 'reasonably certain' that a woman is not pregnant if there are no signs or symptoms of pregnancy and one or more of the following criteria are met. The woman:
  - Has not had intercourse since the last normal menses.
  - Has used a reliable method of contraception correctly and consistently.
  - Is within the first 7 days of the onset of a normal menstrual period.
  - Is within 4 weeks postpartum for non-breastfeeding women.
  - Is within the first 7 days post-termination of pregnancy, or miscarriage.
  - Is fully or nearly fully breastfeeding, amenorrhoeic, and less than 6 months postpartum.
  - A pregnancy test is performed no sooner than 3 weeks since the last episode of unprotected sexual intercourse (UPSI) and is negative.

Basis for recommendation Back to top

This information is based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Quick starting contraception* [FSRH, 2010a (/contraception-assessment#!references)].

What should I do if pregnancy cannot be excluded?

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- If pregnancy cannot be excluded (for example, following emergency contraception) but the woman wishes to start contraception without delay, consider prescribing one of the following:
  - Combined hormonal contraception (pill, transdermal patch, vaginal ring).
  - Progestogen-only pill.
  - Progestogen-only implant.
  - Progestogen-only injectables — if other methods are not appropriate or acceptable.
- Advise the woman to take a pregnancy test no sooner than 3 weeks after the last episode of unprotected sex.

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Quick starting contraception* [FSRH, 2010a (/contraception-assessment#!references)], *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Progestogen-only injectables* [FSRH, 2014c (/contraception-assessment#!references)], and *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)].

What ethical and legal issues do I need to consider when arranging contraception for a girl who is under 16 years of age?

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- Explore their understanding, and consider informing young people of the law in relation to sexual activity.
- The legal age of consent to sexual activity is 16 years in the UK.
  - Sexual activity under the age of consent is an offence even if consensual.
  - Offences are considered more serious (statutory rape) when the person is younger than 13 years of age.
- Reassure her that the consultation is confidential, but explain the circumstances in which confidentiality may need to be breached (for example, suspected child protection issues, exploitation, or coercion).
- Assess her competency to independently consent to treatment, and document in her case notes that she meets (or does not meet) the Fraser Criteria.
- If the Fraser Criteria are not met, consider breaching confidentiality and seeking parental consent.
- Consider child protection issues.
  - If non-consensual sex or sexual abuse is suspected, follow appropriate child protection procedures and refer to a paediatrician if necessary. For more information see the CKS topic on Child maltreatment - recognition and management (/child-maltreatment-recognition-and-management).
- Counsel her on the emotional and physical implications of sexual activity, including the risks and consequences of pregnancy and the risk of sexually transmitted infections (STIs).

Fraser Criteria

- In England and Wales, it is lawful to provide contraceptive advice and treatment to young people without parental consent, provided that the practitioner is satisfied that all the Fraser criteria for competence are met. The criteria are that:
  - The young person understands the practitioner's advice.
  - The young person cannot be persuaded to inform their parents, or will not allow the practitioner to inform the parents, that contraceptive advice has been sought.
  - The young person is likely to begin or to continue having intercourse with or without contraceptive treatment.
  - Unless he or she receives contraceptive advice or treatment, the young person's physical or mental health (or both) are likely to suffer.
  - The young person's best interest requires the practitioner to give contraceptive advice or treatment (or both) without parental consent.
- In Scotland, the Fraser guidelines do not apply, however the Age of Legal Capacity Act 1991 applies similar criteria.
  - Competence is demonstrated if the young person is able to:
    - Understand the treatment, its purpose and nature, and why it is being proposed.
    - Understand its benefits, risks, and alternatives.
    - Understand in broader terms what the consequences of the treatment will be.
    - Retain the information for long enough to use it and weigh it up in order to arrive at a decision.

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guidance *Contraceptive choices for young people* [FSRH, 2010b (/contraception-assessment#!references)], Her Majesty's Government guideline, *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* [HM Government, 2015 (/contraception-assessment#!references)], and the National Institute for Health and Care Excellence (NICE) guideline *Child maltreatment: when to suspect maltreatment in under 18s* [NICE, 2009 (/contraception-assessment#!references)].

Fraser Criteria not met

- The recommendation to consider breaking confidentiality and seek parental consent for children requesting contraception, but who do not meet all of the Fraser Criteria, is based on what CKS considers to be good clinical practice.

What ethical and legal issues do I need to consider when arranging contraception for someone with a learning disability?

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- Support women with learning and/or physical disabilities to make their own decisions about contraception.
- Assess a woman's competence to consent to treatment by her ability to:
  - Understand the information provided, and
  - Weigh up the risks and benefits, and
  - Express her own wishes.

- When a woman with a learning disability cannot understand or take responsibility for decisions about contraception, carers and other involved parties should meet to address issues around the woman's contraceptive need and to establish a care plan.
- For more information, see the Reference guide to consent for examination or treatment (https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition) published by the Department of Health.

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Contraceptive choices in young people* [FSRH, 2010b (/contraception-assessment#!references)] the National Institute for Health and Care Excellence (NICE) guidance *Long-acting reversible contraception* [NICE, 2014 (/contraception-assessment#!references)] and the Department of Health (DH) *Reference guide to consent for examination or treatment* [DH, 2009 (/contraception-assessment#!references)].

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Scenario: Comorbidities and special situations

What methods of contraception are suitable for a woman who is breastfeeding?

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- Contraception is not needed in the first 20 days after delivery, but is required from day 21 if the woman is not fully breastfeeding and does not want to become pregnant.
- **If the woman is breastfeeding and is less than 6 weeks postpartum:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms only) — diaphragms and cervical caps are unsuitable less than 6 weeks postpartum, until uterine involution is complete.
    - Progestogen-only pills (POPs), progestogen-only implants, or progestogen-only injectables.
    - A copper intrauterine device (Cu-IUD) or the levonorgestrel intrauterine system (LNG-IUS), from 4 weeks postpartum (off-label use).
  - Consider the following methods before 4 weeks postpartum (off-label use), only after seeking specialist advice as the risks (uterine perforation) usually outweigh the benefits:
    - Cu-IUD or LNG-IUS.
  - Do not use the following methods:
    - Combined hormonal contraceptives (pill, transdermal patch, or vaginal ring).
    - Female sterilization — delay until the woman is 6 weeks or more postpartum. For more information, see the CKS topic on Contraception - sterilization (/contraception-sterilization).
- **If the woman is fully or almost fully breastfeeding and is between 6 weeks and 6 months postpartum:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - The POP, progestogen-only injectables, and implants.
    - Cu-IUD or LNG-IUS.
    - Combined hormonal contraceptives (pill, transdermal patch, and vaginal ring).
    - Female sterilization.
- **If the woman is breastfeeding and is 6 months or more postpartum:**
  - All methods can be used.
  - For a woman who is postpartum and not breastfeeding, see the section on Postpartum and not breastfeeding (/contraception-assessment#!scenarioRecommendation:9).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)] *a*nd the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

Postpartum use of an intrauterine device [FSRH, 2016 (/contraception-assessment#!references)]

- The most important risk factors for uterine perforation are insertion:
  - In breastfeeding women, where the risk of perforation is six times higher.

- Within 36 weeks of giving birth.

What methods of contraception are suitable for a woman with epilepsy?

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- **For women who are not taking liver enzyme-inducing drugs:**
  - All methods can be used. However, only consider female sterilization if epilepsy is adequately controlled (WHOMEC C).
- **For women taking liver enzyme-inducing drugs (such as phenytoin, carbamazepine, barbiturates, primidone, or topiramate):**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only injectables.
    - Female sterilization — if epilepsy is adequately controlled (WHOMEC C).
  - Topiramate is associated with a risk of fetal malformations and can impair the effectiveness of hormonal contraceptives. Before initiating topiramate in a woman of childbearing potential, pregnancy testing should be performed. The patient should be fully informed of the risks related to the use of topiramate during pregnancy. Ensure that women and girls of childbearing potential are advised that they should be using a highly effective method of contraception. Topiramate is a weak enzyme inducer, but the contraceptive efficacy of the COC may be unaffected by topiramate doses lower than 200 mg daily.
  - If a woman wishes to use combined hormonal contraception (pill, transdermal patch, or vaginal ring), see the section on drug interactions (for the pill (/contraception-combined-hormonal-methods#!scenarioRecommendation:5), patch (/contraception-combined-hormonal-methods#!scenarioRecommendation:14), or ring (/contraception-combined-hormonal-methods#!scenarioRecommendation:22)) in the CKS topic on Contraception - combined hormonal methods (/contraception-combined-hormonal-methods)
  - If a woman wishes to use the progestogen-only pill, or progestogen-only implant, see the section on drug interactions (for the pill (/contraception-progestogen-only-methods#!scenarioRecommendation:5) or the implant (/contraception-progestogen-only-methods#!scenarioRecommendation:12)) in the CKS topic on Contraception - progestogen-only methods (/contraception-progestogen-only-methods).
- **For women taking lamotrigine:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Cu-IUD or the LNG-IUS.
    - Progestogen-only pill, progestogen-only implant, or progestogen-only injectable.
    - Female sterilization — if epilepsy is adequately controlled (WHOMEC C).
  - Advise the woman not to use a combined hormonal contraceptive (CHC) if taking lamotrigine monotherapy, as it may lower the seizure control. For more information, see the section on drug interactions (for the pill (/contraception-combined-hormonal-methods#!scenarioRecommendation:5), patch (/contraception-combined-hormonal-methods#!scenarioRecommendation:14), or ring (/contraception-combined-hormonal-methods#!scenarioRecommendation:22)) in the CKS topic on Contraception - combined hormonal methods (/contraception-combined-hormonal-methods).
    - If the woman is taking lamotrigine in combination with sodium valproate, CHC is unlikely to affect seizure control.

Basis for recommendation

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Drug interactions with hormonal contraception* [FSRH, 2011b (/contraception-assessment#!references)], *the UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)], and the manufacturer's Summary of Product Characteristics [ABPI, 2016a (/contraception-assessment#!references); ABPI, 2017 (/contraception-assessment#!references)].

What methods of contraception are suitable if a woman is postpartum and not breastfeeding?

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- Contraception is not needed in the first 20 days after delivery, but it is required from day 21 if the woman does not want to become pregnant.
- **For a woman who is less than 21 days postpartum:**

- Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
  - Barrier methods (condoms only) — diaphragms and caps are unsuitable less than 6 weeks postpartum, until uterine involution is complete.
  - Progestogen-only pill (POP), progestogen-only injectable, or progestogen-only implant.
- Consider the following method only after seeking specialist advice as the risks usually outweigh the benefits:
  - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine device (LNG-IUS).
  - Combined hormonal contraception (pill, transdermal patch, or vaginal ring) if there are no other risks for venous thromboembolism (VTE).
- Do not use the following methods:
  - Combined hormonal contraception (pill, transdermal patch, or vaginal ring) if there are other risks for VTE.
  - Sterilization — delay until the woman is 6 weeks or more postpartum.

- **For a woman who is 21 days or more postpartum:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods — diaphragms and caps are unsuitable less than 6 weeks postpartum.
    - Combined hormonal contraception (pill, transdermal patch, or vaginal ring) — if there are no other risks for VTE.
    - POP, progestogen-only injectables or progestogen-only implants.
    - Cu-IUD, or LNG-IUS — from 4 weeks postpartum (off-label use).
    - Sterilization — from 6 weeks postpartum.
  - If there are other risks for VTE, only consider combined hormonal contraception after seeking specialist advice.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)], and the Summary of Product Characteristics for Mirena® [ABPI, 2015 (/contraception-assessment#!references)].

Intrauterine contraception use postpartum

- The FSRH advises that the copper intrauterine device (Cu-IUD) and the levonorgestrel intrauterine system (LNG-IUS) can be inserted at least 4 weeks postpartum.
  - However, the manufacturers of Mirena® recommend that insertion should be delayed until 6 weeks postpartum [ABPI, 2015 (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman with menorrhagia, fibroids, or a previous ectopic pregnancy?

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- **For women with idiopathic menorrhagia:**
  - All methods can be used.
  - Consider recommending:
    - The levonorgestrel intrauterine system (LNG-IUS) first-line.
    - The combined oral contraceptive (COC) pill second-line.
    - The progestogen-only pill (POP) and progestogen-only injectables third-line.
  - For information on non-contraceptive treatments, see the CKS topic on Menorrhagia (/menorrhagia).
- **For women with unexplained vaginal bleeding:**
  - Investigate all unexplained vaginal bleeding to rule out any underlying conditions such as pregnancy or malignancy. For more information, see the CKS topic on Gynaecological cancers - recognition and referral (/gynaecological-cancers-recognition-and-referral).
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Combined hormonal contraception (pill, transdermal patch, and vaginal ring).
    - The POP.
    - The copper intrauterine device (Cu-IUD) or LNG-IUS if use is being continued.
  - Consider the following methods only after seeking specialist advice:

    - Progestogen-only implants and progestogen-only injectables.
  - Do not use the following methods:
    - Cu-IUD or LNG-IUS if initiating contraception.
    - Sterilization — this should be delayed until the bleeding is investigated (WHOMEC D).
- **For women with a history of ectopic pregnancy, all methods can be used without restriction.**
- **For women with uterine fibroids:**
  - **Without** distortion of the uterine cavity —all methods can be used.
    - However, depending on the location and size of the fibroid, sterilization may be difficult (WHOMEC C).
  - **With** distortion of the uterine cavity — advise the woman to use one of the following methods:
    - Barrier methods (condoms, diaphragms, and caps).
    - Combined hormonal contraception (pill, transdermal patch, or combined vaginal ring).
    - Progestogen-only pill (POP), progestogen-only implant, or progestogen-only injectable.
    - Female sterilization — depending on the location and size of the fibroid, sterilization may be difficult (WHOMEC C).
  - Consider the following methods only after seeking specialist advice as the risks usually outweigh the benefits:
    - Cu-IUD or LNG-IUS — these may be difficult to fit.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)] and the manufacturer's Summary of Product Characteristics [ABPI, 2016b (/contraception-assessment#!references)].

- The UK Medical Eligibility Criteria advises that the combined vaginal ring can be used in women with unexplained vaginal bleeding, before evaluation [FSRH, 2016 (/contraception-assessment#!references)].
  - However, the manufacturers of Nuvaring® advise that it should not be initiated or continued in women with undiagnosed vaginal bleeding [ABPI, 2016b (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman with diabetes mellitus?

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- **For a woman with diabetes mellitus (insulin and non–insulin dependent) and no vascular disease:**
  - All methods can be used. However, only consider:
    - Female sterilization (WHOMEC C) if well controlled, as there is a risk of hypoglycaemia or ketoacidosis.

  For a woman with diabetes mellitus and nephropathy, retinopathy, neuropathy, or other vascular disease:
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only pill (POP), progestogen-only implants, or progestogen-only injectables.
  - Consider the following methods only after seeking specialist advice as the risks usually outweigh the benefits:
    - Combined hormonal contraceptives (pill, transdermal patch and vaginal ring) — use clinical judgement to determine the appropriate classification.
    - Female sterilization (WHOMEC S) — women with diabetes are more likely to have complications when undergoing sterilization.
- **For a woman with a history of gestational diabetes, all methods can be used without restriction.**

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman with headache or migraine?

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- **For a woman with non-migrainous headaches:**

- All methods can be used.

- **For a woman with migraine without aura:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only pill (POP), progestogen-only implants, or progestogen-only injectable.
    - Combined hormonal contraceptives (pill, patch, and vaginal ring) can be considered if they are being initiated.
    - Female sterilization.
  - Consider the following methods only after seeking specialist advice, as the risks usually outweigh the benefits:
    - Continuation of combined hormonal contraceptives (pill, transdermal patch, and vaginal ring).
- **For a woman with migraine with aura:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Cu-IUD or LNG-IUS.
    - POP, progestogen-only implants, or progestogen-only injectable.
    - Female sterilization.
  - Do not use the following methods due to unacceptable health risk:
    - Combined hormonal contraceptives (pill, transdermal patch, or vaginal ring).
- **For a woman with a past history (5 years or more) of migraine with aura:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Cu-IUD or LNG-IUS.
    - Progestogen-only pill (POP), implants, and injectables.
    - Female sterilization.
  - Consider the following methods only after seeking specialist advice, as the risks usually outweigh the benefits:
    - Combined hormonal contraceptives (pill, patch, and vaginal ring).
- **Definition of aura**
  - Aura are focal neurological symptoms (due to cerebral ischaemia) that start before the headache, such as visual disturbances (for example homonymous hemianopia), unilateral paraesthesia and/or numbness, unilateral weakness, and aphasia, or unclassifiable speech disorder. For more information, see the CKS topic on Migraine (/migraine).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

Migraine and stroke risk [FSRH, 2016 (/contraception-assessment#!references)]:

- Women who have aura are at a higher risk of stroke than those without aura.
- Women with a history of migraine who use combined oral contraceptives are about two to four times as likely to have an ischaemic stroke as non-users with a history of migraine.

What methods of contraception are suitable for a woman with multiple risk factors for cardiovascular disease?

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For a woman with multiple risk factors for cardiovascular disease (such as women aged over 35 years, smoking, diabetes, hypertension, and obesity):

- Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
  - Barrier methods (condoms, diaphragms, and caps).
    - However, advise woman using the diaphragm to seek advice regarding diaphragm fitting if they gain or lose 3 kg or e in weight. For more information, see the section on Obesity (/contraception-assessment#!scenarioRecommendation:1

- Copper intrauterine device (Cu-IUD) or the levonorgestrel intrauterine system (LNG-IUS).
- Progestogen-only pill (POP) or progestogen-only implants.

- Consider the following methods only after seeking specialist advice:
  - Progestogen-only injectables.
  - Combined hormonal contraception (CHC). For more information see the section on CHCs and multiple risk factors for CVD (/contraception-assessment#!scenarioClarification).
  - Female sterilization (WHOMEC S).
- For information on management and contraceptive choice in women who have cardiovascular disease, see the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline Contraceptive choices for women with cardiac disease (https://www.fsrh.org/documents/ceu-guidance-contraceptive-choices-for-women-with-cardiac/).

CHCs and multiple risk factors for CVD Back to top

- CHC may be contraindicated depending on the number and severity of risk factors. Clinical judgement should be used to decide on a suitable method of contraception, however, CHC should be avoided if:
  - Any one of the following risk factors are present:
    - Obesity — body mass index ≥ 35 kg/m^2 (unless there is no suitable alternative).
    - Smoking — 40 or more cigarettes daily.
    - Diabetes mellitus — if complications are present.
    - Family history of arterial disease in first degree relative aged under 45 years — if atherogenic lipid profile.
    - Hypertension —blood pressure above or equal to systolic 160 mmHg or diastolic 100 mmHg.
    - Migraine — with aura (focal symptoms), or severe migraine frequently lasting over 72 hours despite treatment, or migraine treated with ergot derivative.
  - Any two or more of the following risk factors are present:
    - Obesity (body mass index ≥ 30 kg/m^2).
    - Smoking.
    - Diabetes mellitus.
    - Family history of arterial disease in first degree relative aged under 45 years.
    - Hypertension—blood pressure above systolic 140 mmHg or diastolic 90 mmHg.
    - Migraine without aura.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)], and the British National Formulary [BNF 71, 2016 (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman who smokes? Back to top

- **For a woman who is younger than 35 years of age and is currently smoking, or a woman who is 35 years of age or older and stopped smoking 12 months ago or longer:**
  - All methods can be used.
- **For a woman who is 35 years of age or older and smokes less than 15 cigarettes daily, or has stopped smoking in the past 12 months:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Copper intrauterine device (Cu-IUD) or the levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only pill (POP), progestogen-only injectables, and progestogen-only implants.
    - Female sterilization.
  - Consider combined hormonal contraceptives (pill, transdermal patch and vaginal ring) only after seeking specialist advice as the risks usually outweigh the benefits.
- **For a women who is 35 years or older and smokes 15 cigarettes or more daily:**

- Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
  - Barrier methods (condoms, diaphragms, and caps) — can be used alone or in addition to other suitable methods.
  - Cu-IUD or LNG-IUS.
  - POP, progestogen-only injectables, and progestogen-only implants.
  - Female sterilization.
- Do not use the combined hormonal contraceptives (pill, patch and vaginal ring) due to the unacceptable health risk.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman with a sexually transmitted infection (STI) or pelvic inflammatory disease (PID)?

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- **For women with a current sexually transmitted infection (STI)** (such as chlamydia, purulent cervicitis, or gonorrhoea infection):
  - Arrange for the STI to be treated and provide advice on safe sex. For more information, see the CKS topics on Chlamydia - uncomplicated genital (/chlamydia-uncomplicated-genital) and Gonorrhoea (/gonorrhoea).
  - Advise that the following methods are safe to use, but to avoid sexual intercourse (including oral sex) until she and her partner(s) have completed treatment:
    - Progestogen-only pill (POP), progestogen-only implants, and progestogen-only injectables.
    - Combined hormonal contraceptives (pill, patch and vaginal ring).
    - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine system (LNG-IUS) if continuing to use them.
  - Do not start the following methods:
    - Cu-IUD or LNG-IUS.
    - Sterilization — delay until the condition has resolved. After treatment, perform a pelvic examination to rule out recurrent or persistent infection.
- **For women with vaginitis, other STIs (excluding HIV and hepatitis), and increased risk of STIs:**
  - All methods can be used.
- **For women with a history of pelvic inflammatory disease (PID) and with no current risk factors for sexually transmitted infection (STI):**
  - All methods can be used.
- **For women with current PID:**
  - Advise the woman to use of one of the following methods:
    - Barrier methods (condoms, diaphragms, and caps).
    - POP, progestogen-only implants, or progestogen-only injectables.
    - Combined hormonal contraceptives (pill, transdermal patch and vaginal ring).
    - Cu-IUD or LNG-IUS — these can be left in place if the woman already has one fitted.
  - Do not start the following methods:
    - Cu-IUD or LNG-IUS.
    - Sterilization — delay until the condition has resolved. After treatment, perform a pelvic examination to rule out recurrent or persistent infection.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for contraceptive Use* [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman who is obese?

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If the woman's body mass index (BMI) is 30 kg/m^2 or more, or 34 kg/m^2 or less:

- All methods can be used. However, be aware that:
  - Severe obesity may make diaphragms and caps difficult to fit.
    - Advise women using the diaphragm to seek advice regarding diaphragm fitting if they gain or lose 3 kg or more in weight.
  - In obese women, sterilization may be more difficult to perform, and there is an increased risk of complications such as wound infection (WHOMEC C).

If the woman's BMI is 35 kg/m^2 or more:

- Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
  - Barrier methods (condoms, diaphragms, and caps).
    - However, be aware that severe obesity may make diaphragms and caps difficult to fit.
    - Advise woman using the diaphragm to seek advice regarding diaphragm fitting if they gain or lose 3 kg or more in weight.
  - Progestogen-only pill (POP), progestogen-only injectables, or progestogen-only implant.
  - Copper intrauterine device (Cu-IUD) is the most effective form of contraception.
  - Female sterilization — sterilization may be more difficult to perform, and there is an increased risk of complications such as wound infection (WHOMEC C).
- Consider combined hormonal contraception (pill, transdermal patch, or vaginal ring) only after seeking specialist advice.

In addition, note that:

- For women who weigh more than 90 kg — the combined contraceptive patch should not be used if there are other suitable methods, as efficacy may be reduced.
- For 'heavier women' — the progestogen-only contraceptive implant may need to be replaced earlier than the licensed 3 years.
- Women with obesity should be informed that:
  - Combined hormonal contraception use is associated with an increased risk of VTE.
  - Combined hormonal contraception use is associated with a small increased risk of myocardial infarction and ischaemic stroke.
  - If BMI is ≥35 kg/m2 the risks associated with use of combined hormonal contraception generally outweigh the benefits
  - If the woman has additional risk factors (such as smoking or hypertension) then these need to be taken into account when deciding upon a suitable method. For more information, see the section on Multiple risk factors for cardiovascular disease? (/contraception-assessment#!scenarioRecommendation:13).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) *UK Medical Eligibility Criteria for Contraceptive Use* [FSRH, 2016 (/contraception-assessment#!references)]; the FSRH clinical guidelines *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], the Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines *Overweight, Obesity and Contraception* [FSRH, 2019 (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], and *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)]; the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)]; and the manufacturer's Summaries of Product Characteristics for Evra® and Nexplanon® [ABPI, 2016c (/contraception-assessment#!references); ABPI, 2016d (/contraception-assessment#!references)].

- The manufacturers of Evra® advise that the contraceptive efficacy of the patch may be reduced in women weighing 90 kg or more [ABPI, 2016c (/contraception-assessment#!references)].
- The manufacturers of Nexplanon® advise earlier replacement of the implant in 'heavier women', but do not provide guidance on the body mass index (BMI) above which the implant should be replaced earlier [ABPI, 2016d (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman with hypertension?

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- **If the woman has adequately controlled hypertension:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Copper intrauterine device (Cu-IUD) or the levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only pill (POP), progestogen-only implant, or progestogen-only injectable.
    - Female sterilization (WHOMEC C).

- Consider combined hormonal contraception (pill, transdermal patch, and vaginal ring) only after seeking specialist advice, as the risks usually outweigh the benefits.

- **If the woman has consistently elevated blood pressure** (systolic is 140–159 mmHg or diastolic is 90–99mmHg):
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods (condoms, diaphragms, and caps).
    - Cu-IUD or LNG-IUS.
    - POP, progestogen-only implant, or progestogen-only injectable.
    - Female sterilization (WHOMEC C) — there are increased anaesthesia-related risks and an increased risk of cardiac arrhythmia with uncontrolled hypertension.
  - Consider combined hormonal contraception only after seeking specialist advice, as the risks usually outweigh the benefits.
- **If the woman has consistently elevated blood pressure** (systolic is 160 mmHg or more, or diastolic is 100 mmHg or more):
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods.
    - Cu-IUD or LNG-IUS.
    - POP, progestogen-only implant, or progestogen-only injectable.

    Consider the following methods only after seeking specialist advice:
    - Female sterilization (WHOMEC S) — there are increased anaesthesia-related risks and an increased risk of cardiac arrhythmia with uncontrolled hypertension.
  - Do not use combined hormonal contraception, due to the unacceptable health risk.
- **If the woman has hypertension and vascular disease:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier methods.
    - Cu-IUD or LNG-IUS.
    - POP or progestogen-only implant.
  - Consider the following methods only after seeking specialist advice:
    - Progestogen-only injectables.
    - Female sterilization (WHOMEC S).
  - Do not use combined hormonal contraception, due to the unacceptable health risk.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

What methods of contraception are suitable for a woman with a history of venous thromboembolism (VTE)?

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- **For a woman with a history of venous thromboembolism (VTE), known thrombogenic mutations, or who is taking anticoagulants for current VTE:**
  - Discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
    - Barrier method (condom, diaphragm, or cap).
    - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only pill (POP), progestogen-only implant or progestogen-only injectable.
    - Sterilization — only if she is not taking anticoagulants (WHOMEC A).
  - Advise the woman *not to* use the following methods:
    - Combined hormonal contraceptives (pill, transdermal patch or vaginal ring).
    - Sterilization — if she is taking anticoagulants for current VTE (WHOMEC S).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) guideline *UK Medical Eligibility Criteria for Contraceptive Use* [FSRH, 2016 (/contraception-assessment#!references)] and the World Health Organization (WHO) guidance *Medical eligibility for contraceptive use* [WHO, 2015 (/contraception-assessment#!references)].

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Scenario: Prescribing to young people

What do I need to consider when prescribing contraceptives to girls under 18 years of age?

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- Provided that there are no medical contraindications, a girl can use her chosen method of contraception.
- **Before menarche:**
  - Avoid the use of regular hormonal contraception in sexually active girls who have not started menstruating.
  - Recommend the use of condoms both as a contraceptive, and to prevent sexually transmitted infections (STIs).
- **From menarche to 17 years of age**, discuss the following methods of contraception, taking into account her personal circumstances, and how important it is that she avoids pregnancy:
  - Barrier methods (condoms, diaphragms, and caps).
  - Combined oral contraceptive (COC) pills, combined transdermal patch (CTP), or combined vaginal ring (CVR).
  - Progestogen-only pill (POP), progestogen-only injectables, or progestogen-only implants.
  - Copper intrauterine device (Cu-IUD) or the levonorgestrel intrauterine system (LNG-IUS).
- **Advise young people:**
  - About the correct and consistent use of condoms to reduce the risk of STIs.
  - To get tested for STIs 2 weeks after unprotected sexual intercourse (UPSI) to detect any newly acquired infection, and also 12 weeks after UPSI, as it may take time for antibodies for syphilis or HIV to be detectable.
- **Reassure girls and young women about possible adverse effects** of hormonal contraceptives, for example:
  - **Weight gain** — Weight gain may occur with the progestogen-only injectable, depot medroxyprogesterone acetate (DMPA). There is no evidence of weight gain with use of COCs or the CTP.
    - However, weight gain is common in all women, and may simply reflect the normal increase in weight expected during the early reproductive years, and with changes in eating habits and activity levels.
  - **Mood** — POPs and COCs may be associated with mood changes, but there is no evidence that they cause depression.
  - **Bleeding patterns and dysmenorrhoea** — young women should be informed that altered bleeding patterns are common when starting hormonal contraception, especially in the first 3 months of use. However, dysmenorrhoea may improve with use of combined hormonal contraception (CHC).
  - **Bone mineral density** — bone mineral density is influenced by normal pubertal development, exercise, diet, smoking, and some hormonal contraception.
    - The use of the progestogen-only injectable, depot medroxyprogesterone acetate (DMPA), is associated with a small loss of bone mineral density which is usually recovered after discontinuation.
    - Consider the DMPA injection only if all other methods of contraception are unsuitable or unacceptable.
  - **Venous thromboembolism** — the risk of venous thromboembolism is increased with use of COCs, but the absolute risk is very low (5–12 per 10,000 women years). Progestogen-only contraceptives do not appear to increase the risk of venous thromboembolism.
  - **Return of fertility** — normal fertility returns as soon as most contraceptive methods are stopped. However, there may be a delay in conception after stopping:
    - The combined contraceptive patch or the combined vaginal ring (in some women the delay can be up to a few months).
    - The progestogen-only injectable (there could be a delay of up to 1 year in the return of normal fertility).
  - **Risk of cancer**:
    - There is no overall increased risk of cancer with COCs. COCs reduce the risk of ovarian and endometrial cancer and, with less than 5 years' use, do not increase the risk of cervical cancer.
      - There is a small increased risk after 5 years, and a two-fold increase after 10 years, which returns to normal 10 years after stopping the COC.
    - Any increase in risk of breast cancer associated with hormonal contraception is likely to be very small and reduces after stopping the hormonal contraception.
    - The progestogen-only injectable, DMPA, does not appear to have any effect on the risk of ovarian, endometrial, or cervical cancer.
  - For more information, see the section on risks and adverse effects of progestogen-only contraceptives (/contraception-progestogen-only-methods#!scenarioRecommendation:3) and combined hormonal contraceptives (/contraception-combined-hormonal-methods#!scenarioRecommendation:4) in the CKS topics on Contraception - progestogen-only methods (/contraception-progestogen-only-methods) and Contraception - combined hormonal methods (/contraception-combined-hormonal-methods).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Contraceptive choices for young people* [FSRH, 2010b (/contraception-assessment#!references)], *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], *Intrauterine contraception* [FSRH, 2015a (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Progestogen-only injectables* [FSRH, 2014c (/contraception-assessment#!references)], and *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)].

Hormonal contraceptives and mood changes

- Depression is listed as an adverse effect of hormonal contraceptives. However, the FSRH advises that while they may be associated with mood changes, there is no evidence that they cause depression [FSRH, 2010b (/contraception-assessment#!references)].

Scenario: Approaching the menopause Back to top

How does the approach of menopause influence choice? Back to top

- **The UK Medical Eligibility Criteria (UKMEC) also apply to perimenopausal women.** For more information, see the CKS topic on Menopause (/menopause).
  - Provided there are no other contraindications, advise the woman to consider using use of one of the following methods:
    - Barrier methods (condoms, diaphragms, and caps).
    - Copper intrauterine device (Cu-IUD) or levonorgestrel intrauterine system (LNG-IUS).
    - Progestogen-only pill (POP) and progestogen-only implant, and in women 45 years and younger, the progestogen-only injectable.
    - Sterilization.
  - Natural family planning is not generally recommended because irregular menstrual cycles in women approaching the menopause make this method difficult to use.
  - Combined hormonal contraception (pill, transdermal patch, or vaginal ring) is not contraindicated by age alone in perimenopausal women, however consider the UKMEC for women who are:
    - 35 years of age or older and smoke 15 or more cigarettes a day, who have a history of migraine with aura, or who develop migraine with aura while using combined hormonal contraception.
    - 35 years of age or older and smoke fewer than 15 cigarettes a day, or quit smoking less than 1 year ago; and women who have a history (5 years or more) of migraine with aura. Where the combined oral contraceptive (COC) pill is suitable, a pill containing 20 micrograms ethinylestradiol is a reasonable first choice.
- **Consider the non-contraceptive benefits when discussing the choice of contraceptive.**
  - Vasomotor symptoms (hot flushes) may be reduced with combined hormonal contraception.
    - Women experiencing menopausal symptoms while using combined hormonal contraception may wish to try an extended regimen (that is using combined hormonal contraception [pill, patch, or vaginal ring] continuously for 3 months or more, until breakthrough bleeding occurs for 3 to 4 days).
  - Osteoporosis — combined hormonal contraception may increase bone mineral density (BMD); depot medroxyprogesterone acetate may reduce BMD.
  - Menstrual pain, bleeding, and irregularity — combined hormonal contraception may reduce symptoms.
  - Menstrual pain — progestogen-only methods may reduce symptoms.
  - Heavy menstrual bleeding — the LNG-IUS reduces menstrual bleeding and can cause amenorrhoea.
- **Advise women that hormone replacement therapy (HRT) does not provide contraception.**
  - A POP can be used with combined sequential HRT to provide effective contraception and adequate endometrial protection.
    - A POP used with oestrogen-only HRT will not provide an adequate level of endometrial protection.
    - Combined continuous HRT regimens are not appropriate in this age group due to bleeding.
  - Women using oestrogen replacement therapy may use the LNG-IUS as the progestogenic component for HRT (as well as for contraception).
    - When used for this purpose, the LNG-IUS should be retained for no longer than 5 years after insertion (the licence states 4 years), regardless of the age of the woman at insertion.

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Contraception for women aged over 40 years* [FSRH, 2010c (/contraception-assessment#!references)], and *Drug interactions with hormonal contraception* [FSRH, 2011c (/contraception-assessment#!references)].

How long should contraception be continued at the menopause?

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- **Non-hormonal contraception — copper intrauterine device (Cu-IUD) or barrier methods:**
  - Women younger than 50 years of age should continue contraception for 2 years after the last period.
  - Women aged 50 years or more should continue contraception for 1 year after the last period.
  - The copper intrauterine device (Cu-IUD) can be retained longer during the perimenopause.
    - Women who are aged 40 years or older at the time of Cu-IUD insertion can retain the device until 1 year after the last menstrual period if this occurs when she is over 50 years of age, or until 2 years after the last menstrual period if this occurs when she is younger than 50 years of age, after which the device should be removed.
- **Combined hormonal contraception (CHC) — pill, transdermal patch, or vaginal ring:**
  - Stop CHC at 50 years of age, then switch to:
    - A non-hormonal method and stop after 2 years of amenorrhoea, or
    - The progestogen-only pill (POP), progestogen-only implant, or levonorgestrel intrauterine system (LNG-IUS) and follow advice for these methods.
- **Progestogen-only injectable:**
  - Stop the progestogen-only injectable at 50 years of age, then switch to:
    - A non-hormonal method and stop after 2 years of amenorrhoea, or
    - The POP, progestogen-only implant, or LNG-IUS and follow advice for these methods.
- **POP, progestogen-only implants, or LNG-IUS:**
  - If the woman *is not* amenorrhoeic, continue the method over 55 years of age until she has been amenorrhoeic for 1 year, even if this is beyond the recommened duration (off-label use).
    - Consider investigating any abnormal bleeding or changes in bleeding pattern.
  - If the woman *is* amenorrhoeic, consider one of the following options:
    - For a woman over the age of 50 years, check serum follicle stimulating hormone (FSH) levels on two occasions, with an interval of 6 weeks between tests. If both FSH levels are more than 30 IU/L, stop the POP after a further year.
    - Continue the method until the age of 55 years if required and requested, when natural loss of fertility can be assumed for most women.
  - Women who have the LNG-IUS fitted for the purposes of contraception and/or heavy menstrual bleeding at the age 45 years or more can:
    - If amenorrhoeic, retain the device until the menopause (verified by testing FSH levels), even if this is beyond the recommended duration (off–label use) after which the device should be removed.
    - If not amenorrhoeic, use the LNG-IUS for 7 years (instead of the licensed 5 years) if their bleeding pattern is acceptable (off-label use).
    - For more information, see the CKS topic on Menorrhagia (/menorrhagia).
- Do not use menstrual bleeding patterns alone to determine the menopause when a woman is using hormonal contraception because:
  - Regular bleeding may be due to withdrawal bleeding caused by CHCs.
  - Amenorrhoea may be due to contraceptive hormones (progestogen-only contraception, or the LNG-IUS).
- Advise women who wish to stop hormonal contraception before the age of 50 years to switch to a non-hormonal method of contraception and stop once she has been amenorrhoeic for 2 years (or 3 years if switching from the progestogen-only injectable).

Basis for recommendation

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These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Contraception for women aged over 40 years* [FSRH, 2010c (/contraception-assessment#!references)], *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], *Intrauterine contraception* [FSRH, 2015a (/contraception-assessment#!references)], *Fertility Awareness Methods* [FSRH, 2015c (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Progestogen-only injectables* [FSRH, 2014c (/contraception-assessment#!references)], and *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)].

Scenario: Assessment for specific contraceptive methods

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Natural Family Planning

How should I assess a woman who is considering using fertility awareness-based methods of contraception?

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- Fertility awareness-based methods of contraception are not recommended, as there is limited evidence of efficacy compared to more effective methods. For more information, see the section on How effective are the available contraceptive methods? (/contraception-assessment#!backgroundSub).
- In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering fertility awareness-based methods.
  - **Check the World Health Organization (WHO)** Medical eligibility criteria for contraceptive use (http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1).
    - Fertility awareness-based methods are not covered in the UK Medical Eligibility Criteria.
  - **Ask about conditions or factors that could affect fertility signs**, making the fertility awareness–based methods difficult to use, for example:
    - Any conditions that affect the ovaries or menstrual bleeding (for example stroke, serious liver disease, hyperthyroid, hypothyroid, or cervical cancer).
    - Breastfeeding, postpartum, or recent termination of pregnancy.
    - The use of drugs that affect cervical mucus for example lithium, tricyclic antidepressants, and some antibiotics.
      - If the woman wishes to continue with the fertility awareness-based method, advise her to use basal body temperature, calendar charting, or urine hormone levels methods.
    - Irregular menstrual cycle (especially in younger girls and older women), vaginal bleeding between periods, or heavy or long monthly bleeding. Irregular periods may make predicting fertile times with the calendar charting method very difficult or even impossible.
      - If the woman wishes to continue with the fertility awareness-based method, advise her to use basal body temperature, cervical mucus, or urine hormone level methods.
    - Any infections in the last 3 months (in particular, sexually transmitted infections [STIs], pelvic inflammatory disease [PID], or vaginal infections), as vaginal discharge makes methods which reply on cervical secretions more difficult to use — once an infection is treated and reinfection is avoided, the fertility awareness–based methods can be used more easily.
- For more information on fertility awareness-based methods of contraception, see Scenario: Fertility awareness methods (/contraception-natural-family-planning#!scenario) in the CKS topic on Contraception - natural family planning (/contraception-natural-family-planning).

How should I assess a woman who is considering using the lactational amenorrhoea methods of contraception?

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- In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering the lactational amenorrhoea method (LAM).
  - If the woman has a condition which makes pregnancy an unacceptable health risk, or it is important to her that she does not get pregnant, advise her that the LAM may not be appropriate for her, as alternative contraceptive methods have lower failure rates.
  - Check that the woman meets the criteria for the use of the LAM. Women can use the LAM for the first 6 months after giving birth, provided that all the following conditions are met:
    - Complete amenorrhoea.
    - Fully or very nearly fully breastfeeding — a woman is no longer fully, or nearly fully breastfeeding, if the baby is getting less than 85% of its feeds as breast milk.
    - Six months or less since the birth of the baby.
  - For more information, see the section on the LAM (/contraception-natural-family-planning#!backgroundSubSub:2) in the CKS topic on on Contraception - natural family planning (/contraception-natural-family-planning).
  - Ask about other conditions or factors that could make the LAM difficult or not recommended, for example:
    - The use of drugs that are contraindicated in breastfeeding such as mood-altering drugs, reserpine, ergotamine, antimetabolites, ciclosporin, oral corticosteroids (high doses of more than 40 mg per day), bromocriptine, radioactive drugs, lithium, and anticoagulants.
    - The baby's health. Breastfeeding can be difficult or contraindicated in infants with certain metabolic disorders or congenital deformities of the mouth, jaw, or palate, and in newborns who are in intensive care.
    - The effect of expressing milk on the efficacy of the LAM is not known, but it may be reduced.
    - The woman's health and the presence of any condition in which breastfeeding is not advisable, for example HIV (as it can be transmitted through breast milk), or if she has been advised by a healthcare professional not to breastfeed.
    - For more information on the LAM, see the Scenario: Lactational amenorrhea method (/contraception-natural-family-planning#!scenario:1) in the CKS topic on Contraception - natural family planning (/contraception-natural-family-planning).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Fertility awareness methods* [FSRH, 2015c (/contraception-assessment#!references)] and expert opinion in a medical textbook [Hatcher, 2011 (/contraception-assessment#!references)].

How should I assess a woman who is considering using barrier methods and spermicides?

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In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering using a cervical cap or diaphragm.

- **Conduct a vaginal examination** at the initial fitting of a cap or diaphragm to ensure it is suitable and that it fits correctly.
  - Advise women who are using teratogenic drugs (such as lithium and phenytoin) to consider alternative, more effective methods of contraception (such as progestogen-only injectables or a levonorgestrel intrauterine system [LNG-IUS]).
  - The diaphragm and cervical cap are not suitable before 6 weeks postpartum, or 6 weeks following second trimester termination of pregnancy.
    - Advise women to wait 6 weeks after delivery (or second trimester termination) before using the diaphragm or cervical cap, to allow the uterus to return to its pre-pregnancy size and conditions.
      - A different size of cap or diaphragm may be needed postpartum.
  - The diaphragm and cap are not appropriate for women who:
    - Have very poor vaginal muscle tone (this may be a contraindication for the diaphragm).
    - Have a shallow pubic ledge (this applies to the diaphragm only).
    - Have an abnormality of the vagina.
    - Cannot touch their genital area with comfort
    - Have a cervix in a position that makes it difficult to fit.
- In young women and women with special needs, the diaphragm and cervical cap may not be appropriate, given their higher failure rates compared with other methods.
- For more information on barrier methods and spermicides, see the CKS topic on Contraception - barrier methods and spermicides (/contraception-barrier-methods-and-spermicides).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Barrier methods for contraception and STI prevention* [FSRH, 2015b (/contraception-assessment#!references)].

How should I assess someone who is considering sterilization?

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In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for people considering sterilization.

- **Check the World Health Organization (WHO) Medical Eligibility Criteria for contraceptive use** to ensure that sterilization is a suitable choice for the person**.**
- **Assess the person's:**
  - **Mental capacity** to make the decision.
    - If there is any doubt about their mental capacity, seek advice from appropriately experienced colleagues (such as a specialist in learning disabilities).
  - **Level of understanding** of the advantages, disadvantages, procedures involved, and relative failure rates of a vasectomy or tubal occlusion.
    - Offer alternative long-term reversible methods of contraception such as hormonal methods (combined hormonal contraceptives, progestogen-only contraceptives) or intrauterine methods.
  - **Risk for later regret**. Take additional care when counselling people who are:
    - Younger than 30 years of age.
    - Without children.
    - Taking decisions during pregnancy.
    - Taking decisions in reaction to the end of a relationship.

    - Possibly at risk of coercion by their partner, family, or health or social welfare professionals.
  - **Cultural, religious, psychosocial, psychosexual, and psychological issues.**
- **Also assess** their partner's suitability for sterilization, as the couple's clinical history, present symptoms, or abnormal examination findings may influence which partner goes forward to have sterilization. For example:
  - Vasectomy for the man may be preferable if:
    - The woman has any contraindication to general anaesthesia.
    - The woman has had previous abdominal or pelvic surgery — this increases the relative risk of complications and the need for a laparotomy.
  - Tubal occlusion for the woman may be preferable.
    - If a past history of genital or scrotal surgery in the man increases the risk of complications of vasectomy.
  - A hysterectomy may be an alternative if significant gynaecological pathology, such as large fibroids or a prolapse, is present.
- **Perform a scrotal examination** for a man requesting vasectomy to exclude potential problems (for example, a large varicocele or hydrocele may mean that the *vas deferens* is more difficult to palpate and general anaesthesia is required).
- **Perform a bimanual pelvic examination** on a woman requesting tubal occlusion.
- For more information on sterilization, see the CKS topic on Contraception - sterilization (/contraception-sterilization).

Basis for recommendation Back to top

These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Male and female sterilisation* [FSRH, 2014a (/contraception-assessment#!references)].

Progestogen-only contraception Back to top

How should I assess a woman considering taking the progestogen-only pill? Back to top

In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering the progestogen-only pill (POP).

- **Check the UK Medical Eligibility Criteria** to ensure that the woman can safely use a POP.
  - The only UKMEC 4 condition for the POP is current breast cancer.
  - The POP should only be used after consultation with an expert (UKMEC 3) in women with a history of breast cancer and no evidence of recurrence for 5 years, women taking liver enzyme-inducing drugs such as rifampicin, and women with a new diagnosis of ischaemic heart disease while using the POP for example.
- **Check the woman's cervical screening history** to ensure that she has attended routine screening appointments.
- For more information about the POP, see Scenario: Progestogen-only pill (/contraception-progestogen-only-methods#!scenario) in the CKS topic on Contraception - progestogen-only methods (/contraception-progestogen-only-methods).

How should I assess a woman considering using a progestogen-only implant? Back to top

In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering the progestogen-only implant.

- **Check the UK Medical Eligibility Criteria** to ensure that the woman can safely use a progestogen-only implant.
  - The only UKMEC 4 condition for the progestogen-only implant is current breast cancer.
  - The progestogen-only implant should only be used after consultation with an expert (UKMEC 3), for example in women with a history of breast cancer and no evidence of recurrence for 5 years, women with liver tumours (benign and malignant), and women with unexplained vaginal bleeding (before evaluation).
- **Check the woman's cervical screening history** to ensure that she has attended routine screening appointments.
- For more information on the progestogen-only implant, see Scenario: Progestogen-only implant (/contraception-progestogen-only-methods#!scenario:1) in the CKS topic on Contraception - progestogen-only methods (/contraception-progestogen-only-methods).

Progestogen-only injectable Back to top

In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering a progestogen-only injectable.

- **Check the UK Medical Eligibility Criteria** to ensure that the woman can safely use a progestogen-only injectable.
  - The only UKMEC 4 condition for the progestogen-only injectable is current breast cancer.
  - The progestogen-only injectable should only be used after consultation with an expert (UKMEC 3), in women with a history of:
    - Breast cancer and no evidence of recurrence for 5 years.
    - Multiple risk factors for arterial cardiovascular disease (for example older age, smoking, diabetes, and hypertension).
    - Vascular disease, including angina or other ischaemic heart disease, intermittent claudication, hypertensive retinopathy, stroke, or transient ischaemic attack.
- **Check the woman's cervical screening history** to ensure that she has attended routine screening appointments.
- **Assess the woman's risk of osteoporosis.**
  - Consider other methods of contraception for women:
    - Aged under 18 years of age (consider the depot medroxyprogesterone acetate [DMPA] injection only if all other methods of contraception are unsuitable or unacceptable).
    - With significant risk factors for osteoporosis. For more information, see the CKS topic on Osteoporosis - prevention of fragility fractures (/osteoporosis-prevention-of-fragility-fractures).
  - Review the risks and benefits of DMPA injection at least every 2 years, and decide whether treatment can be continued. For more information, see the section on risk factors (/osteoporosis-prevention-of-fragility-fractures#!backgroundSub:4) in the CKS topic on Osteoporosis - prevention of fragility fractures (/osteoporosis-prevention-of-fragility-fractures).
  - For more information on the progestogen-only injectable, see Scenario: Progestogen-only injectables (/contraception-progestogen-only-methods#!scenario:2) in the CKS topic on Contraception - progestogen-only methods (/contraception-progestogen-only-methods).

Basis for recommendation

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Progestogen-only pills

- These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Progestogen–only pills* [FSRH, 2015d (/contraception-assessment#!references)], *Quick starting contraception*, [FSRH, 2010a (/contraception-assessment#!references)] and the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)].

Progestogen-only implants

- These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Quick start contraception* [FSRH, 2010a (/contraception-assessment#!references)], the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)] and the National Institute for Health and Care Excellence (NICE) guidance *Long-acting reversible contraception* [NICE, 2014 (/contraception-assessment#!references)].

Progestogen-only injectables

- These recommendations are based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline Progestogen-only injectable [FSRH, 2014c (/contraception-assessment#!references)], the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], and the National Institute for Health and Care Excellence (NICE) guidance *Long-acting reversible contraception* [NICE, 2014 (/contraception-assessment#!references)].

How should I assess a woman's suitability for combined hormonal contraception (CHC)?

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In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering combined hormonal contraception (CHC).

- **Check the UK Medical Eligibility Criteria**
  - CHC is contraindicated due to unacceptable health risks (UKMEC 4) in women with current breast cancer, women who are breastfeeding and are less than 6 weeks postpartum, and women aged 35 years or more and smoking 15 or more ciga

- CHC should only be used after consultation with an expert (UKMEC 3) in women with a history of breast cancer and no evidence of recurrence for 5 years, woman taking liver enzyme-inducing drugs such as rifampicin, and women with BMI greater than 35 kg/m^2.
- For a full list of UKMEC 4 and UKMEC 3 categories, see the UK Medical Eligibility Critera for contraceptive use (https://www.fsrh.org/standards-and-guidance/uk-medical-eligibility-criteria-for-contraceptive-use/).

- **Enquire specifically about:**
  - Migraine.
  - Cardiovascular risk factors such as smoking, obesity, hypertension, previous venous thromboembolism, hyperlipidaemia, and thrombophilia.
  - Past and current medical conditions.
  - Family history.
- For more information on combined oral contraceptives, see the CKS topic on Contraception - combined hormonal methods (/contraception-combined-hormonal-methods).

Basis for recommendation Back to top

These recommendations are based mainly on the Faculty of Sexual and Reproductive Healthcare clinical guidelines *Combined hormonal contraception* [FSRH, 2011d (/contraception-assessment#!references)] and the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)].

How should I assess a woman's suitability to use the levonorgestrel intrauterine system (LNG-IUS) or the copper intrauterine device (Cu-IUD)?

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In addition to a general assessment to decide on a suitable method of contraception, the following specific assessment is advised for women considering using a levonorgestrel intrauterine device (LNG-IUS) or a copper intrauterine device (Cu-IUD).

- **Exclude pregnancy.** If pregnancy is possible, do not insert intrauterine contraception (IUC). Advise the woman to use a barrier method (such as condoms) until pregnancy can be excluded.
  - If the woman does not wish to use a barrier method of contraception, consider one of the following options:
    - Combined hormonal contraception (pill, patch, or vaginal ring).
    - Progestogen-only pill.
    - Progestogen-only implant.
    - Progestogen-only injectable — if other methods are not appropriate or acceptable.
- **Check the UK Medical Eligibility Criteria** to ensure that IUC is suitable. This will require information from the medical record, clinical history, and clinical examination, which should include bimanual pelvic examination.
  - IUC is a safe option in most women, however it:
    - Is contraindicated (UKMEC 4) in women with current breast cancer (LNG-IUS only), pelvic inflammatory disease, or unexplained vaginal bleeding.
    - Should be used with caution, and after consultation with an expert (UKMEC 3), for example in women with uterine fibroids with distortion of the uterine cavity or women with a history of breast cancer and no evidence of recurrence for 5 years (LNG-IUS only).
- **Assess the woman's risk of sexually transmitted infections** (STIs) and, when appropriate, advise testing, promote safer sex, and/or refer for sexual health counselling.
  - If the woman is at increased risk of STIs:
    - Test for *Chlamydia trachomatis* and, in women from areas where gonorrhoea is prevalent, test for *Neisseria gonorrhoeae*. In asymptomatic women, there is no need to wait for the results or to provide antibiotic prophylaxis before inserting the IUC, provided the woman can be contacted and treated if the test is positive. For more information, see the CKS topics on Chlamydia - uncomplicated genital (/chlamydia-uncomplicated-genital) and Gonorrhoea (/gonorrhoea).
    - Counsel her (or arrange for counselling) about safe sexual practices.
    - Review her decision for choice of contraception, and discuss alternative contraceptive methods or recommend correct and consistent use of condoms with the LNG-IUS.
  - If the woman requests testing for STIs, perform testing before inserting the device. There is no need to wait for the results or to provide antibiotic prophylaxis before inserting the IUD, provided the woman can be contacted and treated if the test is positive.
    - If the woman has symptoms of a possible STI, and/or pelvic inflammatory disease (PID), delay IUC insertion and offer a bridging method of contraception if necessary.
- **If the woman has unexplained vaginal bleeding** that suggests an underlying medical condition (such as bleeding between periods or after sexual intercourse):

- Do not insert the LNG-IUS until the cause of bleeding has been diagnosed.
- Offer an alternative method of contraception.

- For more information on the LNG-IUS and the Cu-IUD, see Scenario: Levonorgestrel intrauterine system (/contraception-iusiud#!scenario) and Scenario: Copper intrauterine device (/contraception-iusiud#!scenario:1) in the CKS topic on Contraception - IUS/IUD (/contraception-iusiud).

Basis for recommendation Back to top

These recommendations are based mainly on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guideline *Intrauterine contraception* [FSRH, 2015a (/contraception-assessment#!references)], the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)] and the National Institute for Health and Care Excellence guideline *Long–acting reversible contraception* [NICE, 2014 (/contraception-assessment#!references)].

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Search strategy

Scope of search

A literature search was conducted for guidelines, systematic reviews and randomized controlled trials on primary care management of contraception - assessment.

Search dates

December 2011 - September 2016

Key search terms

Various combinations of searches were carried out. The terms listed below are the core search terms that were used for Medline.

- exp contraception/

Sources of guidelines

- National Institute for Health and Care Excellence (NICE) (https://www.nice.org.uk/)
- Scottish Intercollegiate Guidelines Network (SIGN) (https://www.sign.ac.uk/)
- Royal College of Physicians (https://www.rcplondon.ac.uk/)
- Royal College of General Practitioners (https://www.rcgp.org.uk/)
- Royal College of Nursing (https://www.rcn.org.uk/)
- NICE Evidence (https://www.evidence.nhs.uk/)
- World Health Organization (https://www.who.int/)
- Guidelines International Network (https://www.g-i-n.net/)
- TRIP database (http://www.tripdatabase.com/)
- Agency for Healthcare Research and Quality (https://www.ahrq.gov/)
- Institute for Clinical Systems Improvement (https://www.icsi.org/)
- National Health and Medical Research Council (Australia) (https://www.nhmrc.gov.au/research-policy)
- Royal Australian College of General Practitioners (https://www.racgp.org.au/clinical-resources/clinical-guidelines)
- British Columbia Medical Association (https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines)
- Canadian Medical Association (https://www.cma.ca/)
- Alberta Medical Association (http://www.topalbertadoctors.org/cpgs/)
- Michigan Quality Improvement Consortium (http://mqic.org/guidelines.htm)
- Singapore Ministry of Health (https://www.moh.gov.sg/resources-statistics)
- National Resource for Infection Control (https://www.nric.org.uk/)
- Patient UK Guideline links (https://patient.info/patientplus)
- RefHELP NHS Lothian Referral Guidelines (https://apps.nhslothian.scot/refhelp)
- Medline (with guideline filter)
- Driver and Vehicle Licensing Agency (https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals)
- NHS Health at Work (http://www.nhshealthatwork.co.uk/oh-guidelines.asp) (occupational health practice)

Sources of systematic reviews and meta-analyses

- The Cochrane Library (https://www.cochranelibrary.com/):
  - Systematic reviews
  - Protocols
  - Database of Abstracts of Reviews of Effects
- Medline (with systematic review filter)
- EMBASE(with systematic review filter)

Sources of health technology assessments and economic appraisals

- NIHR Health Technology Assessment programme (https://www.nihr.ac.uk/funding-and-support/funding-for-research-studies/funding-programmes/health-technology-assessment/)
- The Cochrane Library (https://www.cochranelibrary.com/):
  - NHS Economic Evaluations
  - Health Technology Assessments
- Canadian Agency for Drugs and Technologies in Health (https://www.cadth.ca/)
- International Network of Agencies for Health Technology Assessment (http://www.inahta.org/)

Sources of randomized controlled trials

- The Cochrane Library (https://www.cochranelibrary.com/):
  - Central Register of Controlled Trials
- Medline (with randomized controlled trial filter)
- EMBASE (with randomized controlled trial filter)

Sources of evidence based reviews and evidence summaries

- Bandolier (http://www.bandolier.org.uk/)
- Drug and Therapeutics Bulletin (https://dtb.bmj.com/)
- TRIP database (http://www.tripdatabase.com/)
- Central Services Agency COMPASS Therapeutic Notes (http://www.medicinesni.com/index.asp)

Sources of national policy

- Department of Health (https://www.gov.uk/government/organisations/department-of-health-and-social-care)
- Health Management Information Consortium (HMIC)

Patient experiences

- Healthtalk (http://www.healthtalk.org/)
- BMJ - Patient Journeys (https://www.bmj.com/specialties/patient-journeys)
- Patient.co.uk - Patient Topics (https://patient.info/health)

Sources of medicines information

The following sources are used by CKS pharmacists and are not necessarily searched by CKS information specialists for all topics. Some of these resources are not freely available and require subscriptions to access content.

- British National Formulary (https://bnf.nice.org.uk/) (BNF)
- electronic Medicines Compendium (https://www.medicines.org.uk/emc) (eMC)
- European Medicines Agency (https://www.ema.europa.eu/en) (EMEA)
- LactMed (https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm)
- Medicines and Healthcare products Regulatory Agency (https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency) (MHRA)
- REPROTOX (http://www.reprotox.org/)
- Scottish Medicines Consortium (https://www.scottishmedicines.org.uk/home)
- Stockley's Drug Interactions (https://about.medicinescomplete.com/publication/stockleys-drug-interactions/)
- TERIS (http://depts.washington.edu/terisdb/terisweb/index.html)

- TOXBASE (https://www.toxbase.org/)
- Micromedex (https://www.micromedexsolutions.com/home/dispatch)
- UK Medicines Information (https://www.ukmi.nhs.uk/)

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Stakeholder engagement

Our policy

The external review process is an essential part of CKS topic development. Consultation with a wide range of stakeholders provides quality assurance of the topic in terms of:

- Clinical accuracy.
- Consistency with other providers of clinical knowledge for primary care.
- Accuracy of implementation of national guidance (in particular NICE guidelines).
- Usability.

Principles of the consultation process

- The process is inclusive and any individual may participate.
- To participate, an individual must declare whether they have any competing interests or not. If they do not declare whether or not they have competing interests, their comments will not be considered.
- Comments received after the deadline will be considered, but they may not be acted upon before the clinical topic is issued onto the website.
- Comments are accepted in any format that is convenient to the reviewer, although an electronic format is encouraged.
- External reviewers are not paid for commenting on the draft topics.
- Discussion with an individual or an organization about the CKS response to their comments is only undertaken in exceptional circumstances (at the discretion of the Clinical Editor or Editorial Steering Group).
- All reviewers are thanked and offered a letter acknowledging their contribution for the purposes of appraisal/revalidation.
- All reviewers are invited to be acknowledged on the website.All reviewers are given the opportunity to feedback about the external review process, enabling improvements to be made where appropriate.

Stakeholders

- Key stakeholders identified by the CKS team are invited to comment on draft CKS topics. Individuals and organizations can also register an interest to feedback on a specific topic, or topics in a particular clinical area, through the Getting involved (http://cks.clarity.co.uk/get-involved/) section of the Clarity Informatics (https://clarity.co.uk/) website.
- Stakeholders identified from the following groups are invited to review draft topics:
  - Experts in the topic area.
  - Professional organizations and societies(for example, Royal Colleges).
  - Patient organizations, Clarity has established close links with groups such as Age UK and the Alzheimer's Society specifically for their input into new topic development, review of current topic content and advice on relevant areas of expert knowledge.
  - Guideline development groups where the topic is an implementation of a guideline.
  - The British National Formulary team.
  - The editorial team that develop MeReC Publications.
- Reviewers are provided with clear instructions about what to review, what comments are particularly helpful, how to submit comments, and declaring interests.

Patient engagement

Clarity Informatics has enlisted the support and involvement of patients and lay persons at all stages in the process of creating the content which include:

- Topic selection
- Scoping of topic
- Selection of clinical scenarios
- First draft internal review
- Second draft internal review
- External review

- Final draft and pre-publication

Our lay and patient involvement includes membership on the editorial steering group, contacting expert patient groups, organizations and individuals.

Evidence exclusion criteria

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Our policy

Scoping a literature search, and reviewing the evidence for CKS is a methodical and systematic process that is carried out by the lead clinical author for each topic. Relevant evidence is gathered in order that the clinical author can make fully informed decisions and recommendations. It is important to note that some evidence may be excluded for a variety of reasons. These reasons may be applied across all CKS topics or may be specific to a given topic.

Studies identified during literature searches are reviewed to identify the most appropriate information to author a CKS topic, ensuring any recommendations are based on the best evidence. We use the principles of the GRADE and PICOT approaches to assess the quality of published research. We use the principles of AGREE II to assess the quality of published guidelines.

Standard exclusions for scoping literature:

- Animal studies
- Original research is not written in English

Possible exclusions for reviewed literature:

- Sample size too small or study underpowered
- Bias evident or promotional literature
- Population not relevant
- Intervention/treatment not relevant
- Outcomes not relevant
- Outcomes have no clear evidence of clinical effectiveness
- Setting not relevant
- Not relevant to UK
- Incorrect study type
- Review article
- Duplicate reference

Organizational, behavioural and financial barriers

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Our policy

The CKS literature searches take into consideration the following concepts, which are discussed at the initial scoping of the topic.

- Feasibility
  - Studies are selected depending on whether the intervention under investigation is available in the NHS and can be practically and safely undertaken in primary care.
- Organizational and Financial Impact Analysis
- Studies are selected and evaluated on whether the intervention under investigations may have an impact on local clinical service provision or national impact on cost for the NHS. The principles of clinical budget impact analysis are adhered to, evaluated and recorded by the author. The following factors are considered when making this assessment and analysis.
  - Eligible population
  - Current interventions
  - Likely uptake of new intervention or recommendation
  - Cost of the current or new intervention mix
  - Impact on other costs
  - Condition-related costs
  - In-direct costs and service impacts

    - Time dependencies
- Cost-effectiveness or cost-benefit analysis studies are identified where available.

We also evaluate and include evidence from NICE accredited sources which provide economic evaluations of recommendations, such as NICE guidelines. When a recommended action may not be possible because of resource constraints, this is explicitly indicated to healthcare professionals by the wording of the CKS recommendation.

Declarations of interest

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Our policy

Clarity Informatics requests that all those involved in the writing and reviewing of topics, and those involved in the external review process to declare any competing interests. Signed copies are securely held by Clarity Informatics and are available on request with the permission of the individual. A copy of the declaration of interest form which participants are asked to complete annually is also available on request. A brief outline of the declarations of interest policy is described here and full details of the policy is available on the Clarity Informatics website (https://cks.clarity.co.uk/). Declarations of interests of the authors are not routinely published, however competing interests of all those involved in the topic update or development are listed below. Competing interests include:

- Personal financial interests
- Personal family interest
- Personal non-financial interest
- Non-personal financial gain or benefit

Although particular attention is given to interests that could result in financial gains or losses for the individual, competing interests may also arise from academic competition or for political, personal, religious, and reputational reasons.An individual is not obliged to seek out knowledge of work done for, or on behalf of, the healthcare industry within the departments for which they are responsible if they would not normally expect to be informed.

Who should declare competing interests?

Any individual (or organization) involved in developing, reviewing, or commenting on clinical content, particularly the recommendations should declare competing interests. This includes the authoring team members, expert advisers, external reviewers of draft topics, individuals providing feedback on published topics, and Editorial Steering Group members. Declarations of interest are completed annually for authoring team and editorial steering group members, and are completed at the start of the topic update and development process for external stakeholders.

Competing interests declared for this topic:

None.

Contraception - assessment: Summary

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- An assessment should be carried out on all women requesting contraception to identify any relevant medical conditions or medication that could affect her choice of contraceptive method.
- The UK Medical Eligibility Criteria (UKMEC) should be checked to ensure that the preferred method is not contraindicated.
    - If the woman is considering sterilization, or natural family planning, the World Health Organization Medical Eligibility Criteria should be checked, as these methods are not covered by the UKMEC.
- Factors which should be considered when deciding upon a method of contraception include:
    - Comorbidities and other conditions — cardiovascular disease (CVD) risk factors; diabetes mellitus; epilepsy; headache or migraine; hypertension; menorrhagia; fibroids; previous ectopic pregnancy; obesity; sexually transmitted infections (STIs) or pelvic inflammatory disease (PID); smoking; and venous thromboembolism (VTE).
    - Concurrent medication — liver enzyme-inducing drugs (such as medicines for epilepsy, anti-retrovirals and St John's Wort) can affect some forms of contraception.
        - If the woman is taking teratogenic drugs (for example lithium or warfarin), more effective methods of contraception should be used (such as a progestogen-only implant, or intrauterine contraception).
    - Age of the woman — if approaching the menopause or under 18 years.
- Pregnancy should be excluded — any suitable method of contraception can then be considered.

- If pregnancy cannot be excluded (for example, following emergency contraception) but the woman wishes to start contraception without delay, one of the following options can be considered:
  - Combined oral contraceptives (COCs), combined transdermal patch (CTP) or combined vaginal ring (CVR).
  - Progestogen-only pill (POP).
  - Progestogen-only implant.
  - Progestogen-only injectables — if other methods are not appropriate or acceptable.
  - A pregnancy test should be performed no sooner than 3 weeks after the last episode of unprotected sex.
- The woman's risk of sexually transmitted infections (STIs) should be assessed and advice about safe sex should be given when appropriate.
- Choice of contraception should take into account the woman's preferences and her:
  - Requirements for contraception, including future plans for having children, and the attitudes of her partner and her family towards contraception.
  - Personal beliefs and views about contraception.
  - Understanding of her preferred method, its efficacy, risks and adverse effects, advantages and disadvantages, and how to use it.
- Advice should be offered on long-acting reversible contraception (copper intrauterine device, levonorgestrel intrauterine system, progestogen-only injectables, progestogen-only implant, and the combined vaginal ring).
- Girls younger than 16 years of age should be assessed for their competency to independently consent to treatment, and it should be documented in the case notes whether or not she meets the Fraser Criteria.
- A young person's competence to consent to treatment can be assessed by her ability to:
  - Understand the information provided, and
  - Weigh up the risks and benefits, and
  - Express her own wishes.
- Young people should be assured that the consultation is confidential and informed of the circumstances in which confidentiality may need to be breached (for example, suspected child protection issues, exploitation, or coercion).
- Women with learning and/or physical disabilities should be supported in making their own decisions about contraception.

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Have I got the right topic?

From age 13 years to 60 years.

This CKS topic is based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], *Male and female sterilization* [FSRH, 2014a (/contraception-assessment#!references)], *Intrauterine contraception* [FSRH, 2015a (/contraception-assessment#!references)], *Barrier methods for contraception and STI prevention [FSRH, 2015b (/contraception-assessment#!references)]*, *Fertility awareness methods* [FSRH, 2015c (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Progestogen-only injectable contraception* [FSRH, 2014c (/contraception-assessment#!references)], *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)], the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) *Decision-making tool for family planning clients and providers* [WHO, 2005 (/contraception-assessment#!references)], and expert opinion in a medical textbook [Hatcher, 2011 (/contraception-assessment#!references)].

This CKS topic covers the assessment of women for various methods of contraception, including those with comorbidities or special situations, those under 18 years of age, and women approaching the menopause.

This CKS topic does not cover the assessment of women requesting emergency contraception.

There are separate CKS topics on Contraception - barrier methods and spermicides (/contraception-barrier-methods-and-spermicides), Contraception - combined hormonal methods (/contraception-combined-hormonal-methods), Contraception - emergency (/contraception-emergency), Contraception - IUS/IUD (/contraception-iusiud), Contraception - natural family planning (/contraception-natural-family-planning), Contraception - progestogen-only methods (/contraception-progestogen-only-methods), Contraception - sterilization (/contraception-sterilization), Infertility (/infertility), Menorrhagia (/menorrhagia), and Pre-conception - advice and management (/pre-conception-advice-and-management).

The target audience for this CKS topic is healthcare professionals working within the NHS in the UK, and providing first contact or primary healthcare.

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How up-to-date is this topic?

- Changes
- Update

Goals and outcome measures

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- Goals
- Outcome measures
- Audit criteria
- QOF indicators
- QIPP - Options for local implementation
- NICE quality standards

Background information

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- Comparative effectiveness of contraceptive methods
- Available contraceptive methods in the UK

Management

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- **Scenario: Issues to discuss and consider (/contraception-assessment#!scenario):** covers the general principles of how to help a woman choose a method of contraception that is suitable for her and her partner, safe sex advice, and advice about assessing the risk of sexually transmitted infections. It also includes information on how to be reasonably sure that a woman is not pregnant, and ethical and legal issues around prescribing contraception for girls under the age of 16 years, or for women with learning disabilities.
- **Scenario: Comorbidities and special situations (/contraception-assessment#!scenario:1):** covers common situations that can influence the choice of contraceptive such as breastfeeding; postpartum; menorrhagia; diabetes; epilepsy; headache and migraine; hypertension; obesity; sexually transmitted infection; smoking; the presence of multiple risk factors for cardiovascular disease; and venous thromboembolism.
- **Scenario: Prescribing to young people (/contraception-assessment#!scenario:2):** covers the choice of contraception for girls aged under 18 years.
- **Scenario: Approaching the menopause (/contraception-assessment#!scenario:3):** covers the choice of contraceptive for perimenopausal women, and the duration of contraception in this age group.
- **Scenario: Assessment for specific contraceptive methods (/contraception-assessment#!scenario:4):** covers additional assessment and considerations required for women considering a specific method. This includes natural family planning; sterilization; progestogen-only contraception; combined hormonal contraception; and intrauterine contraception.

Supporting evidence

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This CKS topic is based on the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical guidelines *Combined hormonal contraception* [FSRH, 2012 (/contraception-assessment#!references)], *Male and female sterilization* [FSRH, 2014a (/contraception-assessment#!references)], *Intrauterine contraception* [FSRH, 2015a (/contraception-assessment#!references)], *Barrier methods for contraception and STI prevention* [FSRH, 2015b (/contraception-assessment#!references)], *Fertility Awareness Methods* [FSRH, 2015c (/contraception-assessment#!references)], *Progestogen-only implants* [FSRH, 2014b (/contraception-assessment#!references)], *Progestogen-only injectables* [FSRH, 2014c (/contraception-assessment#!references)], *Progestogen-only pills* [FSRH, 2015d (/contraception-assessment#!references)], the *UK Medical Eligibility Criteria for contraceptive use* [FSRH, 2016 (/contraception-assessment#!references)], the World Health Organization (WHO) *Decision-making tool for family planning clients and providers* [WHO, 2005 (/contraception-assessment#!references)], and expert opinion in a medical textbook [Hatcher, 2011 (/contraception-assessment#!references)].

How this topic was developed

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This section briefly describes the processes used in developing and updating this topic. Further details on the full process can be found in the About Us (http://cks.nice.org.uk/development) section and on the Clarity Informatics (https://clarity.co.uk/) website.

References

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